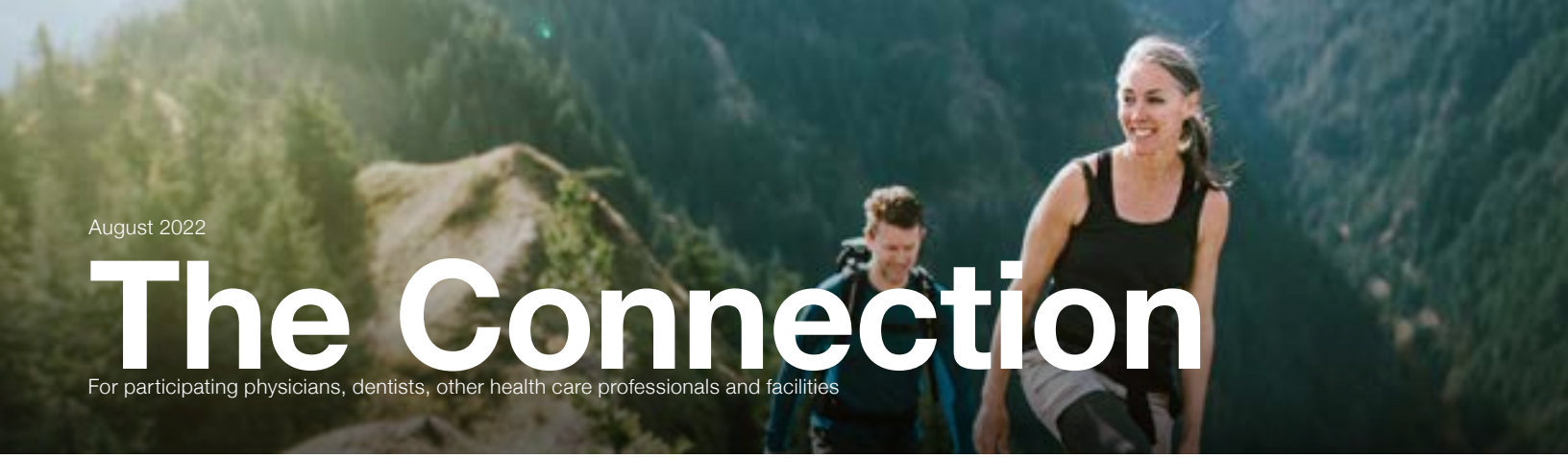

August 2022

The Connection

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

National immunization month

National Immunization Awareness Month (NIAM), **cdc.gov/vaccines/events/niam/index.html**, is observed each August to highlight the importance of vaccination for people of all ages.

Providers play a key role in educating patients and parents about the importance of vaccination. Your recommendation can help protect your patients against serious diseases, such as COVID-19, HPV, meningitis, shingles and influenza.

We appreciate your continued efforts to ensure your patients receive necessary vaccinations. Ensuring patients are up to date on all vaccines and other preventive care can protect them and help them maintain good health.

COVID-19 vaccines and boosters

The Centers for Disease Control and Prevention (CDC) recommends everyone six months and older get a COVID-19 vaccination (with some rare exceptions) to help protect against the disease. The CDC also recommends COVID-19 boosters when eligible to further enhance or restore protection after the primary series vaccination. In addition, the CDC advises that patients can get other immunizations at the same time as the COVID-19 vaccine. This is important because many people, especially children, are behind on regular vaccinations.

Resources

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

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

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 hen 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 must read
▲ DME must read

We encourage you to read the other articles because they may apply to your specialty.

Click on a title to read the article.

Feature
National immunization month 1, 3

News
About The Connection 2
Provider quality resources and member surveys 3
New and improved provider search experience 4

Administrative and billing
■ Administrative Manual updates 3
■ Medically unlikely edits to be applied to free-standing surgical center claims 3
Update your directory information 4
Work with us to end health inequity 5
Submit SDoH Z codes to help connect patients to services and resources 5
Documentation and coding tips for respiratory conditions 6
Review your information in CMS' NPPES 7

Availity Essentials
▲ Availity tips for reimbursement schedules 7
Use Availity's Attachments application to respond to record requests 8

Authorizations
■ Pre-authorization updates 9
■ Concurrent review reminders 9

Policies
‡ ■ Dental policy updates 9
■ The Bulletin recap 10

Pharmacy
■ Medication policy updates 11-14

Behavioral health corner
988 now available nationwide for suicide prevention hotline 15
■ Reminder: Reimbursement changes 15
Facilities can request pre-authorization online 16
Facilities receiving care management and discharge information 16
Knowing when to share patient information avoids unnecessary risks 16
Improve outcomes for patients post-discharge 17
Telehealth can support PCPs and facilities 18
Stepdown form simplifies process for facilities 18

Patient care
Resources to support working with diverse populations 7
Childhood immunizations 19
Flu season is just around the corner 19
Discussing urinary incontinence with patients 20
Tools available for treatment of low back pain 20

Medicare
Medicare QIP reminders 21

About *The Connection*

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

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

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

The Bulletin

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

Share your feedback

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

Continued from page 1

The CDC has developed a COVID-19 Vaccination Clinical and Professional Resources library, available at **cdc.gov/vaccines/covid-19/index.html**. It includes multiple resources, including:

- An *Interim COVID-19 Immunization Schedule for 6 Months of Age and Older*
- Information about COVID-19 vaccination for specific populations
- Tools to help providers talk to their patients about COVID-19 vaccination

Healthwise's Knowledgebase has helpful information and tools about immunizations and vaccinations. Access their site and materials in English and Spanish at **healthwise.net/asuris**. Search Healthwise's Knowledgebase for:

- Immunizations
- Vaccinations
- Or search for specific vaccines or immunizations (e.g., coronavirus, hepatitis B)

Our provider website, **asuris.com**, includes a COVID-19 Vaccine Toolkit with information about coverage for our members, claims submission and provider reimbursement.

