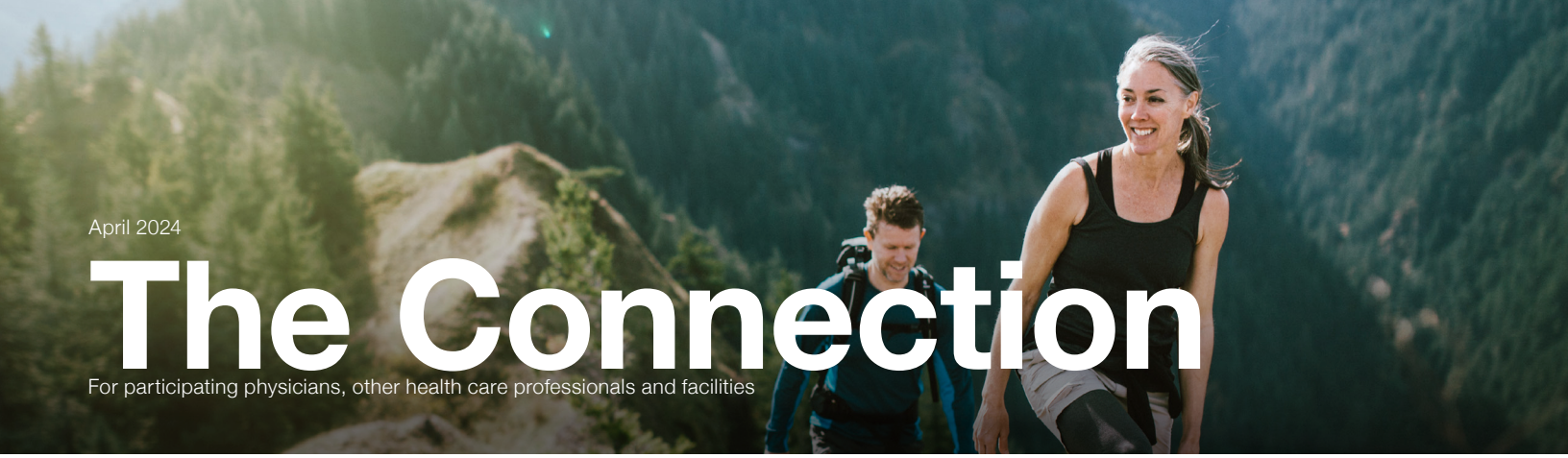


April 2024

The Connection

For participating physicians, other health care professionals and facilities

National Healthcare Decisions Day

National Healthcare Decisions Day, observed annually on April 16, aims to inspire, educate and empower all of us to share our preferences for medical treatment should an unexpected illness occur. We encourage you to begin or continue advance care planning (ACP) conversations with all your patients as part of the preventive and treatment services you provide.

We reimburse providers who bill for ACP conversations with members, regardless of age or health status.

ACP conversations may include:

- Designating a medical decision-maker
- Discussing current medical status and prognosis
- Discussing important personal elements that often influence treatment choices (e.g., personal values, social, cultural and spiritual beliefs)
- Reviewing, editing or creating documents, such as an advance directive, durable power of attorney or POLST/MOLST form

To support our Medicare Advantage members, we cover ACP conversations (CPT 99497 or 99498) at no cost share ($0 copay), regardless of the visit type or place of service:

- This benefit enhancement applies to telehealth appointments (conducted via audio and video) and in-person visits.
- To ensure members feel supported in having these conversations with their provider, the benefit covers one ACP conversation per day with no annual limit.

Continued on page 3

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
- ● Dental
- ♥ Cardiovascular
- ★ 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. 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.

Continued from page 1

If you participate in our Medicare Advantage Quality Incentive Program (QIP), you can earn an incentive by having an ACP conversation with your attributed Asuris Medicare Advantage patients and submitting a claim with CPT 99497, 99483 or CPTII 1123F, 1124F, 1158F or HCPCS S0257. **Note**: To support gap closure for this measure, we will continue to allow you to report CPT II codes with visits where your patient's wishes may only require a review and not a full conversation that justifies reporting CPT 99497. **Related**: See *Medicare Advantage QIP reminders* on pages 19-20.

Serious Illness Messaging Toolkit

Terms like hospice, palliative care and advance care planning can be confusing to patients. The Serious Illness Messaging Toolkit includes tips for how to talk about serious illness using evidence-based research. The toolkit is available at **seriousillnessmessaging.org/using-the-toolkit**.

Vynca supports members facing serious illness diagnoses

Vynca is a telehealth palliative care provider that focuses on addressing physical, emotional and social impacts of a disease. It's in network for commercial and Medicare Advantage members. Vynca doesn't replace traditional medical care; its specialists collaborate with a member's established PCP to offer additional care coordination and support tailored for serious illness. Vynca's providers must be licensed in the state in which the member resides.

Vynca uses telehealth (phone and video), which allows for more accessibility, and they coordinate closely with each member's established care team. Its providers focus on empowering those living with a disease and mitigating ongoing symptoms in the comfort of their own home. Depending on a member's diagnosis, Vynca will coordinate and connect them with a range of palliative care physicians, as well as nursing and social service providers, who know their care plan. Services are available 24 hours a day.

Learn more and access Vynca services by visiting **vyncacare.com** or by calling 1 (888) 227-8884.

Other resources

Visit our provider website for more information and resources: Programs>Medical Management> Personalized Care Support. You'll find links to the following:

- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversationproject.org**
- Vital Talk: **vitaltalk.org**

Center to Advance Palliative Care (CAPC) membership offer

Asuris is offering one year of online training from CAPC at no cost for participating providers interested in developing their advance care planning and palliative care teams. This national organization is dedicated to increasing the availability of quality, equitable health care for people living with serious illness. CAPC offers more than 500 online courses and tools that can be filtered by topic, practice area or discipline. To learn more and register for this opportunity to earn free continuing education credits, email **DL-PersonalizedCareSupport@asuris.com**.

