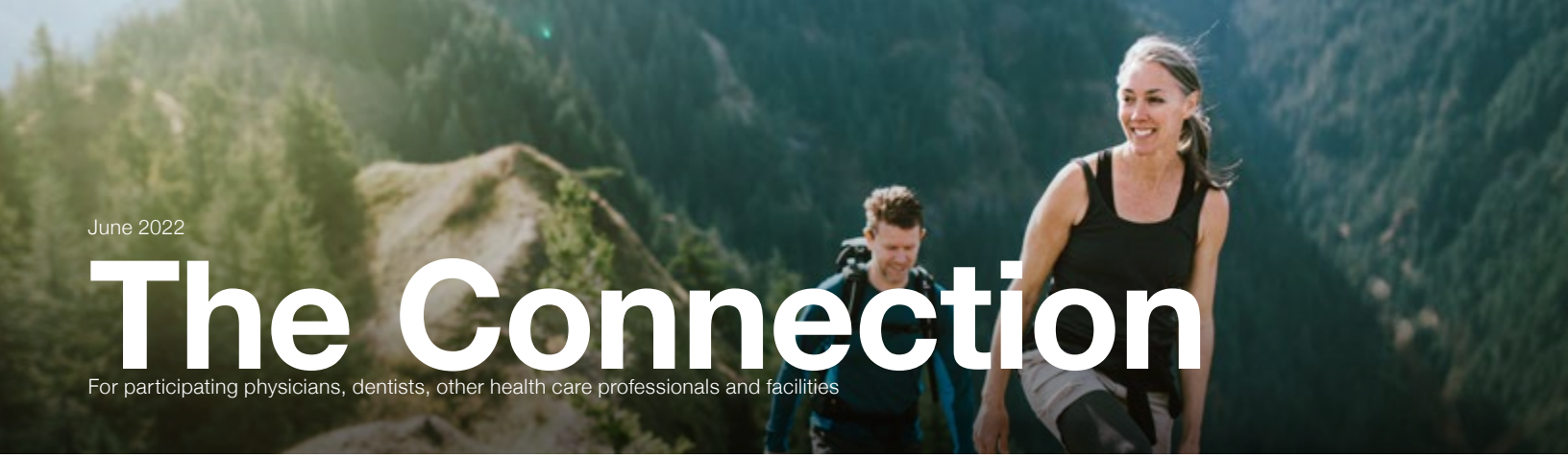

June 2022

The Connection

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

Behavioral health resources for the primary care setting

To support primary care providers (PCPs), we've launched a behavioral health toolkit on our provider website, **asuris.com**: Behavioral Health>Behavioral Health Toolkit.

Most behavioral health treatment is provided in the primary care setting and, when needed, mental health and substance use treatment are integral to patients' overall health.

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

It also includes an extensive list of screening tools and trusted resources for treating members who may have the following diagnoses and challenges:

- Anxiety
- Alcohol use
- Attention-deficit/hyperactivity disorder (ADHD)
- Bipolar disorder
- Depression
- Eating disorders
- Gender identity
- Opiate use
- Pain management
- Post-traumatic stress disorder (PTSD)
- Substance use disorder
- Suicide prevention

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

Click on a title to read the article.

About *The Connection*

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

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

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

The Bulletin

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

Share your feedback

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

Centers for Medicare & Medicaid Services (CMS) sequestration

The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare fee-for-service (FFS) claims as follows: There is a 1% payment adjustment from April 1 through June 30, 2022; the 2% payment adjustment will begin on July 1, 2022. We will apply these payment adjustments to our Medicare Advantage claims.

Visit our provider website for COVID-19 Updates and Resources.

Help patients make the most of their benefits

Members who sign in to their account on the member website, **asuris.com**, now have a more intuitive experience, personalized just for them. Members can quickly access tools and resources that help them stay on top of their coverage and make more informed health care decisions.

Most members have access to new features this year:

- **Care timeline**: Members can see their health and medication history in a chronological timeline. They can view past provider visits, lab work, prescription fills and more for themselves and family members on their plan.
- **Tools and resources**:
  - They can estimate their out-of-pocket costs and compare prices of hospital stays, treatments, MRIs, X-rays and more. The costs are shown based on the member's deductible and out-of-pocket maximums.
  - Members can also view virtual care options; behavioral health resources; wellbeing programs and support; as well as discounts on health-related products and services.
- **Medication support**: Members can compare medications for safety and effectiveness, see costs and safety alerts, and connect with a licensed pharmacist to get answers to medication questions.

Please encourage your patients to sign in to their member account to help make managing their care easier.