Related: See *Childhood immunizations* and *Flu season is just around the corner* on page 19.

Administrative Manual updates

The following updates were made to our manual on August 1, 2022:

Facility Guidelines

- Clarified the billing and waiver information in the deluxe products/upgrades section
- Updated the types of admissions subject to our *Inpatient Hospital Readmissions* (Administrative #111) reimbursement policy

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

Provider quality resources and member surveys

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.

This year we have expanded our hybrid survey to include not only our Medicare Advantage members, but also our commercial members. Including more members will give us insight into how care may differ across populations. It will also give us the opportunity to identify and share areas of opportunity with our provider partners in our hybrid survey project and quality measures.

Our members will be asked questions about such topics as getting needed care, getting care quickly and care coordination. Our Medicare Advantage members will also be surveyed on topics related to whether their provider talks to them about fall risk reduction strategies, incontinence management or increasing their activity.

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.

Medically unlikely edits to be applied to free-standing surgical center claims

For dates of service beginning November 1, 2022, we will apply medically unlikely edits (MUEs) to free-standing ambulatory surgical center (ASC) claims for commercial members. When billed units of a procedure/item exceed the practitioner MUE value, we will allow units up to the maximum limit and deny excess units.

For additional information about MUEs, see our *Maximum Daily Units* (Administrative #120) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

New and improved provider search experience

In August 2022, we will launch improvements to the Find a Doctor tool on **asuris.com** and the Asuris app. Through intuitive design and a user-friendly interface, the refreshed experience will make it easier than ever for members to find the care they need.

What members can expect

In the new user interface, members will experience changes when they use the provider search and cost estimator tools. They'll be able to locate providers within their area and filter results to target precisely those who best meet their needs.

Provider search

- **Intuitive navigation**: The new interface presents the most vital information first, enabling members to quickly find what they need.
- **Easy filters**: Filters are easily navigable via drop-down menus for specific results, allowing members to precisely identify and apply the best filters for their situation.
- **Filter by ethnicity, gender, and LBGTQ+ care**: The improved filter interface helps members quickly narrow results to choose a provider they are comfortable with. **Related**: See *Work with us to end health inequity* on page 5.
- **Compare providers**: Members can view providers side-by-side for a straight-forward comparison of key attributes.
- **Improved map experience**: With a larger and more detailed map feature, members can easily locate providers in their area and make the best choice for their care.

Cost estimator

The same navigation and design changes that make provider search seamless and easy to use will also be applied to the member cost estimator tool. Members will be able to filter results, see more detailed information about chosen providers, and get clear cost information to make informed decisions.

Update your directory information

Accurate provider directories are essential to help members find providers who are right for their health care needs. 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 the Centers for Medicare & Medicaid Services (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 (based on their specialty and current credentialing status) be listed in our 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

Learn more about our *Provider Directory Attestation Requirements for Providers* policy and validating directory content on our provider website: Contact Us>Update Your Information.

Work with us to end health inequity

All people should have an equal opportunity to achieve wellness as part of a health care system that prioritizes diversity, equity and inclusion. Health equity gaps impact your patients' length and quality of life; rates and severity of disease, disability and death; and access to treatment.

We know many patients prefer providers who share their race or ethnicity, or who speak the same language, which can improve communication and care quality. LGBTQ+ or queer-affirming providers can validate LGBTQ+ patients' identities and make a big difference for health outcomes.

We've expanded our provider directory information to help our members connect with providers they feel best meet their health care needs and individual preferences.

The expanded demographics and areas of interest include:

- Gender identity
- Race or ethnicity
- Preferred pronoun
- LGBTQ+-inclusive care

We invite you to add health equity information and areas of interest to your directory information by submitting a *Provider Information Update Form* on our provider website: Contact Us>Update Your Information.

The information you provide about your race, gender, correct pronouns and whether you provide LGBTQ+-inclusive care will be displayed on our online provider directory, the Find a Doctor tool. Members will be able to select providers who are LGBTQ+-affirming and have competence in behavioral health and transgender medicine. This information helps our members build more trusting relationships with their health care providers, resulting in more appropriate care and better health outcomes.

Together, we can advance diversity, equity and inclusion on behalf of our members and the communities we serve.

Related: See *Resources to support working with diverse populations* on page 7.

Submit SDoH Z codes to help connect patients to services and resources

Good health is influenced by the environments where your patients live, learn, work, play, worship and age. These factors—known as social determinants of health (SDoH)—affect health outcomes and may lead to medication non-compliance, hospital readmissions, unnecessary emergency department visits and other medical issues.

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

SDoH Z codes can only be captured via a claim and when documented within the medical record for the service being billed on that claim. Including these codes will help us identify opportunities to provide support to our members, such as transportation or in-home care, as well as connections to food banks and other community resources.

Categories of codes

- Education/literacy
- Employment and unemployment
- Occupational exposure to risk factors
- Physical environment
- Housing and economic circumstances
- Social environment
- Upbringing
- Primary support group, including family circumstances
- Psychosocial circumstances
- Other psychosocial circumstances
- Lifestyle
- Life management difficulty
- Care provider dependency
- Medical facilities and other health care
- Personal risk factors not elsewhere classified

These are supplemental diagnosis codes and should not be used as the admitting or principal diagnosis code to indicate the medical reason for the visit.

View our *Social Determinants of Health Z Codes* flyer, which includes a list of the codes that make it possible to measure social risk factors and social needs. The flyer is available on our provider website: Library>Printed Material.

Documentation and coding tips for respiratory conditions

Accurate and complete documentation of a patient's condition(s) is key to being compliant in risk adjustment to ensure that the true health or illness burden and related risk of a patient is captured.

Unspecified or poorly specified medical record documentation can result in a risk score that does not reflect the patient's true health condition. Here are some important tips and reminders to support accurate and complete medical record documentation and coding for respiratory conditions.