Are you?

- ☑ **Scheduling visits with your Medicare Advantage patients**: It's time to schedule annual wellness visits (AWVs) or preventive care visits (PCVs) with your Medicare Advantage patients. **Related**: See *Medicare Advantage QIP preventive care visits bonus* on page 21.
- ☑ **Helping your patients understand where to go for care**: To help your patients save time and money, we encourage you to remind them about their care options before they need sudden medical care. **Related**: See *Connect patients to the right care at the right time* on page 14.
- ☑ **Registered for Availity Essentials**: Access eligibility, benefits, claims-related information and more. You can submit your medical pre-authorization requests electronically using Availity Essentials. Register today at **availity.com**.

PRIA offers financial and quality data on your terms

We will soon launch our Provider Reporting Insights & Analytics (PRIA) platform. 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. PRIA will be available to providers on alternative payment model (APM) arrangements with more than 1,000 attributed members.

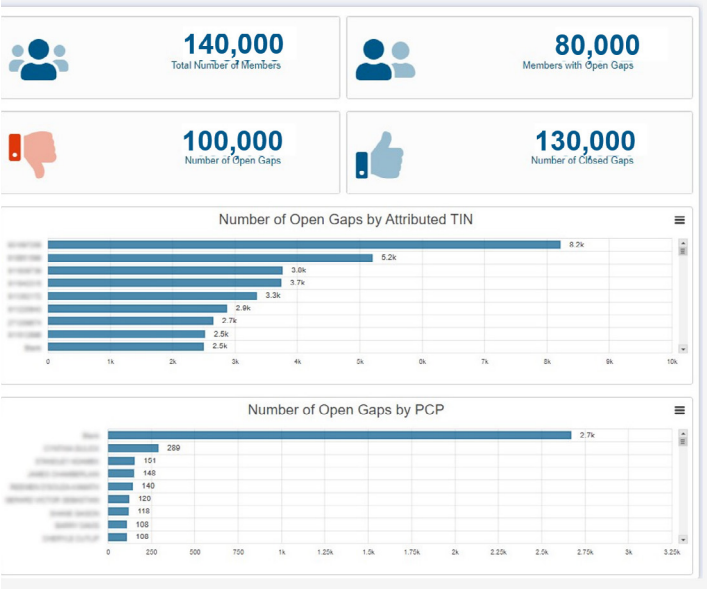
PRIA can help you create and execute data-driven interventions for care gaps that improve quality while reducing the total cost of care—ultimately improving your financial and quality performance.

A tool for your entire organization. PRIA's self-service reporting allows you to create, filter, download and share information across your organization. Whether you have a team of analysts, are a member of a care team or simply an end user viewing reports, PRIA's ease of navigation and sophisticated data allows anyone to decide how much information they want, and how deep they want to dive.

Access information at your convenience. Not only does PRIA reduce the delay in obtaining actionable data compared to similar reporting available today, but you can access your information how and when your schedule allows, instead of waiting on our staff to provide this information to you. Some reports, such as monthly quality reports, can even be scheduled to run automatically at your preferred cadence.

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

Dashboard preview



The following self-service reports will be available at launch:

Report name	Description
Clinical Identification	High-risk and actionable members
Cost and Utilization Variance	Cost and utilization trends by service categories: Allowed per member per month (PMPM), unit cost and utilization/1000
ER Utilizers	Members with emergency room (ER) opportunity (high risk, avoidable visit, frequent utilizers)
Financial Trend Estimates	Commercial financial estimates for Total Care and Accountable Health Network (AHN) agreements
IP Utilizers	Members with inpatient opportunity (high risk, avoidable visits, readmissions)
Overview of Population	Population overview with high-level member counts by attribution, age and gender
Quality Contract Summary	Commercial quality program scores for Total Care and AHN agreements
Quality Gaps	Healthcare Effectiveness Data and Information Set (HEDIS®) quality gaps for commercial Total Care and AHN agreements
Savings Opportunity	Areas with cost-saving improvement opportunities within key standard areas and subcategories: avoidable ER, drug switch, imaging, injectable drugs, avoidable admits, and surgery

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

Join us for a webinar to improve patient experience

We recognize that access to care and its impacts on patient experience are a challenge across the health care industry. We have partnered with Press Ganey Consulting to offer a free webinar series, providing best-in-class insights, tools and techniques to improve patient experience. 1.0-hour continuing education (CE) will be available.

Redefining Access to Improve Patient Experience

- The webinar will cover the following topics:
- Redefining access to improve quality and experience
- Providing access throughout the patient journey
- Setting expectations to support access to care for both PCP and specialty care
- Specific interventions that promote access beyond traditional face-to-face appointments
- Applying tactics that can be implemented starting your next day at the office

Join us for a 60-minute webinar on one of the following dates:

- April 5, 2024, noon (PT) Register
- June 7, 2024, noon (PT) Register
- August 2, 2024, noon (PT) Register

We are excited to offer this opportunity and hope you can join.

Administrative Manual updates

The following updates were made to our manual on April 1, 2024:

Medicare Advantage Plans

- Added Cultural Competency requirements

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

Medicare risk adjustment reviews starting

In May 2024, we will begin requesting and reviewing medical records to support the diagnosis data we submit to the Centers for Medicare & Medicaid Services (CMS). The dates of service for this review are January 1, 2023, to current. We have partnered with the vendors Advantmed and Episource to assist us in the collection of medical records for Medicare Advantage members.

Learn more about risk adjustment on our provider website: Programs>Risk Adjustment.

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**.

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. To learn more about providing culturally competent and linguistically appropriate services, view *An Implementation Checklist for the National CLAS Standards* (available in English and Spanish). Links to these checklists are included in our Cultural Competency Toolkit, available on the homepage of our provider website.