Share the *Keep Track of your Health* flyer with your patients: Programs>Cost & Quality>Member Tools

Administrative Manual updates

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

Provider Appeals

- Updated the process for submitting appeals or disputes

Facility Guidelines

- Updated home health services to require pre-authorization beginning on the 31st day
- Revised concurrent review requirements for diagnosis-related group (DRG) facilities

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

Hearing aid rates increased

Effective May 1, 2022, we increased reimbursement rates for hearing aids. We have established higher caps for reimbursement of HCPCS V5221 and V5254-V5261.

The new rates apply to dates of service May 1, 2022, and later; they will not be applied retroactively. This change applies to all commercial plans that do not specify a benefit limit.

If a member's needs will not be met by the hearing aid(s) within our reimbursement cap, suppliers should call our Provider Contact Center to fax us documentation including:

- The wholesale invoice with all discounts
- The make/model of the proposed hearing aid(s)
- The product literature, including the technical specifications
- Medical records to document what options were tried, why the lower-level device will not meet the medical needs of the member and what features of the proposed hearing aid make it medically necessary

For members whose hearing aid benefits are not based on the allowed amount, we will process claims according to their plan benefits.

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

Update your directory information

Accurate provider directories are essential to help members find providers who 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 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.

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

Reminder: Pneumatic compression device codes

As a reminder, we require the use of the following pneumatic compression device (PCD) HCPCS codes:

- **E0650, E0651, E0652**: For patients with lymphedema or chronic venous insufficiency
- **E0675**: For patients with peripheral artery disease (PAD)
- **E0676**: For post-surgical deep vein thrombosis (DVT) prevention (Post-surgical home-use of an intermittent PCD [HCPCS E0676] to prevent venous thrombosis is not eligible for reimbursement)

Please refer to our *Pneumatic Compression Device* (Administrative #134) commercial and Medicare Advantage reimbursement policies for applicable sleeve codes: Library>Policies & Guidelines>Reimbursement Policy.

Using unlisted codes (e.g., HCPCS A9900) in place of any of listed codes will result in non-payment.

Important: Reimbursement for a PCD used in a facility or provided by the facility/surgeon (before or after surgery) for post-surgical home use is included in the facility reimbursement and is not separately allowable when billed by the facility or a DME supplier. Allowing a DME supplier to separately bill for this is not appropriate and may result in higher out-of-pocket costs for the member.

Claim attachments reminders

We do not require attachments to be included as part of claims submission unless indicated in our Clinical Edits by Code Lists or if we send you a request.

Note: We are receiving an increase in providers submitting unsolicited incident (accident) reports. Incident reports should only be completed and submitted by the member when they receive a request.

We may request the following types of attachments from providers:

- Certificates of medical necessity
- Chart notes
- Dental or medical records
- Laboratory reports
- Operative reports
- X-rays

Submitting attachments

- **Only send attachments if indicated in our Clinical Edits by Code Lists or if you receive a request.** View the Clinical Edits by Code Lists in the Coding Toolkit on our provider website: Claims & Payment> Coding Toolkit.
- Please **respond to requests using the same format** in which they were received (e.g., Availity Essentials, fax or email).
- Sending **unsolicited attachments can delay** the processing of your claim.

Secondary claims to be automatically processed

When a member has two active health plans with Asuris, the member is considered to have secondary (or dual) coverage. Currently, we manually copy the information from the primary claim into the secondary claim for processing.

Beginning in July 2022, once the primary claim has finished processing, we will automatically copy the primary claim into the secondary claim for processing. This will expedite processing for most secondary claims.

- Please allow 30 days from the date the claim processed on the primary plan to be transferred and processed to the secondary. You can check the status of your claims on Availity Essentials.
- You may see denials for claims that have already been processed (e.g., duplicate claims).
- This impacts commercial (medical and dental) and Medicare claims. It excludes BlueCard and joint administration claims.

Our provider website includes information about secondary claims processing: Claims & Payment> Claims Submission>Benefit Coordination.

Timely claims filing reminder

As a participating provider, you may have received a new provider agreement or will be receiving a new provider agreement this year as part of our recontracting effort.

The new agreement indicates that claims for medical services must be submitted within 90 days of the date of service or otherwise as required by law. This requirement helps expedite claims processing and timely financial reporting. (If you have not yet received the new agreement, the terms of your current agreement will prevail.) **Note**: Some member benefits also require 90 days timely claim filing. Verify member benefits on Availity Essentials.

View answers to frequently asked questions about recontracting in the Contracting & Credentialing section of on our provider website.