Medical record reminders

- Document all active respiratory conditions with a minimum of current:
  - **Specificity** (e.g., acute, chronic, with infection)
  - **Status** (e.g., stable, exacerbated, compensated)
  - **Treatment** (e.g., on medication, therapy, sees specialist)
- Review ICD-10 guidelines on the assignment of status and specificity:
  - An acute exacerbation is a worsening or a decompensation of a chronic condition.
  - An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.
- Ensure all components of the encounter notes support the final diagnosis. In electronic medical records (EMRs), these are often left in the auto-populated state and may conflict with the condition:
  - Physical exam
  - Assessment and plan
  - Review of systems (ROS)
  - History of present illness (HPI)

Coding reminders

- All respiratory conditions that exist and affect the care and decision-making on the encounter date of service should be documented and coded.
- Different combinations of existing conditions dictate code assignment and mapping.
- Documentation of obstruction or conditions coexisting with chronic obstructive pulmonary disease (COPD) are often categorized to the COPD diagnosis code.
- The AHA Coding Clinic has advised that COPD almost always affects patient care, treatment or management.
- Additional codes for the presence of tracheostomy or oxygen dependence should be added when noted.

Avoid these documentation and coding mistakes

Here are some things to avoid when documenting and coding respiratory conditions:

- Omitting a coexisting/underlying diagnosis at least once per year in an otherwise uncomplicated patient
- Lacking specificity of diagnosis
- Assigning unnecessary signs and symptoms codes (cough with asthma)
- Failing to assign code combinations of respiratory disease according to ICD-10 hierarchy
- Conflicting documentation within the ROS or physical exam
  - Many EMR templates auto-populate as "normal."
  - It is important to update these fields when assigning diagnosis codes in the assessment and plan.

For more information about risk adjustment, visit our provider website: Programs>Risk Adjustment.

The information shared here is intended for informational and educational purposes to help you understand best documentation practices in support of our efforts to submit complete and accurate diagnosis information to CMS. It is not intended to substitute for or provide clinical advice or clinical recommendations.

Review your information in CMS' NPPES

As part of your routine review of provider directory information, please also review your National Provider Identifier (NPI) data in the Centers for Medicare & Medicaid Services' (CMS') National Plan & Provider Enumeration System (NPPES). By ensuring accurate provider data is displayed in NPPES, Medicare Advantage organizations can rely on it as a primary data resource for provider directories, decreasing the frequency you are contacted for updated directory information and providing more reliable information to Medicare beneficiaries.

When reviewing your provider data in NPPES, please update any inaccurate information in modifiable fields including provider name, mailing address, telephone and fax numbers and specialty. Also include all addresses where you practice and actively see patients and where a patient can call and make an appointment. Do not include addresses where you could see a patient, but do not actively practice and remove any practice locations that are no longer in use. Once you update your information, you will need to confirm it is accurate by certifying it in NPPES. **Note**: NPPES has no bearing on billing Medicare Fee-For-Service.

Visit NPPES help for more information at **nppes.cms.hhs.gov/webhelp/nppeshelp**.

Resources to support working with diverse populations

You may care for patients who have a variety of cultural, linguistic, ethnic and racial differences or who experience health care or economic disparities. Perhaps your patients speak limited English or have poor reading comprehension; face homelessness or food scarcity; exhibit mental or physical disabilities; or simply come from cultural or ethnic backgrounds different from your own.

Culture, language, customs, personal beliefs and experiences all impact how patients participate in their health care. To help you support a patient with unique needs or preferences regarding their care, we created an online library to connect you to national standards and essential resources. These resources focus on ways to provide culturally sensitive health care to diverse populations, including behavioral health, health literacy, interpreter services and health equity.

You can find the Cultural Competency and Health Literacy Resources page on our provider website: Programs>Cost and Quality>Quality Program>Cultural Competency. We encourage you to bookmark this resource.

Related: See *Work with us to end health inequity* on page 5.

Availity tips for reimbursement schedules

Participating providers can view reimbursement schedules and other pricing documents on Availity Essentials. Use the following tips when accessing reimbursement schedules.

- From Availity Essentials, navigate to Claims & Payments>Fee Schedule Listing.
  - Some reimbursement schedules can also be found in Payer Spaces.
  - 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.
  - Users will only be able to access the reimbursement schedule for which they are contracted.
- Non-standard (negotiated) schedules are not available.
  - Non-standard fees can be calculated by using standard fees and applying your contracted rate.
- Generally, use the individual provider's 10-digit NPI (Type 1) to access the schedule, unless your agreement is at the facility or organizational level only.
- You can either enter specific CPT or HCPCS codes or download the entire reimbursement schedule.
  - 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).
- If you cannot open the reimbursement schedule, right click on the link for the reimbursement schedule, then select **Save target as**. You can then save the spreadsheet to your computer and open it in Microsoft Excel or a similar program.

Use Availity's Attachments application to respond to record requests

When claim processing requires medical records or supporting documentation, we request them through Availity's Attachments application, fax, email or U.S. Postal Service. We are increasing the number of requests sent through Availity Essentials.

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

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

Receiving a request

Requests for supporting documentation can be found in Availity Essentials: Requests>Work Queue or within the inbox of the attachments dashboard. The Availity Notification Center provides quick access to new requests in your work queue or attachments dashboard inbox.

Submitting requested documentation

Use the attachments dashboard to review requests and send requested documentation. Sign in to Availity Essentials: Claims & Payments>Attachments—New.

- The inbox tab includes new requests and a history of the request.
  - Select the row of a record to display the attachments detail window for requested attachments, add files and submit.
  - To upload a document to be sent, select the plus sign icon (+) and follow your system's prompts.
- The send attachment button also sends attachments electronically as a response to a request for documentation.

Check Availity Help for the most up-to-date information about acceptable file types and sizes.

Messaging

You can message us directly from the Attachments application if you have any questions about requested documents. If you want to use this option, make sure user accounts have the Messaging App role.