Reimbursement schedule tips

Participating providers can view reimbursement schedules and other pricing documents after signing in to Availity Essentials.

- From Availity Essentials, navigate to Claims & Payments>Fee Schedule Listing.
  - You must have the Provider Fee Schedules role assigned to you to access the application. Your Availity administrator can assign that role for you.
  - Your Availity administrator can also add additional tax IDs to your account to allow you to access fees for other providers within your clinic or organization.
- Reimbursement schedules are available for medical, dental and durable medical equipment (DME) providers with standard provider agreements.
  - Alcohol and drug treatment services reimbursement schedules can be found in Payer Spaces. **Related**: See *Reminder: ADTS reimbursement changes* on page 13.
  - Users will only be able to access the reimbursement schedule for which they are contracted.
- Non-standard (negotiated) schedules are not available.

To access the reimbursement schedule, select a payer and enter your:

- Organization
- Tax ID
- National Provider Identifier (NPI) (Type 1)
- Date of service

You can either enter specific CPT or HCPCS codes or download the entire reimbursement schedule.

- You can enter up to 100 individual procedure codes on the Enter Codes tab. The field searches for text as you type, so you can enter the procedure code or any word from the description. Non-facility and facility fees are returned in search results.
- The Code Range tab will return up to 500 codes, including all available modifiers.
- If you are unable to download the schedule, enter a previous month's date of service.
- The date of service entered should be after your network participation effective date (after your agreement is in effect).

View more tips on Availity Essentials: Help & Training>Find Help>Fee Schedules and Help & Training>Get Trained>Fee Schedules - Training Demo.

Partnering with TriWest to support our military communities

TriWest Healthcare Alliance (TriWest) was awarded a contract to administer the U.S. Department of Defense's (DoD's) next generation TRICARE program—a uniformed services health care program for active-duty service members, known as T-5—for its 26-state West Region territory. As part of our partnership with TriWest, Asuris:

- Is creating and maintaining provider networks in Washington to support both TriWest's Community Care Network (CCN) and the TRICARE T-5 programs.
- Provides credentialing and contracting for both the CCN and TRICARE provider networks in our service area.

Will add our providers to the TRICARE networks beginning January 1, 2025.

Contracting for TRICARE networks

Providers on standard agreements have been emailed contracts or amendments to add them into the TRICARE provider networks.

- **If you are already a participating CCN provider**, no action is needed. You should automatically be sent an amendment to be included in the networks.
- **If you are not currently a participating CCN provider**, you will need to electronically sign the agreement via DocuSign to be added to the T-5 program.

Learn more

To learn more about TRICARE provider networks, you can:

- Visit TriWest's provider website: **triwest.com/en/provider/join-the-triwest-provider-network/learn-more-about-tricare/**
- Email **TriWest_contracting@asuris.com**.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective April 1, 2024
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- Q4121
Expanded Molecular Panel Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	- 0444U
Noninvasive Prenatal Testing to Determine Fetal Aneuploidies, Microdeletions, Single-Gene Disorders, and Twin Zygosity (Genetic Testing #44)	- 81243
Small Bowel, Small Bowel/Liver, and Multivisceral Transplant (Transplant #09)	- 44135, 44136, 47135, 48554, S2053, S2054, S2152
Transurethral Water Vapor Thermal Therapy and Transurethral Water Jet Ablation (Aquablation) of the Prostate (Surgery #210)	- 0421T, C2596
Procedure/medical policy	**Adding codes effective July 1, 2024**
Cardiology	- 93650, 93653, 93654, 93656, 93228, 93229, 33285, C1764, E0616, K0606

Medicare Advantage

Procedure/medical policy	Added codes effective March 1, 2024
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0339U, 0229U, 0314U, 0105U
Intensity Modulated Radiation Therapy (IMRT) (Medicine #136)	- 77301, 77338, G6015, G6016
Intensity Modulated Radiotherapy (IMRT) for Breast Cancer (Medicine #166)	- 77301, 77338, G6015, G6016
Intensity Modulated Radiotherapy (IMRT) for Tumors in Close Proximity to Organs at Risk (Medicine #167)	- 77301, 77338, G6015, G6016
Intensity Modulated Radiotherapy (IMRT) of the Central Nervous System (CNS), Head, Neck, and Thyroid (Medicine #164)	- 77301, 77338, G6015, G6016
Intensity Modulated Radiotherapy (IMRT) of the Thorax, Abdomen, Pelvis, and Extremities (Medicine #165)	- 77301, 77338, G6015, G6016
Transcatheter Heart Valve Procedures (Surgery #221)	- 0483T
Procedure/medical policy	**Added codes effective April 1, 2024**
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	- 0445U
Electrical Stimulation and Electromagnetic Therapy Devices (Durable Medical Equipment #83)	- A4542, E0734
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0031U, 0032U, 0039U, 0441U, 0442U, 0446U, 0447U, 0070U-0076U, 0115U, 0156U, 0218U, 0355U, G9143