Risk adjustment reviews starting

Medicare Advantage and Affordable Care Act (ACA) health plans must report member diagnosis data to the Centers for Medicare & Medicaid Services (CMS) or the Department of Health and Human Services (HHS) annually to calculate risk-adjusted payments to health plans. Most of this data is collected via claims. To ensure we are reporting all relevant data to CMS or HHS, our retrospective program collects information that may not have been reported through claims. CMS and HHS require all reported data to be fully supported by valid medical record documentation.

Medicare Advantage retrospective medical record reviews underway

We are in the process of requesting and reviewing medical records to support the diagnosis data we submit to CMS, and to capture members' complete health status. We have partnered with vendors Advantmed and Episource LLC to assist us in collecting medical records for Medicare Advantage members. You may have already received, or may soon be receiving, a request packet that explains what information we need and how to submit your records for our review.

Data validation audits underway

CMS and HHS conduct risk adjustment data validation (RADV) audits of the data submitted by health plans. These audits enable CMS or HHS to validate the diagnoses that were used to calculate payments made to health plans under risk adjustment. Providers and facilities play a critical role during the RADV audit process. In a RADV audit, diagnoses submitted for risk adjustment can be validated only by medical record review. If you assessed a member identified in the RADV audit sample, CMS and HHS require you to submit medical records when we request them. Your assistance and timely compliance to such requests enable us to meet our RADV audit obligations in the brief time frame allowed by CMS and HHS.

This month, we will begin requesting and reviewing medical records to support a RADV audit for HHS for dates of service in 2021. We have partnered with Advantmed to assist us in the collection of medical records for commercial members for this audit. If we need to collect records from you for this audit, you will receive a request packet that explains what information we need and how to submit your records for the audit.

Complete and accurate documentation is critical for risk adjustment. If medical record documentation does not support the diagnosis data we submitted to CMS or HHS, they will be unable to verify the diagnosis data. This can result in CMS or HHS imposing payment adjustments on Asuris that can impact the products and services we offer our members. We appreciate your efforts to ensure your Asuris patients' medical records are complete and accurate, and for responding to requests as quickly as possible.

More information about risk adjustment, including medical record reviews in process, is on our provider website: Programs>Risk Adjustment.

Tips for documenting chronic conditions

According to the Centers for Disease Control and Prevention (CDC), chronic conditions affect approximately 50% of the U.S. population. Accurately and completely documenting the status of your patients' conditions, including chronic conditions, is important to:

- Support and evaluate the patient's management of the condition over time
- Provide information to other providers who care for the patient
- Review routine screenings and test results
- Support complete and accurate claim submission

We recommend that you have policies and processes in place to support accurate and complete documentation and coding. This includes:

- Submitting complete and accurate diagnosis information on claims
- Keeping up to date with the latest guidelines for coding
- Coding chronic conditions annually with the highest level of specificity
- Documenting the monitoring, evaluation, assessment or treatment of conditions during the visit
- Describing the status of the chronic condition to accurately capture the patient's health (e.g., controlled, uncontrolled, new, acute, severe, worsening, improving)
- Documenting how a condition affects daily function (e.g., no longer able to climb stairs, unable to shop for food), when applicable

For more information about documentation and coding for chronic conditions, visit our provider website: Programs>Risk Adjustment.

Compliance program requirements

We want to remind you that all providers, their clinical and administrative staff, as well as contractors and any board or trustee members, must meet our Government Programs compliance requirements, including monthly verification that they are not on an exclusion list and that they are completing annual trainings about compliance and fraud, waste and abuse (FWA).

We contract with CMS to provide health care services to members with coverage through our Medicare Advantage Plans, Medicare Part D prescription drug products and the exchanges through the Qualified Health Plans (QHP). Through these contracts, we must oversee the first-tier, downstream and related entities (FDRs) and downstream and delegated entities (DDEs) that assist us in providing services for our Medicare and QHP beneficiaries.

Exclusion lists

All Medicare- and QHP-contracted providers, medical groups, facilities and suppliers are required to check the Office of Inspector General (OIG) and General Services Administration (GSA) federal exclusion lists for all employees, contractors, board or trustee members prior to hire and monthly thereafter. If an individual is confirmed to be excluded, they must immediately be removed from working on our government programs. We are prohibited from paying government funds to any entity or individual found on these federal lists:

- GSA exclusion list: **sam.gov/content/exclusions**
- OIG exclusion list: **oig.hhs.gov/exclusions**

Documentation of these verifications must be maintained and made available upon request by either Asuris or CMS. We ask contracted entities to verify that the entity is compliant with this requirement during initial credentialing and at recredentialing.