Setup

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

Notes:

- Do not submit medical records with a claim unless indicated on our Clinical Edits by Code List, on our provider website: Claims & Payment>Coding Toolkit.
- If medical records are required, we will send you a request.
- Sending unsolicited attachments can delay the processing of your claim. Only use the Attachments application to submit documentation when you receive a notification in your Availity Essentials work queue.
- Please continue to respond to requests using the same format in which they were received to avoid claims processing delays.

Learn more

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

Pre-authorization updates

Commercial Pre-authorization List updates

Procedure/medical policy	Added codes effective August 1, 2022
Cytochrome p450 and VKORC1 Genotyping for Treatment Selection and Dosing (#GT10)	- 81227
Evaluating the Utility of Genetic Panels (#GT64)	- 81227
Genetic and Molecular Diagnostic Testing (#GT20)	- 81227

Medicare Advantage Pre-authorization List updates

Procedure/medical policy	Added codes effective July 1, 2022
Genetic and Molecular Diagnostics—Next Generation Sequencing and Genetic Panel Testing (#M-DME64)	- 0323U, 0326U, 0327U, 0329U-0331U
Procedure/medical policy	**Added code effective August 1, 2022**
Hypoglossal Nerve Stimulation (#M-SUR215)	- C1767

Our complete pre-authorization lists are available in the Pre-authorization section of our provider website. Please review the lists for all updates and pre-authorize services accordingly.

You can submit standard medical pre-authorizations through Availity Essentials. Learn more on our provider website: Pre-authorization>Electronic Authorization.

Concurrent review reminders

Effective September 1, 2022, we will make the following changes to concurrent review requirements:

- **Newborn intensive care unit (NICU) and pediatric intensive care unit (PICU)**: We will require notification of NICU and PICU admissions within 24 hours. We are making this change to align with our concurrent review requirements for other admissions.
- **Diagnosis-related group (DRG) facilities**: We will decrease the time frame in which in-network DRG facilities must submit clinical information for urgent admissions (commercial and Medicare Advantage) and ongoing elective admissions (Medicare Advantage only).

All hospital and behavioral health admissions require notification within 24 hours and are subject to concurrent review. Upon receipt of the admission notification, we will respond with an acknowledgment fax that includes the date clinical information will be due.

Dental policy updates

We review our dental policies on an annual basis. The following policies were recently reviewed with no changes made:

- *Assessment of Salivary Flow by Measurement* (Diagnostic #72)
- *Biopsy of Oral Tissue* (Oral and Maxillofacial Surgery #47)
- *Blood Glucose Level Test* (Diagnostic #71)
- *Cone Beam Computed Tomography* (Diagnostic #74)
- *Dental Accident* (Miscellaneous #67A)
- *Dental Radiographs* (Diagnostic #78)
- *Dental Restorations* (Restorative #77)
- *Frenulectomy* (Oral and Maxillofacial Surgery #53)
- *HbA1C In-office Point of Service Testing* (Diagnostic #69)
- *Non-Reimbursable Dental Services* (Miscellaneous #70)
- *Pulp Vitality Tests* (Diagnostic #5)
- *Pulpal Debridement* (Endodontics #22C)

The effective date of these policies was updated to July 1, 2022.

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

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 June 2022 issue of *The Bulletin* about the following medical policies, which are effective September 1, 2022:

- *Gender Affirming Interventions for Gender Dysphoria* (#MED153)
- *Intensity Modulated Radiotherapy (IMRT) for Breast Cancer* (#MED166)
- *Intensity Modulated Radiotherapy (IMRT) of the Thorax, Abdomen, Pelvis, and Extremities* (#MED165)
- *Reconstructive Breast Surgery/Mastopexy, and Management of Breast Implants* (#SUR40)

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

- *Leadless Cardiac Pacemakers* (#SUR217)
- *Ventral (Including Incisional) Hernia Repair* (#SUR12.03)

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 June 2022 issue of *The Bulletin* about changes to the *Reimbursement of Facility Room and Board* (Facility #103) reimbursement policy, which are effective September 1, 2022.

Our reimbursement policies are reviewed on an annual basis.

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

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

Medication policy updates

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

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

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

New U.S. Food & Drug Administration (FDA)-approved medications: New-to-market medications are subject to pre-authorization based on their FDA-labeled indication, pivotal trial criteria and dosage limitations until we complete a full medication review and develop a coverage policy.

Product not available (PNA) status: We allow a 90-day grace period to use any existing supply for medications that CMS has designated as PNA before they become ineligible for reimbursement. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.

Effective May 25, 2022	Description
Revised medication policy	
Non-Preferred Injectable Insulins, dru372	- Added authorized generic insulin glargine and brand Rezvoglar (insulin glargine) as non-preferred long-acting insulins - The preferred product is insulin glargine-yfgn (unbranded product, Semglee)

Effective June 14, 2022	Description
Revised medication policy	
Drugs for chronic inflammatory diseases, dru444	- Added newly FDA-approved Adbry (tralokinumab) for atopic dermatitis (AD) as a level 1 option - Added newly FDA-approved Cibinqo (abrocitinib)for atopic dermatitis (AD) as a level 3 option - Added Rinvoq (upadacitinib) for ulcerative colitis (UC) as a level 3 option - Added Rinvoq (upadacitinib)for ankylosing spondylitis (AS) as a level 2 option - Added Actemra (tocilizumab) IV for Giant Cell Arteritis (GCA) - Updated Entyvio (vedolizumab) for Crohn's disease (CD) to a level 1 option - Updated policy to allow dosing escalation of Simponi Aria (golimumab) to every 6 weeks

Effective July 15, 2022	Description
New medication policies	
Enjaymo, sutimlimab, dru716	- Limited coverage to patients with symptomatic cold agglutin disease with a history of RBC transfusions after failure of rituximab-containing regimens
Fyarro, nab-sirolimus, protein-bound sirolimus, dru700	- Added that use for PEComa is considered not medically necessary and therefore not covered because of lack of proven additional benefit versus lower-cost formulations of sirolimus; all other uses are considered investigational