Continued on page 9

Continued from page 8

Medicare Advantage

Procedure/medical policy, continued	Added codes effective April 1, 2024
Genetic and Molecular Diagnostics – Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	- 0011M, 0017M, 0005U, 0009U, 0016U-0019U, 0022U, 0023U, 0026U, 0027U, 0037U, 0045U-0049U, 0069U, 0080U, 0089U, 0090U, 0111U, 0154U, 0155U, 0171U, 0172U, 0177U, 0179U, 0229U, 0239U, 0242U, 0244U, 0245U, 0250U, 0288U, 0306U, 0307U, 0314U, 0326U, 0329U, 0331U, 0334U, 0338U-0340U, 0343U, 0356U, 0362U, 0364U, 0375U, 0376U, 0379U, 0387U, 0388U, 0391U, 0395U, 0398U, 0404U-0406U, 0409U, 0410U, 0413U, 0414U, 0418U, 0420U, 0422U, 0424U, 0428U, 0433U, 0436U, 81120, 81121, 81162-81168, 81170, 81175, 81176, 81191-81194, 81206-81208, 81210, 81212, 81216, 81218, 81219, 81233, 81235-81237, 81245, 81246, 81261-81264, 81270, 81272, 81273, 81275-81279, 81287, 81301, 81305, 81309-81311, 81313-81316, 81320, 81327, 81334, 81338-81342, 81345, 81347, 81348, 81351, 81352, 81357, 81360, 81400, 81401-81408, 81445, 81449-81451, 81455-81459, 81462-81464, 81504, 81518-81523, 81525, 81529, 81538-81542, 81546, 81551, 81552, G0327, 0444U, 0448U
Genetic and Molecular Diagnostics - Testing for Inherited Cancer Risk (Genetic Testing #02)	- 0101U, 0129U, 0131U, 0133U, 0134U, 0235U, 0238U, 81162-81167, 81201-81203, 81212, 81215-81217, 81288, 81292-81300, 81307, 81308, 81317-81319, 81321-81323, 81351-81353, 81400-81408, 81432, 81433, 81435-81438, 0130U, 0162U

Procedure/medical policy	Adding codes effective July 1, 2024
Cardiology	- 93650, 93653, 93654, 93656, 93228, 93229, 33285, C1764, E0616

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.

Cardiology program to include additional services

We are expanding our cardiology program to review additional outpatient cardiovascular tests, procedures and certain cardiac devices for commercial and Medicare Advantage members. The program will require pre-service medical necessity review and pre-authorization through Carelon Medical Benefits Management (Carelon) for the following types of cardiac services delivered on or after July 1, 2024:

- Ambulatory cardiac rhythm monitoring
- Cardiac ablation
- Wearable cardioverter defibrillator—*for commercial only*

About the program

Carelon administers the program, which reviews outpatient cardiovascular tests, procedures and implantable cardiac devices. **Note**: Procedures performed in an inpatient setting or on an emergent basis are not subject to this program's pre-authorization requirements.

Providers will be able to contact Carelon to request pre-authorization for these additional services in June 2024. Read the June 2024 issue of this newsletter for more details.

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

If a provider does not verify that a pre-authorization request has been approved before performing an outpatient cardiac service, the claim may be denied as provider responsibility or pended for post-service review, depending on the line of business.

Learn more

- Program details are available on our provider website: Programs>Medical Management> Cardiology.
- **Related**: See *Pre-authorization updates* for a complete list of affected codes on pages 8-9.

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 February 2024 issue of *The Bulletin* about changes to the following medical policies, which are effective May 1, 2024:

- *Biomarkers for Cardiovascular Disease* (Laboratory #78)
- *Micro-Invasive Glaucoma Surgery (MIGS)* (Surgery #227)—Medicare Advantage

We provided 90-day notice in the March 2024 issue of *The Bulletin* about the new *Folate Testing* (Laboratory #79) medical policy, which is effective June 1, 2024.

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 March 2024 issue of *The Bulletin* about changes to the *Maternity Care* (Medicine #107) reimbursement policy, which are effective June 1, 2024.

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

Ambulance bundled services reimbursement

We are expanding our ambulance bundled services editing to our primary editor, Lyric, effective for dates of service on or after March 1, 2024.

In the December 2022 issue of this newsletter, we announced this editing change and stated that reimbursable ambulance services would be limited to the base fee for transportation and mileage. Services including, but not limited to, oxygen, medications, additional attendants, supplies, electrocardiograms (EKGs) and night differentials will be denied when billed as part of an ambulance transportation service.

Beginning in July 2024, we will apply a clinical edit to review these claims.

Asuris EquaPathRx™ program implementation update

In the December 2023 issue of this newsletter, we provided an update on our plans for Asuris EquaPathRx in 2024. We have additional program updates to share with you below.

We continue to work with providers to contract with the Prime IntegratedRx™ - Medical network to become a designated provider for this program. Until further notice, all Asuris network providers are temporarily eligible to provide medications included in the Asuris EquaPathRx program (subject to otherwise applicable conditions) to members with this benefit. **Members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based the member's benefits and your existing contract terms with us.**

Notes:

- Medications included in this program must be pre-authorized according to our medication policies, including the *Provider-Administered Specialty Drugs* (dru764) policy.
- Claims should be submitted directly to Asuris; there is no need to split claims and submit medication claims separately to Prime for this program.

Prime Therapeutics contracting and credentialing

Please complete the credentialing and contracting process with Prime for the IntegratedRx - Medical Network as soon as possible so we can finalize the contracting setup and next steps in our systems.

To start IntegratedRx - Medical network credentialing, please visit Prime's credentialing website: **pharmacy.primetherapeutics.com/content/primetherapeutics/en/provider-credentialing.html**.

If you need further assistance, you can reach out to your Prime contact to complete the process. If you do not have a Prime contact established, please email Prime Provider Relations at **providerrelations@primetherapeutics.com**.

If you do not contract with Prime, we will work closely with you and our members to ensure they continue to have uninterrupted access to their treatment.

Find more information about Asuris EquaPathRx on our provider website: Programs>Medical Management>Pharmacy.

Cultural Competency Toolkit updates

We've collected tools and resources to help your practice provide care that meets every patient's unique social, cultural and linguistic needs.