Required compliance training

FWA, general compliance and code of conduct trainings for all employees, contractors, board or trustee members are a contractual requirement for participation in our Medicare Advantage and QHP networks. This training must be completed within 90 days of hire and annually thereafter.

Your organization's code of conduct should clearly state that reporting noncompliance, FWA and code violations is everyone's responsibility. It should also provide methods for reporting (e.g., anonymous hotline, email.) If your organization does not have a code of conduct, it may use our Code of Business Conduct.

Your organization's executive staff is required to sign a *Conflict of Interest* disclosure at appointment and annually thereafter.

Please ensure that your staff complete required training and maintain documentation for auditing purposes.

Compliance for board and/or trustee members

Your organization's board or trustee members are required to participate in all Asuris Government Programs compliance activities, including:

- Signing a *Conflict of Interest* disclosure at appointment and annually thereafter
- Completing OIG and GSA screenings prior to appointment and monthly thereafter
- Completing FWA, general compliance and code of conduct training within 90 days of appointment and annually thereafter
- Acknowledging receipt of your organization's code of conduct within 90 days of appointment and annually thereafter

Documentation must be maintained and made available upon request by either Asuris or CMS.

Learn more

More information about our compliance program and related resources are available on our provider website:

- Products>Medical>Medicare> Medicare Compliance Training
- *Government Programs Compliance Tips*: Library>Printed Material.
- *Administrative Manual*: Library> Administrative Manual
  - Qualified Health Plans
  - Medicare Advantage Compliance Requirements

Appointment accessibility results

This past winter, we conducted our annual Provider Access Survey of primary care providers (PCPs), behavioral health providers, and providers in high-volume and high-impact specialties related to patient appointment access. Your answers helped us measure compliance with our published standards for after-hours phone coverage and appointment wait times.

Overall, we found that members' access to primary care appointments met our standards, with minor delays for non-urgent, persistent symptom appointments. Timely access to specialty and behavioral health care fell a little short of our standards; however, we recognize and appreciate your efforts to deliver timely care for our members despite tremendous ongoing challenges.

After the survey, Provider Relations contacted a sample of providers to learn more about the challenges you are facing in meeting access standards. Your open and honest responses have helped us better understand the challenges you and our members face when it comes to timely access to care.

During our discussions with providers, common themes emerged:

- Providers are facing long-term COVID-19-related impacts that have affected scheduling, such as delays because of reduced office hours or office closures.
- Many offices are working with reduced staff and struggling to hire in a highly competitive environment, particularly when recruiting to rural and coastal areas.
- Despite these obstacles, offices try to schedule patients as quickly as possible or help them find care elsewhere if they cannot be seen in the office as soon as needed.

Access to specialty care

The survey showed us that scheduling patients for urgent specialty care appointments within 24 hours remains difficult, while patient access to non-urgent appointments within 30 calendar days became more difficult for many in the past few years.

From our outreach, we learned that the urgent appointment requirement may not be appropriate for all specialties. Additionally, many providers have processes in place to triage members and help them get the right care at the right time, which may not be within 24 hours. We ask that you remain mindful of the urgent care requirement to ensure patients can get timely care when needed.

Access to behavioral health care

The survey data shows us that scheduling patients for behavioral health care is also difficult, particularly to see a new patient within 10 business days. We recognize the unprecedented demand for behavioral health care services, and from our outreach, we learned of ways that you are working hard to meet this growing need. Offering extended hours and adding more virtual visit opportunities are helping members receive behavioral health care as quickly as possible.

We appreciate your commitment to meeting our members' behavioral health needs and working to provide them access to care. We recognize the need for additional behavioral health providers and are actively recruiting providers to increase accessibility.

Please be mindful of the access requirements for behavioral health care:

- Non-life-threatening emergency (crisis) will be treated within six hours or directed to the nearest emergency room or crisis unit.
- Urgent care appointments will be scheduled within 48 hours.
- Routine office visits will be scheduled within 10 business days.

All our standards are published on our provider website: Programs>Cost and Quality>Quality Program>Accessibility and Availability Standards.

Submit claims appeals on Availity Essentials

You can now use the new Appeals application on Availity Essentials to submit claims appeals.

- The new application streamlines the appeals process, making it faster and easier to submit appeals directly from the Claim Status screen.
- Submit claims appeals with required documentation and receive immediate confirmation of submission.
- Review the progress of your appeal and access past appeals in the Appeals dashboard.