Continued on page 12

Continued from page 11

Effective June 14, 2022 (continued)	Description
New medication policies (continued)	
Kimmtrak, tebentafusp-tebn, dru701	- Limited coverage to HLA-A*02:01-positive patients with untreated unresectable or metastatic uveal melanoma when used as monotherapy
Opdualag, nivolumab-relatlimab-rmbw, dru718	- Limited coverage to patients with unresectable or metastatic melanoma when used in the front-line setting; label does not address treatment setting
Revised medication policies	
Chimeric Antigen Receptor (CAR) T-cell Therapies, dru523	- Added coverage criteria for Yescarta (axicabtagene ciloleucel) in the second-line diffuse large B-cell lymphoma (DLBCL) setting, a newly FDA-approved indication
Enhertu, fam-trastuzumab deruxtecan, dru623	- Added coverage criteria for patients with unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive breast cancer after one prior anti-HER2-based regimen in the metastatic, neoadjuvant or adjuvant setting, a newly FDA-approved indication
Keytruda, pembrolizumab, dru367	- Added coverage criteria for several newly FDA-approved indications: • Add-on to standard chemotherapy for advanced, PD-L1-positive (CPS>1) cervical cancer • Adjuvant use in completely resected RCC with intermediate-high to high risk of recurrence • Second- and subsequent-line use in advanced, MSI-H/dMMR endometrial cancer - Added that use in the newly FDA-approved indication for localized, completely resected, stage IIB and IIC cutaneous melanoma is considered investigational and therefore not covered because of the lack of evidence of meaningful health outcomes
Medications for Sickle Cell Disease, dru628	- Added coverage criteria for Oxbryta (voxelotor), which was previously considered not medically necessary based on provider feedback - Updated Adakveo (crizanlizumab) coverage criteria to require at least two vaso-occlusive crises (rather than more than two) to coincide with trial inclusion criteria
Monoclonal antibodies for asthma and other immune conditions, dru538	- Added coverage criteria for the provider-administered newly FDA-approved drug Tezspire (tezepelumab) - Updated the reauthorization time frame for nasal polyps: • Initial reauthorization will move from 12 months to 24 weeks in accordance with treatment guidelines; current authorizations will not be affected
Non-preferred pegfilgrastim products, dru563	- Added newly FDA-approved biosimilar Flylnetra (pegfilgrastim-pbbk) to policy as non-preferred
Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620	- Added newly FDA-approved biosimilar Alymsys (bevacizumab-maly) to policy as non-preferred

Continued on page 13

Continued from page 12

Effective September 1, 2022	Description
New medication policies	
Camzyos, mavacamten, dru720	- Will limit coverage to patients with symptomatic hypertrophic obstructive cardiomyopathy when prescribed by or in consultation with a specialist and when standard, lower-cost options are ineffective, not tolerated or not a treatment option
Hyftor, sirolimus 0.2% topical gel, dru721	- Will limit coverage to patients with facial angiofibroma associated with tuberous sclerosis complex (TSC) when diagnosed by a specialist; there is documentation of pain, disability or functional impairment interfering with activities of daily living (ADLs); the patient is not on concurrent systemic mechanistic target of rapamycin inhibitor (mTORi) treatment for other manifestations of TSC; and the patient is not a current candidate for laser therapy or surgery
Pyrukynd, mitapivat, dru719	- Will limit coverage to adults with clinically confirmed pyruvate kinase deficiency when prescribed by a hematologist; red blood cell transfusion therapy (RBCT) or iron chelation therapy (ICT) have been ineffective; and splenectomy has occurred
Tarpeyo, budesonide, dru712	- Will limit coverage to patients with biopsy confirmed IgAN at a high risk of progression (as outlined in the coverage criteria) when managed by a specialist; after three months of adherent use with a stable maximized dose of an ACEI/ARB; optimized supportive therapy have been ineffective; and previous therapy with systemic glucocorticoids was ineffective
Vonjo, pacritinib, dru717	- Will limit coverage to patients with myelofibrosis when baseline platelet count <50K
Revised medication policies	
Cholbam, cholic acid, dru402	- Updating authorization duration from every three months to three months initially, followed by annual reauthorization
Complement Inhibitors, dru348	- Adding coverage criteria for ravulizumab (Ultomiris) for use in generalized myasthenia gravis (gMG)
Corlanor, ivabradine, dru413	- Modifying continuation of therapy (COT) to allow for coverage if established with benefit
Cost-Share Exception Criteria for Preventative Medications, dru399	- Updating exception criteria to be in compliance with updated ACA guidelines, specifically FAQ51, which requires zero cost share coverage of all contraceptives if deemed medically appropriate by the provider
Direct Acting Antivirals for HCV, dru599	- Adding criteria for treatment with ledipasvir/sofosbuvir in genotype 1, 4, 5 or 6, decompensated cirrhosis and ribavirin ineligible in line with guideline updates - Removing Daklinza (daclatasvir) from policy; product has been discontinued
Dupixent, dupilumab, dru493	- Removing age requirement for atopic dermatitis
High-Cost Medications for Chronic Constipation, dru519	- Modifying criteria for Ibsrela (tenapanor) to require additional step agents, aligning with tegaserod (Zelnorm), in irritable bowel syndrome with constipation (IBS-C) - Removing age requirement for Zelnorm (tegaserod)