We recently added the following resources to our Cultural Competency Toolkit to help support your practice:

- **American Hospital Association's Disparities Toolkit**: This toolkit includes resources for systematically collecting race, ethnicity and primary language data from patients.
  - **aha.org/hretdisparities/toolkit**
- **Rural Health Literacy Toolkit**: This toolkit compiles evidence-based and promising models and resources to support organizations implementing programs to improve health literacy in rural communities across the U.S.
  - **ruralhealthinfo.org/toolkits/health-literacy**
- **TeamSTEPPS**: This site includes resources and tools to address language and cultural barriers and improve patient safety. In addition, they offer a guide for hospitals treating patients with limited English proficiency.
  - **ahrq.gov/health-literacy/professional-training/lepguide/app-e.html**
  - **ahrq.gov/sites/default/files/publications/files/lepguide.pdf**
- **U.S. Department of Health and Human Services (HHS)**: The HHS website outlines which entities must comply with non-discrimination laws and how to help those entities implement and maintain compliance. HHS has also created the Implementation Checklist for the National CLAS Standards in English and Spanish.
  - **hhs.gov/civil-rights/for-providers/index.html**
  - **thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistforthe NationalCLASStandards.pdf**
  - **thinkculturalhealth.hhs.gov/assets/pdfs/ListaDeVerificacionParaLaImplementacion DeLosEstandaresNacionalesCLAS.pdf**

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

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 June 1, 2024	Description
Revised medication policies	
Medications for Phenylketonuria (PKU), dru551	- Adding that Javygtor will require step therapy through the more cost-effective generic sapropterin

Effective July 1, 2024	Description
Revised medication policies	
Oxlumo, lumasiran, dru668	- Adding requirement for minimum eGFR (≥ 30 mL/min) and baseline urinary oxalate excretion level (≥ 0.7mmol/1.73m2)
Drugs for chronic inflammatory diseases, dru444	- Removing Amjevita (adalimumab-atto) as a preferred product - Preferred adalimumab products will include Humira and Hadlima (adalimumab-bwwd)

Behavioral health corner

About behavioral health corner

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

Articles in this issue with behavioral health content	Page
National Healthcare Decisions Day	1, 3
Reimbursement schedule tips	7
Cultural Competency Toolkit updates	11
Reminder: ADTS reimbursement changes	13
Social determinants of health impact health outcomes	13
Connect patients to the right care at the right time	14
Improving members' experience with medications	15
Cancer screenings and prevention	17
Tobacco cessation resources	18

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

Reminder: ADTS reimbursement changes

To align with current market rates, we are revising reimbursement for alcohol and drug treatment services (ADTS) for providers with our standard *Participating Ancillary Provider Agreements* effective May 1, 2024.

Updated reimbursement rates will be available on Availity Essentials. **Related**: See *Reimbursement schedule tips* on page 7.

Social determinants of health impact health outcomes

We strive to close health equity gaps to ensure simpler, better, more affordable health care for those we serve—from all backgrounds and walks of life. This includes collecting and tracking social determinants of health (SDoH) information about our members to understand barriers and support equitable access to quality health care and health education.

SDoH have a major impact on people's health, well-being and quality of life. Examples of SDoH include:

- Polluted air and water
- Language and literacy skills
- Racism, discrimination and violence
- Education, job opportunities and income
- Safe housing, transportation and neighborhoods
- Access to nutritious foods and physical activity opportunities

The SDoH ICD-10-CM Z codes make it possible to measure social risk factors and social needs. They add greater specificity to capture a more holistic view of a patient's health.

Provider resources

- Our *Social Determinants of Health Z Code* flyer, available on our provider website, includes information about submitting Z codes and resources for your patients: Library>Printed Material.
- CMS, 2024 ICD-10-CM updates: **cms.gov/medicare/icd-10/2024-icd-10-cm**
- CMS ICD-10-CM Official Guidelines for Coding and Reporting: **cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf**
- ICD10data.com: **icd10data.com/ICD10CM/Codes/Z00-Z99**

Member resources

- **Community resources**: Individuals can find support to address social needs (e.g., food insecurity, housing instability, transportation access and more) by visiting **211.org** or **findhelp.org**.
- **Asuris Customer Service**: Members can call the number on the back of their member ID card for help with SDoH resources, finding a PCP, understanding their benefits and more.

Connect patients to the right care at the right time

We are committed to providing our members access to high-quality care at the lowest price. We continue to educate our members about their care options to ensure that they are receiving the care they need in a setting that's clinically appropriate and most cost-effective.

An emergency department (ED) visit can cost up to 10 times the rate of an urgent care center or PCP visit and often includes a long wait time. Studies have shown that:

- More than 30% of ED visits are avoidable.
- More than 70% of ED visits are by patients who are receiving their first treatment for a condition at the ED.

To help your patients save time and money, we encourage you to remind them about their care options before they need sudden medical care.

Convenient care options

- In-person care
  - Share your office hours with your patients, especially if you offer extended hours.
  - If your patient does not have a PCP, encourage them to use the Find a Doctor tool on our website or call Customer Service at the phone number on the back of their member ID card for help finding an in-network provider.
- Virtual care
  - If you offer telehealth services, share information with your patients about how they can schedule a virtual appointment with you. To indicate whether you offer telehealth services, update your directory information on our provider website: Contact Us> Update Your Information.
  - Our members have access to in-network telehealth vendors and behavioral health providers.
- Nurse line
  - For questions about common health issues and whether a patient should see a doctor, most members can contact Asuris Advice24.
- Same day in-home care (available in the Spokane area)
  - With DispatchHealth, members can receive urgent care, hospital-level care and post-hospital care in the comfort of their home to avoid a trip to an urgent care clinic or ED. They are available 7 days a week, including holidays, from 8 a.m. to 10 p.m. Services vary by location. Learn more at **dispatchhealth.com**.
- Urgent care
  - Remind patients to consider urgent care clinics for illnesses and injuries beyond the scope of virtual care, such as migraine; abdominal pain; sprains, strains and cuts; and severe cold and flu symptoms. Many urgent care clinics are conveniently located and more accessible than EDs, allowing members to save time and money.
- ED care
  - Remind patients to go to the ED if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.
  - To help our members have a better understanding of their care options, our care advocates contact members who had three or more ED visits in a six-month period or one or more avoidable ED visits to provide information about alternative treatment options.