Messaging will display if the claim you are disputing does not meet criteria for submission via the application. A messaging guide has been added to our provider website to assist you with alternate appeals options: Claims & Payment>Receiving Payment>Appeals.

Access the new Appeals dashboard on Availity Essentials: Claims & Payments>Appeals.

Note: Pricing disputes are not appeals and should be submitted using our *Pricing Dispute Form* and dedicated workflow.

Get trained for free

View the training options available by clicking the Help & Training link in the Availity Essentials menu.

Pre-authorization updates

Commercial Pre-authorization List updates

Procedure/medical policy	Added codes effective May 1, 2022
Evaluating the Utility of Genetic Panels (#GT64)	81324-81326
Genetic and Molecular Diagnostic Testing (#GT20)	81324-81326
Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies (#GT66)	81324-81326, 81448
Procedure/medical policy	**Adding codes effective September 1, 2022**
Joint management—eviCore healthcare (eviCore)	23000, 23020, 23120, 23130, 23410, 23412, 23420, 23430, 23440, 23455, 23462, 23466, 23700, 27332-27334, 27403, 27405, 27415, 27418, 27420, 27422, 27425, 27427-27429, 27430, 27570

Medicare Pre-authorization List updates

Procedure/medical policy	Adding codes effective September 1, 2022
Joint management—eviCore	23000, 23020, 23120, 23130, 23410, 23412, 23420, 23430, 23440, 23455, 23462, 23466, 23700, 27332-27334, 27403, 27405, 27415, 27418, 27420, 27422, 27425, 27427-27429, 27430, 27570

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.

Concurrent review changes for DRG facilities

Effective September 1, 2022, we will decrease the time frame in which in-network diagnosis-related group (DRG) facilities must submit clinical information for urgent admissions (commercial and Medicare Advantage) and on-going elective admissions (Medicare Advantage only). This change applies to all elective and urgent admissions for commercial and Medicare Advantage members.

We continue to require notification for all hospital and behavioral health admissions within 24 hours, which 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.

Our goal in performing concurrent review is to:

- Increase transparency and collaboration to improve quality outcomes for our members
- Reduce the administrative burden for facilities by eliminating concurrent review for members who are low risk and likely to follow normal patterns of care

Related: See *Administrative Manual updates* on page 3.

Concurrent review to be required at hour 24 for NICU and pediatric ICU

Effective September 1, 2022, we will require concurrent review for newborn intensive care unit (NICU) and pediatric intensive care unit (PICU) notifications within 24 hours. We are making this change to align with our concurrent review requirements for other admissions.

This change applies to commercial and Medicare Advantage members.

Clinical Practice Guidelines update

We reviewed the Preventive Services Guideline for Adults Clinical Practice Guideline, effective May 1, 2022:

- We added endorsement of the U.S. Preventive Services Task Force (USPSTF) Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis guideline
- We continue to endorse the USPSTF guidelines for breast, cervical and colorectal cancer screening, as well as depression and osteoporosis screening, and the Centers for Disease Control and Prevention's (CDC's) immunization recommendations

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

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

- *Eating Disorder Inpatient Treatment* (#BH25)
- *Eating Disorder Intensive Outpatient* (#BH26)
- *Eating Disorder Partial Hospitalization* (#BH27)
- *Eating Disorder Residential Treatment* (#BH28)
- *Investigational Gene Expression and Multianalyte Testing* (#LAB77)
- *Psychiatric Inpatient Hospitalization* (#BH29)
- *Psychiatric Intensive Outpatient* (#BH30)
- *Psychiatric Partial Hospitalization* (#BH31)
- *Psychiatric Residential Treatment* (#BH32)

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

- *Implantable Peripheral Nerve Stimulation and Peripheral Subcutaneous Field Stimulation* (#SUR205)
- *Noninvasive Prenatal Testing to Determine Fetal Aneuploidies, Microdeletions, and Twin Zygosity Using Cell-Free DNA* (#GT44)
- *Occipital Nerve Stimulation* (#SUR174)

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 April 2022 issue of *The Bulletin* about changes to the *Modifier 53; Discontinued Procedure* (Modifiers #102) reimbursement policy, which are effective July 1, 2022.

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

- *Correct Coding Guidelines* (Administrative #129)
- *DME Purchase and Rental Limitations and Reimbursement* (commercial and Medicare Advantage Administrative #131)
- *Reimbursement of Intravenous (IV) Solutions, Premixed IV Medications, Epidural, Intra-arterial and Intrathecal Solutions and Total Parenteral Nutrition (TPN) for Facilities* (Facility #109)

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.

eviCore clinical guidelines to be revised

Effective September 1, 2022, eviCore will revise the advanced musculoskeletal clinical guidelines below for several components of our Physical Medicine program.