Continued on page 14

Continued from page 13

Effective September 1, 2022 (continued)	Description
Revised medication policies (continued)	
High-cost medications for overactive bladder, dru460	- Removing brand Enablex from policy, as it is no longer available; generic darifenacin will continue to require pre-authorization
lapatinib (generic, Tykerb), dru145	- Adding generic lapatinib to policy; brand Tykerb will require step therapy with generic lapatinib prior to coverage
Medications for Multiple Myeloma, other cancers, and other hematologic disorders, dru672	- Removing Farydak (panobinostat) from policy because it will no longer be marketed in the U.S.
Medications for thrombocytopenia, dru648	- Revising reauthorization criteria for ITP from six months to 12 months after an initial 12-week reauthorization
Non-Preferred GLP1-Agonist-Containing Medications, dru347	- Adding newly FDA-approved Mounjaro (tirzepatide) as non-preferred
Non-Preferred Inhaled Corticosteroid (ICS)-Containing and Muscarinic-Antagonist (LAMA)-Containing Medications, dru380	- Adding fluticasone propionate HFA (authorized generic for Flovent HFA), fluticasone furoate/vilanterol DPI (authorized generic for Breo Ellipta) and mometasone/formoterol MDI (authorized generic for Dulera) - For these products, the brand-name version remains the best value
Non-preferred Oral Medications for Inflammatory Bowel Disease, dru473	- Updating reauthorization criteria from may review every six months to may review every 12 months
Radicava, edaravone, dru510	- Adding Radicava ORS (edaravone oral solution)
Scenesse, afamelanotide, dru625	- Updating quantity limits to clarify that it is covered as one implant every eight weeks during seasons of increased sunlight
Archived medication policies	
Aemcolo, rifamycin, dru601	- Aemcolo will no longer require pre-authorization
Helixate FS, antihemophilic Factor (recombinant), dru537	- Product discontinued
Stivarga, regorafenib, dru284	- Stivarga will no longer require pre-authorization

Effective November 1, 2022	Description
Revised medication policy	
Immune Globulin Replacement Therapy, dru020	- Moving Asceniv to be considered not medically necessary for both COT and new starts because of significantly higher cost without additional health benefit

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
Work with us to end health inequity	5
Resources to support working with diverse populations	7
988 now available nationwide for suicide prevention hotline	15
Reminder: reimbursement changes	15
Facilities can request pre-authorization online	16
Facilities receiving care management and discharge information	16
Knowing when to share patient information avoids unnecessary risks	16
Improve outcomes for patients post-discharge	17
Telehealth can support PCPs and facilities	18
Stepdown form simplifies process for facilities	18

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

Recurring topics likely to affect your specialty	Page
Administrative Manual updates	3
Update your directory information	4
Pre-authorization updates	9
The Bulletin recap	10
Medication policy updates	11-14

988 now available nationwide for suicide prevention hotline

On July 16, 2022, the U.S. transitioned to using the three-digit 988-dialing code to operate through the existing National Suicide Prevention Lifeline's, 1 (800) 273-8255, network of over 200 locally operated and funded crisis centers across the country. This lifeline provides free and confidential support 24/7 to people in suicidal crisis or mental health-related distress.

988 is a direct connection to compassionate, accessible care and support for anyone experiencing behavioral health-related distress—whether that means thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a partner toolkit that includes fact sheets, key messaging, suicide prevention resources and more.

Please share this information with your patients experiencing behavioral health-related distress.

Resources

- 988 SAMHSA Partner Toolkit: **samhsa.gov/find-help/988/partner-toolkit**
- 988 Suicide and Crisis Lifeline: **samhsa.gov/find-help/988**

Reminder: Reimbursement changes

Effective October 1, 2022, we are revising reimbursement for the following codes and licensing types for providers on our standard agreements:

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

The updated rates will be available on Availity Essentials after October 1, 2022.

Behavioral health corner

Facilities can request pre-authorization online

Behavioral health facilities can now submit pre-authorization requests and supporting clinical documentation for acute mental health and substance use disorder treatment through Availity Essentials.

Availity's Electronic Authorization application replaces the need to fax records and provides faster turnaround on requests. When you submit a request, you'll receive immediate acknowledgement of receipt or be notified of a submission error.

In the future, some requests will receive automatic approvals for targeted services.

When submitting a pre-authorization request through Availity Essentials, attach the *Initial Request Form* available on our provider website: Library>Forms. This form is required for inpatient, residential, partial hospitalization and intensive outpatient treatment.

This change applies to commercial and Medicare Advantage members.

Get training

Providers have told us they had a better experience with Availity's Electronic Authorization application after completing training. Trainings are available on Availity Essentials: Help & Training>Get Trained. Search for Authorizations and Referrals—Training Demo.

Facilities receiving care management and discharge information

To increase follow-up treatment rates after discharge from a behavioral health inpatient admission, we are faxing facilities information about care during that critical period. Faxes include copies of:

- A letter to the attending provider that outlines how our care management team can support them
- A letter to share with the member at discharge that provides basic information about discharge planning and encourages them to attend their follow-up appointment
- An *Authorization to Disclose Protected Health Information* form if the member would like us to coordinate with another person on their behalf

Knowing when to share patient information avoids unnecessary risks

It is common for providers to overinterpret privacy rules in behavioral health, resulting in unnecessary restrictions and obstacles that negatively impact care coordination. A lack of coordinated care can lead to serious and unnecessary safety risks, delay services, worsen outcomes and increase the cost of care.

Under HIPAA's coordination of care clause, for care coordination purposes, providers can share protected health information (PHI) about a patient who has a mental health diagnosis with other providers who are treating the patient. **This means a facility can share such information as assessments, progress notes, discharge summaries and medication lists with relevant providers regardless of whether the patient has signed an *Authorization to Disclose Protected Health Information* form.**

There are exceptions regarding psychotherapy process notes and substance use disorder (SUD) specialists. Health and Human Services' (HHS's) HIPAA FAQ provides details about exclusions: **hhs.gov/hipaa/for-professionals/faq**.

Sharing patient information to aid care coordination helps:

- Ensure timely care coordination by removing unnecessary barriers
- Avoid drug interactions and alert the provider to check for side effects
- Ensure the patient will receive appropriate follow-up care
- Protect patients—including children—who may not be able to communicate their needs
- Break down the myth and stigma that behavioral health is separate from other types of health care and should be treated differently

Behavioral health corner

Improve outcomes for patients post-discharge

The Healthcare Effectiveness Data and Information Set (HEDIS®) behavioral health measure Follow-Up After Hospitalization for Mental Illness (FUH) is a key quality measure that ensures members transition safely from an acute hospital setting back to their home environments. Our goal is to help members receive the post-discharge care they need.