Resources for providers and members

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

Improving members' experience with medications

Many factors influence members' experience with obtaining medications and adhering to their treatment plan. We are increasing the support and assistance we offer for members to improve their health outcomes and experience.

Reasons your patient may not be taking medications you prescribed

Sometimes members are prescribed medications they cannot obtain for various reasons (e.g., cost, nonformulary, pre-authorization or step therapy requirements or medications excluded from coverage). These barriers can lead to untreated or poorly controlled conditions and impact the quality of care the patient feels they received.

Look for the **Medications and member experience with medications** category in the Quality Improvement Toolkit, available on the homepage of our provider website. The toolkit includes best practices and action items, along with a variety of flyers you can share with your patients.

Helping your Medicare Advantage patients

To help your patients get their needed prescription medications, consider the following:

- Look up your patient's formulary to determine coverage and cost information: **asuris.com/medicare/pharmacy**
  - Selecting a drug in Tier 1 or a generic drug will decrease costs for your patient.
  - If pre-authorization or formulary exception is required, submit a request before prescribing the treatment.
  - Take quantity limits into consideration.
- Prescribe a 100-day supply for chronic medications (e.g., non-insulin diabetes medications, antihypertensives, statins). Even if your patient already receives a 90-day supply, switching them to a 100-day supply gives them 10 more days of medication at no additional cost.
- If you prescribe an over-the-counter (OTC) medication, remind your patients that they may have OTC benefits. They can call the number on the back of their insurance card to find out.
- Avoid prescribing CMS-excluded drugs. These include but are not limited to:
  - Fertility drugs
  - Nonprescription drugs
  - Drugs used for anorexia, weight loss or gain
  - Drugs for symptomatic relief of cough and colds
  - Drugs used for cosmetic purposes or hair growth
  - Drugs for the treatment of sexual or erectile dysfunction
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride
- If the patient has difficulty with transportation, consider sending the prescription to a home delivery pharmacy or a pharmacy that delivers.

Home delivery pharmacies

Pharmacy	Website	Phone/Fax
Express Scripts Home Delivery	**express-scripts.com**	**Phone**: 1 (833) 599-0451 **Fax**: 1 (800) 837-0959
AllianceRx Walgreens Pharmacy	**alliancerxwp.com/home-delivery**	**Phone**: 1 (888) 832-5462 **Fax**: 1 (800) 332-9581
Postal Prescription Services	**ppsrx.com**	**Phone**: 1 (800) 552-6694 **Fax**: 1 (800) 723-9023
PillPack by Amazon Pharmacy	**pillpack.com**	**Phone**: 1 (855) 745-5725, ext. 3
Amazon Pharmacy Home Delivery	**pharmacy.amazon.com/prescribers**	**Phone**: 1 (855) 206-3605 **Fax**: 1 (512) 884-5981

Statin use for cardiovascular disease or diabetes

As a reminder, please update patient records to include statin use for your Medicare Advantage patients who have diabetes or clinical atherosclerotic cardiovascular disease (ASCVD).

We know you are familiar with statin adherence and compliance measures, but we wanted to reiterate the importance of updating patient records each year with the appropriate ICD-10 code for patients who have demonstrated an intolerance to statins in the past. Each patient who has a reported intolerance must have it documented each year at a provider visit. The codes that are acceptable to indicate statin intolerance are listed below.

In most electronic medical records (EMRs), statin intolerance needs to be added to the billing diagnoses, addressed in the assessment/plan section of the encounter note, and added to the problem list in order for the exclusion diagnosis to be submitted to us in a claim. Documenting statin intolerance in the allergy list does not route the code to us.

Providing these codes helps us identify patients who could benefit from the addition of a statin and minimize education to those patients who have demonstrated an intolerance. This will also limit the amount of information sent to you regarding your patients who are listed under this measure because their records do not indicate an exclusion.

Notes:

- Diagnosis codes must be submitted each year to exclude the patient from the statin quality measures.
- Exclusion conditions do not always need to occur in the same year the code was billed. The medical record can reflect the patient has a history of these conditions.

Learn more about the Medicare Advantage Quality Incentive Program on our provider website: Programs>Medicare QIP.

Asuris-accepted ICD-10 codes for statin intolerance

Exclusion conditions	ICD-10 codes
End-stage renal disease	- I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
Lactation (diabetes only)	- O91.03, O91.13, O91.23, O92.03, O92.13, O92.5, O92.70, O92.79, Z39.1
Cirrhosis	- K70.30-31, K71.7, K74.3-6, K74.69, P78.81
Polycystic ovarian syndrome (diabetes only)	- E28.2
Prediabetes (diabetes only)	- R73.03, R73.09
Pregnancy	- Numerous codes (>2300 codes)
Rhabdomyolysis, myopathy	- G72.0, G72.89, G72.9, M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9, M62.82
Other muscular pain (ASCVD only)	- G72.2, M60.811-2, M60.821-2, M60.831-2, M60.841-2, M60.851-2, M60.861-2, M60.871-2, M60.88-9, M79.10-12, M79.18

Cancer screenings and prevention

According to the Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in the U.S. Leading risk factors for preventable cancers are driven by lifestyle, including smoking, getting too much ultraviolet (UV) radiation from the sun or tanning beds, being overweight or having obesity, and drinking too much alcohol.

While cancer affects people of all ages, races, ethnicities and sexes, it does not affect them equally. Differences in genetics, hormones, environmental exposures and other factors can lead to differences in risk among different groups of people. For most cancers, though, increasing age is the most important risk factor.

Between 30-50% of cancer cases are preventable. We cover a variety of preventive services, including cancer screenings, at no cost (no copay and no deductible) to our members. Preventive screening services can help detect the following cancers in early stages, when treatment is more likely to be successful.