Pain management

- Epidural Steroid Injections (#200)
- Facet Joint Injections/Medial Branch Blocks (#201)
- Trigger Point Injections (#202)
- Sacroiliac Joint Procedures (#203)
- Ablations—Denervations of Facet Joints and Peripheral Nerves (#208)
- Regional Sympathetic Blocks (#209)
- Implantable Intrathecal Drug Delivery Systems (#210)
- Anesthesia Services for Interventional Pain Procedures (#400)
- Discography (#401)
- Greater Occipital Nerve Block (#402)

Joint surgery

- Knee Replacement—Arthroplasty (#311)
- Knee Surgery—Arthroscopic and Open Procedures (#312)
- Hip Replacement—Arthroplasty (#313)
- Hip Surgery—Arthroscopic and Open Procedures (#314)
- Shoulder Surgery—Arthroscopic and Open Procedures (#315)
- Shoulder Arthroplasty—Arthrodesis (#318)
- Arthroscopy—Ankle (#406)
- Arthroscopy—Subtalar Joint (#407)

Spine surgery

- Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) with or without Fusion (#604)
- Cervical Microdiscectomy (#605)
- Lumbar Microdiscectomy (Laminotomy, Laminectomy or Hemilaminectomy) (#606)
- Lumbar Decompression (#608)
- Sacroiliac Joint Fusion or Stabilization (#611)
- Grafts (#612)
- Thoracic Decompression/Discectomy (#613)
- Thoracic/Thoracolumbar Fusion (Arthrodesis) (#614)

These upcoming guidelines revisions are published in the Musculoskeletal: Advanced Procedures section of eviCore's website under the Future tab: **evicore.com/provider/clinical-guidelines**.

AIM revising clinical guidelines

Effective September 11, 2022, AIM Specialty Health (AIM) will revise the following guidelines:

- Radiology guidelines: **aimspecialtyhealth.com/resources/clinical-guidelines/radiology**
  - Extremity Imaging
  - Spine Imaging
  - Vascular Imaging
- Sleep disorder management guidelines: **aimspecialtyhealth.com/resources/clinical-guidelines/sleep**

AIM announces upcoming revised guidelines in the Coming Soon section below each set of current guidelines.

Supply codes to be added to NRS list

Effective September 1, 2022, we will add 43 DME-related HCPCS codes to our non-reimbursable services (NRS) list for commercial and 21 codes for Medicare Advantage claims.

Codes that will be listed as NRS for commercial

- A4400
- A4459
- A5510
- A7047
- A9285
- E0144
- E0175
- E0350
- E0575
- E0620
- E0840
- E0850
- E0856
- E0983-E0984
- E2230
- E2358
- E2360
- E2362
- E2364
- E2372
- K0806-K0808
- K0868-K0871
- K0877-K0880
- K0884-K0886
- L2840
- L2850
- L4394
- L4398
- L5990
- L7600
- L8031
- L8035

Codes that will be listed as NRS for Medicare Advantage

- A4337
- A4400
- A4459
- E0350
- E0352
- E0983-E0984
- E2358
- K0868-K0871
- K0877-K0880
- K0884-K0886
- L4394
- L4398

These NRS codes will be added to the Clinical Edits by Code List on our provider website: Claims & Payment>Coding Toolkit.

Medication policy updates

Effective September 1, 2022, we will update the following policies:

- *Enzyme Replacement Therapies* (dru426)
  - Adding generic carglumic acid to the policy
  - Adding criteria for confirmation of diagnosis for all enzyme replacement therapies (ERTs), with biochemical, genetic, and/or enzymatic testing
  - Clarifying continuation of therapy and reauthorization criteria to include review for use of lowest effective dose
  - Adding step therapy with generics (carglumic acid, nitisinone) prior to coverage of brandname equivilants (Carbaglu, Orfadin, Nityr)
  - Updating quantity limit for Kanuma to reflect new FDA-approved dose escalation, with criteria reflecting meeting need for dose escalation
- *High-Cost Medications for Chronic Constipation* (dru519)
  - Adding additional step therapy requirements for Isbrela (linaclotide and lubiprostone)

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 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.

Changes to DME coverage for CGMs

Durable medical equipment (DME) coverage for continuous glucose monitors (CGMs) will transition into a pharmacy-only benefit in 2023. This change will apply to fully insured Individual and group members, including administrative services only (ASO) group members, with both medical and pharmacy benefits through Asuris.