Timely follow-up (within seven days) and effective care coordination help improve outcomes. Care coordination is a vital aspect of good treatment planning. We encourage communication among a member's providers and the health plan.

These best practices meet the measure's standard and have proven to be effective in achieving positive outcomes:

- Follow-up can occur any time between days one and seven; the day of discharge is day zero, and appointments on the day of discharge do not count toward the measure.
- Follow-up must occur with a behavioral health provider.
- Follow-up visits may be held in office, via telehealth or through billable visits by phone.

Qualifying provider types and programs

Provider types

- Psychiatrist
- Licensed clinical social worker (LCSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)
- Psychiatric nurse
- Psychologist

Programs

- Intensive outpatient (IOP)
- Partial hospitalization (PHP)

The following provider types and programs do not meet the FUH measure:

- PCP
- Drug and alcohol counselor
- Non-licensed clinicians
- Support groups

Set patients up for success

By working with us, the member and the member's family or support system, we can collectively ensure members have successful discharge plans and are able to function to their highest ability when they leave the hospital setting.

Your facility should:

- Begin follow-up planning at the time of inpatient admission and involve and educate the patient's family about the follow-up plan
- Encourage your patients to sign an *Authorization to Disclose Protected Health Information* form, available on our provider website: Behavioral Health Providers>Toolkit for PCPs; in most case, this form is not required for care coordination, but it can improve communication among various providers
- Discuss the follow-up plan with your patient and the importance of follow-up visits
- Schedule follow-up appointments, including one within seven days of discharge
- Ensure accurate post-discharge contact and follow-up information
- Call your patient to remind them of the follow-up appointment

Our care management team will:

- Determine a follow-up plan during the inpatient review process
- Assist in securing follow-up appointments, including locating new providers if needed
- Offer support by contacting members after their discharge to discuss the follow-up plan
- Help our members understand the importance of follow-up appointments
- Encourage timely outpatient follow-up with a licensed behavioral health provider

Learn more

Read about the FUH measure in our *Quality Measures Guide*: Programs>Cost & Quality>Quality Program>HEDIS Reporting.

Behavioral health corner

Telehealth can support PCPs and facilities

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

For PCPs: If your patient needs a referral for behavioral health evaluation treatment, you can recommend they check which of the following providers are in-network.

For facilities: To improve our members' outcomes and to reduce or avoid readmissions, it is important that patients are seen by a behavioral health provider within seven days of discharge from an inpatient or residential facility. We encourage you to share the following telehealth options with your patients to help them receive needed post-discharge care.

Note: Discharge appointments do not count as follow-up appointments.

Telehealth providers

- **Boulder Care**: Addiction treatment, including medication-assisted treatment (MAT) for opioid use disorders, that offers support through peer coaching, care coordination and other recovery tools
  - **www.boulder.care**
- **Charlie Health**: Mental health intensive outpatient treatment for teens and young adults, as well as their families
  - **charliehealth.com**
- **Eleanor Health**: Addiction and substance use disorder treatment provider with integrated evidence-based outpatient care and recovery for opioid and other substance use disorders
  - **eleanorhealth.com/locations/washington**
- **NoCD**: Specialized care for obsessive compulsive disorder (OCD) using exposure and response prevention (ERP) treatment
  - **treatmyocd.com**
- **Talkspace**: Mental health counseling available 24/7/365 via text, audio or video messaging
  - **talkspace.com/partnerinsurance**

Resources

Learn more about telehealth, including national vendors not mentioned here: COVID-19 Updates> Telehealth Visits.

Not all telehealth options are available to all members. Members can use the Find a Doctor tool on our member website, **asuris.com**, and search Places by Name for the telehealth providers listed below. They can also call or chat online with Customer Service for assistance.

Providers can check members' standard telehealth benefits by performing an eligibility and benefits inquiry in Availity Essentials: Eligibility and Benefits>Benefit Type>Professional (Physician) Visit—Home.

Stepdown form simplifies process for facilities

Behavioral health facilities should use our *Stepdown Request Form* to request immediate stepdown authorization from a higher level of care to a lower level of care.

This form eliminates the need for a facility to submit a *Discharge Notification Form* for a member being discharged from their current level of care and an *Initial Request Form* for the authorization to the new level of care, resulting in a more efficient process for facilities.

Behavioral health forms are available on our provider website: Library>Forms.

Childhood immunizations

On-time vaccination throughout childhood helps provide immunity before children are exposed to potentially life-threatening diseases. Childhood immunization rates for our health plan currently fall below the 50th percentile nationally.

As a PCP, you are a trusted resource and educator to parents and caregivers about the importance of routine checkups and recommended vaccination schedule. Scheduling office visits in advance can help parents and caregivers ensure their child stays on track.

Vaccine schedules recommended by agencies and organizations, such as the CDC, the American Academy of Pediatrics and the American Academy of Family Physicians, cover up to 14 diseases.

Sometimes, parents and guardians are concerned about the safety of vaccines. To help overcome this hesitancy, it is important to help them understand the United States' long-standing vaccine safety system ensures that vaccines are as safe as possible. Currently, the U.S. has the safest vaccine supply in history.

Here are some tips for talking to parents who are hesitant to vaccinate their children:

- Understand the parent's concerns
- Ask why the parent is hesitant
- Counter any misinformation
- Tailor your message
- Address parents' fears about side effects
- Prepare your staff to answer questions

Resources

Healthwise's Knowledgebase, **healthwise.net/asuris**, includes the following resources in English and Spanish to share with your patients:

- *Childhood Immunization Schedule: Ages 0 to 6 Years*
- *Childhood Immunization Schedule: Ages 7 to 18 Years*
- *Why Get Your Child Immunized?* video

Flu season is just around the corner

The CDC estimates that there were at least 8 million flu illnesses, 82,000 hospitalizations and 5,000 deaths from flu during the 2021-2022 flu season. It's difficult to know what the 2022-2023 flu season will bring, so prevention is the best protection.