Screening coverage for commercial members

- Breast cancer prevention counseling (for those at high risk) and screening mammogram (ages 40+ or at high risk)
- Cervical cancer screening (Pap smear test) (ages 21+)
- Colorectal cancer screening (ages 45+)
- Lung cancer (ages 50-80 with history of smoking)
- Skin cancer counseling (ages 6 months-24 years for those with fair skin type)

Preventive vs. diagnostic care

When scheduling appointments, please remind your patients that during the preventive care visit, if diagnostic care is needed to treat a new symptom or an existing problem, cost share (e.g., copay, coinsurance or deductible) amounts may apply for these additional services.

View our preventive care lists

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

Earn incentives for preventive care visits

By opting in to participate in our Medicare Advantage Quality Incentive Program, you can earn incentives for completing preventive care visits and annual wellness visits with your attributed Medicare Advantage patients.

Learn more on our provider website: Programs> Medicare Quality Incentive. **Related**: See *Medicare Advantage Quality Incentive Program (QIP) reminders* on page 19-20.

Member reminders for colorectal cancer, breast cancer and cervical cancer

Eligible members including Medicare Advantage, fully insured group and Individual, and ASO members—may receive opt-in texts asking whether they would like to receive preventive screening reminders. If the member agrees, they receive a text message emphasizing the importance of the screening and letting them know they might be due and should make an appointment The member can respond to the text to request help scheduling their appointment. The member's request triggers a call from a Asuris care advocate to help the member find a provider or schedule an appointment.

Best practices and member flyers

Our Quality Improvement Toolkit, available on the homepage of our provider website, includes best practices and resources you can share with your patients that address the importance of breast, cervical and colorectal cancer screenings.

Tobacco cessation resources

Tobacco is the leading cause of preventable disease, disability and death in the U.S. Cigarette smoking is linked to diseases of nearly all organs of the body, particularly cardiovascular, metabolic and pulmonary diseases.

We measure the rate at which our members are advised to quit smoking. Currently, our score for this measure is lower than national benchmarks, indicating that this is an area of opportunity for us. Providers play a key role in helping patients decrease tobacco use by introducing and encouraging tobacco cessation tools and resources.

Integrating treatment into the routine clinical workflow and engaging the entire health care team in treatment delivery can make a difference. Here are some suggestions:

- Advise patients to quit.
  - Talk to patients at every visit about their tobacco use. Even brief advice can influence a patient's decision to quit using tobacco.
  - Advise patients that quitting is one of the most important things they can do to improve their health and prognosis.
  - Remind patients that it is never too late to quit using tobacco. Quitting is beneficial at any age.
  - Provide patients support, regardless of their readiness to quit.
- Offer a combination of counseling and medications for treatment.
- Refer patients to additional support (e.g., cessation resources and programs in your health system and community).
- Follow up.
  - Assess your patients' progress over time and provide additional support. It may take several attempts for them to quit using tobacco.
  - Try new strategies (e.g., new medications the patient hasn't tried, medication combinations or new approaches to handling triggers).
  - Provide ongoing support to encourage members to quit.

Resources

Healthwise Knowledgebase flyers

Our Quality Improvement Toolkit, available on the homepage of our provider website, includes Healthwise Knowledgebase flyers in English and Spanish for you to share with your patients. Select Tobacco cessation from the dropdown list.

CDC website

The CDC also has information about tobacco use, including resources to help people quit using tobacco: **cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm**.

Tobacco cessation resources for members

Starting this month, administrative services only groups (ASO) with 51+ employees may purchase Pelago. This program for members 18 and older offers 12-month access to a virtual program through the Pelago app. Once registered, members receive an onboarding call from a certified tobacco treatment specialist; ongoing one-on-one coaching; guided online sessions; and nicotine replacement therapy.

Members 18 and older may have access to additional virtual programs for managing or ceasing tobacco use. Members can learn about their benefits by logging in to **asuris.com** or calling Customer Service at the number on the back of their member ID card.

Medicare corner

About Medicare corner

This section highlights the articles that affect Medicare 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

Medicare Advantage QIP reminders

Please note the following reminders and updates for our Medicare Advantage QIP.

2023 program year

Payout for the 2023 program year will be mailed by June 30, 2024.

2024 program year

2024 program data in the CGMA

The 2024 QIP program year gaps and performance data are now visible in the CGMA.

Gap status report – reminder

A new report is available on the CGMA called the Gap Status Report. This report is a self-serve option for providers who require a report documenting the status of all identified gaps, not just open gaps.

To run the report:

1. Navigate to the **menu** on the upper right-hand corner.
2. Select **Reports.**
3. Select **Gap Status Report.**
4. Set your desired filters.
5. Select **Generate Report.**
6. Success message appears.
7. Once new notification appears, select the bell icon.
8. Select the notification text to download your report.

New features in the CGMA

We continue to partner with Novillus to improve your user experience in the CGMA and have implemented the following enhancements for 2024:

- **Providers will opt-in** to the 2024 program through the CGMA
- The **scorecard has been redesigned** to include frequently requested data that wasn't displayed previously