Note: If a member does not have Asuris pharmacy benefits and only has a medical benefit, the CGM and supplies will be covered under the DME benefit in 2023.

Behavioral health corner

About behavioral health corner

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

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

Changes to psychotherapy and other reimbursement rates

Based on your feedback and a recent review, we are making an off-cycle reimbursement change for behavioral health providers with our standard *Professional Services Agreements* effective October 1, 2022.

This will result in higher reimbursement rates for psychiatrists, psychologists and master's-level clinicians billing CPT 90837. There will also be an adjustment for master's-level clinicians that may result in higher reimbursement rates for other codes.

Reimbursement schedules with the updated rates will be available on Availity Essentials.

Behavioral health corner

Reimbursement changes for alcohol and drug treatment services

Effective October 1, 2022, we will make the following changes to alcohol and drug treatment services (ADTS) codes:

- We will reimburse five additional ADTS codes.
- We will increase reimbursement rates for the five ADTS codes currently in place.

Reimbursable ADTS CPT codes effective October 1, 2022

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

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

Reminder: July 1 telephonic reviews requirement

Our behavioral health utilization management team will complete telephonic concurrent and discharge reviews for services—including intensive outpatient (IOP) programs—delivered on or after July 1, 2022, for the following member and diagnostic groups:

- Child and adolescent—all levels of care and diagnoses
- Eating disorder—all levels of care
- Residential substance use disorder (SUD)

Note: Applied behavior analysis (ABA) and transcranial magnetic stimulation (TMS) services are excluded from this requirement.

After a provider submits the *Initial Request Form*—available on our provider website: Library>Forms—our staff will contact the requestor to schedule a review.

Improving care for patients treated with antipsychotics

We continue to monitor the following HEDIS measures evaluating the care of children, adolescents and adults who are prescribed antipsychotics. Results for each of these measures remain below national benchmarks:

- Metabolic Monitoring for Children and Adolescents on Antipsychotics assesses annual glucose and cholesterol testing for children and adolescents on antipsychotics.
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications assesses annual diabetes screening for people with schizophrenia or bipolar disorder taking antipsychotic medications.
- Diabetes Monitoring for People with Diabetes and Schizophrenia assesses annual glucose and cholesterol monitoring for people with diabetes and schizophrenia.

Collaborating with primary care and behavioral health providers attending our Provider Advisory Council (PAC), we work to identify actions that can improve patient care. When we discussed the metabolic testing and monitoring recommended for patients taking antipsychotics, providers acknowledged that coordination between primary care and psychiatry can require extra steps. The PAC developed these suggestions to improve the safety of care for patients treated with antipsychotics:

Best-practice suggestions for PCPs

- Ensure you are aware of antipsychotic prescriptions by encouraging patients to bring all medications to their scheduled wellness appointments.
- When children and adolescents are taking antipsychotics, ensure recommended annual HbA1c and cholesterol tests are ordered.

Best-practice suggestions for psychiatrists

- When prescribing antipsychotics, communicate with the PCP to confirm roles in ordering tests, reviewing results, following up and managing the patient's health based on lab results.
- Establish a process for ordering labs if you are practicing telemedicine exclusively.
- Encourage patients to see their PCP for monitoring of metabolic abnormalities associated with medications.

Behavioral health corner

Screening for behavioral health conditions in primary care

Reminder: We reimburse behavioral health screening by primary care providers (PCPs). As COVID-19 rates decline and patient visits increase, we encourage PCPs to screen patients for behavioral health conditions.

Because some patients may not schedule routine wellness exams, we recommend that you include behavioral health screening during non-preventive encounters.

We have expanded our network of behavioral health providers to treat members with positive screening results, and we continue to broaden the number of network providers, resources and treatment options available to our members. Members can use the Find a Doctor tool and also find other behavioral health resources on our member website, **asuris.com**.

Related: See *Behavioral health resources for the primary care setting* on page 1.

Help parents check in with teens

Each of us has experienced our own unique mental health challenges during the pandemic, and this is especially true for younger generations. COVID-19 affected the lives of youths both inside and outside of school, creating a sense of fear, isolation and uncertainty. In the previous year, more American youths have experienced a major depressive episode, according to the *2022 State of Mental Health in America* report by Mental Health America: **mhanational.org/issues/state-mental-health-america**.

Now is a great time to learn about resources to support teenagers, including these tips from Mental Health First Aid:

- Have open conversations and talk honestly about their feelings or worries.
- Help them look for patterns or be aware of situations that make them feel particularly worried or anxious. Help them learn relaxation or distraction techniques when they are in these situations.
- Help them to understand that they aren't alone. Many people are experiencing stress, and we should be kind and patient with one another.
- Be on the lookout for physical changes or new medical issues, these could be signs of teens internalizing stress.
- If feelings of overwhelm and distress continue, seek guidance from a mental health professional.