The CDC recommends that everyone six months and older be vaccinated every flu season (with some rare exceptions) to reduce flu illness and serious outcomes. The flu vaccine is especially important for those considered high-risk and for older adults because they are at a higher risk of getting seriously ill from influenza and serious cases of flu can lead to hospitalization or death.

Tips to consider as we approach flu season:

- Educate support staff about the importance of the flu vaccine.
- Update your standing order protocol for the 2022-2023 flu season.
- If you don't currently have a standing order protocol for vaccines, consider creating one.
- Make resources about the flu vaccine available to patients to encourage informed decision making.
- If vaccines are not included in your pre-visit planning, consider adding vaccines to your pre-visit workflow.
- With pre-visit planning, consider adding the word "flu" to the appointment note for patients who are due for their vaccine. This will remind the care team at the time of the appointment that the patient hasn't yet received their flu vaccine.
- Consider hosting flu clinics or outreach campaigns to schedule patients for a vaccination appointment with a nurse or medical assistant.

To help educate your patients about the importance of the flu vaccine, an educational flyer, *Flu: Should I Get a Flu Vaccine?*, is available in English and Spanish. You can use the flyer to reinforce the conversation with your patient or make it available for patients to review in the waiting room before an appointment. The flyers are available on our provider website: Cost & Quality> Provider Quality Resources.

Discussing urinary incontinence with patients

Urinary incontinence can dramatically impact a person's quality of life. It can cause people to avoid activities, such as exercise; limit social outings; increase their risk of falls; impact their mental health; and affect their sleep, among many other things.

Discussing urinary incontinence can be uncomfortable; however, the more often these conversations happen with patients, the easier they become. With repetition, providers and patients can become comfortable discussing the topic.

There are many reasons to include urinary incontinence among the list of topics discussed at primary care visits.

- Many patients may see urinary incontinence as a sign of aging and just accept it as a part of life.
- Patients may hint at having issues with urinary incontinence and may want to have a conversation about it.
- Patients may be waiting for their provider to bring up the subject because they are embarrassed and do not want to bring it up on their own.
- Your patient may plan to discuss the topic when scheduling their appointment but then forget about it as the visit takes place.

Many providers screen for urinary incontinence issues as part of the patient completing an annual health risk assessment for their annual wellness visit.
You may also consider discussing issues about urinary incontinence during conversations around fall risk and physical activity because building core strength can help reduce the risk of falling as well as address incontinence, especially if Kegel exercises are discussed.

Improving Bladder Control is a Medicare Star Ratings measure and a health issue that we closely monitor. This is also an area where we rely on our provider partners to help us improve our scores.

Member flyers

To help you facilitate a conversation with your patients, we have Healthwise flyers available on our provider website in English and Spanish: Programs> Quality Program>Provider Quality Resources.

The flyers are designed to reinforce your conversations. They use motivational interviewing and behavioral science techniques to help engage members. The flyers can also be made available for patients to review in the waiting room before an appointment.

Tools available for treatment of low back pain

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

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

The measure looks at the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (X-ray, MRI, CT scan) within 28 days of the diagnosis. Asuris scored between the 75th and 90th percentile for this measure.

Care support flyers

We also have a series of printable educational flyers available that address different aspects of back pain, including:

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

Copies of these flyers are available by emailing the Quality Department at **Quality@asuris.com**.

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

Medicare QIP reminders

The following important reminders about the 2022 Medicare Quality Incentive Program (QIP) will help you with gap closure.

HCC EPB important dates

The hierarchical condition categories (HCC) early performance bonus (EPB) offers your practice an opportunity to earn $20 per member if you meet **both** of the following qualifications:

- Close 70% of your members' HCC gaps by 11:59 PM (PT) on August 31, 2022
- Close 80% of your members' HCC gaps by 2022 program end

Reminder: Gap closure means completely and accurately capturing the condition profile for the member, including both validating and invalidating conditions. Validating conditions should be done via claim submission. Invalidations must be submitted with medical record documentation via the Care Gap Management Application (CGMA).

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

Attribution lock coming October 1

Medicare QIP member attribution locks after our last attribution load in CGMA on October 1. We encourage you to prepare by reviewing your member roster on the CGMA.

- If there is a recycling bin icon next to a member's line, you can remove the member from your roster, if they are not one of your patients.
- If there is a lock icon, the member cannot be removed because of program rules that may include contractual obligations.

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

- How to find the recycling bin and lock icons
- How to remove a member from your roster before October 1
- Why you may not be able to remove a member from your roster, even before October 1

Learn about attribution adjustment options by member type on our provider website: Programs>Medicare Quality Incentive Program.

Attribution methodology update

We recently updated our attribution methodology for this program. Attribution steps are as follows:

1. Members attribute to providers in value-based arrangements (VBAs) through contract logic.
2. PPO members attribute to their selected PCP (if they have selected one).
3. Members who have at least one visit in 24 months attribute to that provider. If the member has visits with multiple PCPs:
   - Ties for number of visits by multiple providers are broken by the highest RVU total.
   - Ties for RVU total are broken by the most recent visit date.
   - **Note**: Previously, this rule required a minimum of two visits in 24 months.

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

CGMA tip: Mark as Reviewed

Have you tried using the new Mark as Reviewed workflow tool in the CGMA? This optional feature lets you move any gap into a Reviewed Gaps section without changing its status. The gaps will be out of your way but remain visible to you until they have been closed through other methods. For your reference, you can note the date and the reason for moving them. Try using this for gaps you have already addressed through claims submission.

To learn more about how to use Mark as Reviewed to manage your workflow, open CGMA, select the question mark icon at the top of the screen, and then select What's New.

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