Continued on page 20

Medicare corner

Continued from page 19

- The **Member Level Gap Report** has been redesigned and now includes the ability to download multiple reports at once. Report enhancements include:
  - Gaps listed by type
  - Gap submission status
  - Appropriate data fields by gap type
  - Recoverable days listed for medication adherence gaps
  - Gaps listed in the same order as they appear on the member-level gap screen
  - Fracture date listed for osteoporosis management in women (OMW) gaps
- **Ability to close multiple gaps with the same documentation**
  - A bulk upload button now appears at the top of the member-level gap screen.
  - The user only has to upload documentation once if the document can be used to close multiple gaps.
- **Incorrect files uploaded to a member gap in error: Notification and removal**
  - When an internal reviewer identifies that a provider has attached the wrong members' documentation to a member gap, providers will be notified in the application's notification center.
  - Once a provider selects the gap through the notification center, they can review the gap and confirm whether the wrong record was attached.
  - The documentation will be removed by the system 24 hours after the provider reviews the gap.
  - If the provider does not review the gap, the document will automatically be removed by the system 30 days after the reviewer sent the notification.
- **OMW measure reporting and display improvements**
  - Reporting now includes the event date and due date
  - From the Gap Management tab, there's a new filtering option for days remaining so you can review gaps in the following actionable timeframes:
    - 120-180 days remaining
    - 90-119 days remaining
    - 1-89 days remaining
    - Timed out
  - On the member-level gap screen, badges appear on OMW gap with information about days remaining before the gap is timed out:
    - Blue—120-180 days remaining
    - Yellow/Orange—90-119 days remaining
    - Red—1-89 days remaining
    - Gray—The gap has timed out
- **Additional detail about the provider's structured supplemental data submission (SDS)**
  - Providers will now see data graphics in the SDS performance area.
  - Each graphic reflects the provider's performance on the individual components of the SDS incentive (measures, months, members).
- **The following formerly aggregate measures are now listed as individual gaps**
  - Plan All-Cause Readmissions (PCR)
  - Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
- **There is now a disagree option available on statin therapy for patients with cardiovascular disease (SPC) gaps**
  - Providers may submit evidence for exclusions.
- **Invalidation reasons for risk adjustment gaps have been simplified**
  - There are now only three options.
  - Diagnosis is no longer required when selecting the severity level reason.
- **Transient measure gaps** have "new evidence required" label for gaps that were previously compliant but have re-opened.

Do you want to have access to CGMA for yourself or a colleague? Email us at **QIPQuestions@asuris.com** to get connected or to learn more about the Medicare Advantage QIP. You can also learn more about the Medicare Advantage QIP on our provider website: Programs>Medicare Advantage Quality Incentive Program.

Medicare Advantage QIP preventive care visits bonus

We encourage you to see every member every year for an annual wellness visit (AWV) or preventive care visit (PCV). PCVs and AWVs are the perfect visits at which to address your patient's Medicare Advantage QIP care gaps as well as to document the status of their chronic conditions. Conducting these visits increases gap closure rates for many measures at the same time.

In the 2024 Medicare Advantage QIP, you can earn the base incentive for completing PCVs and AWVs, and you can also earn a performance bonus for completing visits earlier in the year (see below).

PCV base incentive

PCV gap closure performance	Incentive per PCV
60-69%	$50
70-79%	$70
80-89%	$90
90-94%	$110
95-100%	$130

Notes:

- Codes that close the PCV gap:
  - CPT 99381-99387, 99391-99397
  - HCPCS G0402, G0438, G0439
- The PCV gap can only be closed via claims submission.
- Members who have an in-home assessment are still eligible for an AWV/PCV.
- An in-home assessment conducted by a vendor does not close the PCV gap for the attributed PCP.
- Most preventive visits are covered without a member copay; check Availity Essentials for member eligibility.
- We cover AWVs and PCVs billed once per calendar year; there is no requirement to wait 11 months between visits.
- We will give credit for PCV visits completed in 2024, even if the member had other health plan coverage at the time of service. Please submit evidence of the previously performed PCV to **QIPQuestions@asuris.com**.

PCV early performance bonus (EPB)

Our 2024 Medicare Advantage QIP also includes a new early performance bonus (EPB) for our PCV incentive.

Earn an additional $20 per visit bonus by meeting both requirements:

- Completing visits for 40% of your attributed patients for a PCV/AWV by June 30, 2024

and

- Completing visits for at least 70% of your attributed patients for a PCV/AWV by December 31, 2024

Learn more about our Medicare Advantage QIP on our provider website: Programs>Medicare Advantage Quality Incentive Program.

Health assessments for Medicare Advantage members

We have partnered with a team of providers who conduct comprehensive in-home and virtual health assessments to accurately assess and document a member's current health status. During the assessment, the provider also observes and documents social determinants of health (SDoH). Signify Health and Advantmed, our contracted vendors for these assessments, began outreach to Medicare Advantage members in February 2024.

Who qualifies for an assessment?

All Asuris Medicare Advantage members are eligible.

- Members with the highest care needs are prioritized for outreach.
- In-person visits in rural areas may be more limited because of clinician availability.
- Members receiving hospice care are excluded from outreach but still qualify to receive the visit if they initiate the request.

What is included in the visit?

Signify Health and Advantmed will provide the following services to members during each in-home or virtual health assessment:

- Pain assessment
- Medication review
- SDoH assessment
- Fall risk assessment
- Family history review
- Depression screening
- Safety and functional review
- Cognitive impairment screening
- Review of preventive services history

Members may qualify to receive these ancillary tests as appropriate:

- Spirometry
- Bone density test (Signify Health only)
- Diabetic retinal eye exam
- Peripheral artery disease testing
- Colorectal cancer screening (FIT kit)
- Diabetes: Blood sugar control (HbA1c)
- Kidney health evaluation for patients with diabetes

What happens after the visit?

- Notes are provided to the member to remind them what care to follow-up on.
- A summary report is generated and sent to the member's PCP.
- Any lab results are sent to the member and the PCP by mail.
- If concerns are identified during the visit, we receive urgent and non-urgent referrals to follow-up with members.

How to refer your patients

Contact Customer Service by calling the number on the back of the member's ID card.

Learn more about our Risk Adjustment program on our provider website: Programs>Risk Adjustment.

Resources for you

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

Publications team

Sara Perrott: Publications editor and writer

Sheryl Johnson: Managing editor and writer

Cindy Price: Designer and writer

Carrie White: Writer

Jayne Drinan: Writer

Janice Farley: Editor