Resource

- Mental Health First Aid has many tips for parents and their kids: **mentalhealthfirstaid.org/2020/04/tips-to-help-teens-cope-during-covid-19**.

Women's health: Screening reminders

We cover the following preventive health services at 100% for most commercial members:

- Cervical cancer screening (Pap) (ages 21 and older)
- Screening for gonorrhea, syphilis and chlamydia
- HIV screening and counseling (ages 15 to 65 or at high risk)
- Human papillomavirus (HPV) screening, every three years (ages 30 and older) and HPV immunizations (up to age 45)
- Screening mammogram (ages 40 and older or at high risk)
- Sexually transmitted disease counseling during wellness exams

Members may not be aware that these services are covered at 100%. They can view the list of covered services on our member website, or by calling Customer Service at the phone number on the back of their member ID card.

Cervical cancer screening

We encourage you to schedule cervical cancer screenings with your patients who may be overdue. These screenings may find cancers earlier when they are more easily treated. Women who have not been screened face the greatest risk of developing invasive cervical cancer.

Our most recent Healthcare Effectiveness Data and Information Set (HEDIS®) results, based on 2020 care, indicate that 68% of Asuris members who are eligible received the screening, which put our health plans at the 25th percentile nationally for this measure.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer with the Pap test alone every three years in women ages 21 to 29. In women ages 30 to 65, the USPSTF recommends the Pap test alone every three years or HPV testing, with or without Pap co-testing, every five years.

Chlamydia screening

Because people often do not have symptoms, many chlamydia infections go undetected and untreated which can have severe long-term health consequences.

The HEDIS specifications for chlamydia recommend screening one time per year in women ages 16 to 24 who are sexually active. Our most recent HEDIS results, based on 2020 care, indicate that only 36% of Asuris members who are eligible received the screening, which put our health plans at the 25th percentile nationally for this measure.

The USPSTF recommends screening for chlamydia in sexually active women 24 and younger and in older women who are at increased risk for infection.

Resources

List of preventive care services covered at no cost for our group and Individual members (available in English and Spanish): **asuris.com/member/members/preventive-care-list**

List of preventive care services covered at no cost for our Medicare members: **asuris.com/medicare/resources/preventive-care**

Chlamydia—CDC Fact Sheet: **cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm**

Link to Healthwise's Knowledgebase, including the video *Why Get a Chlamydia Test* and *Your Test: Chlamydia Test* flyer (in English or Spanish), available by emailing **Quality@asuris.com**.

Well-child visits are important

Well-child visits provide opportunities for infants and young children to receive recommended preventive care screenings, immunizations and vaccinations; chronic condition prevention and management; identification and treatment of major illnesses; early identification of special health care needs; and other important services. These visits can also address identified needs and provide referrals to community resources to help build and support strong families that are able to successfully care for children.

Pediatric primary care providers (PCPs) are a trusted resource for parents and care givers regarding their children's health and have a vital role in ensuring children receive timely well-child care.

One of our 2022 goals for our group and Individual members, is to increase the number of children who receive six or more well-child visits with a PCP during the first 15 months of life as measured using HEDIS criteria. The American Academy of Pediatrics (AAP) schedule includes at least six visits at the following times:

- Birth
- Three to five days following birth
- By one month of age
- One visit each at two, four, six, nine, 12 and 15 months of age

We support the AAP recommendations for preventive pediatric health care. We encourage you to provide well-child services at appropriate intervals and to remind parents of the need for these visits and their timing by:

- Scheduling office visits in advance, based on the recommended schedule
- Pursuing missed appointments with letters and reminder calls
- Submitting claims for well-child services using the following codes:
  - CPT 99381-99385, 99391-99395, 99461
  - HCPCS G0438, G0439, S0302
  - ICD-10-CM Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Resources

- Bright Futures Health Care Professionals Tools and Resources: **brightfutures.aap.org/clinical-practice/Pages/default.aspx**
- Vaccination schedules for children and adolescents, as well as catchup schedules, published by the CDC: **cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**
- *Social Determinants of Health Z codes* flyer: Available on our provider website: Library> Printed Materials (under Cultural competency)
- Healthwise's Knowledgebase flyers (available in English and Spanish), which are available by emailing **Quality@asuris.com**).

Following up on test results

As a health plan, we are evaluated through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on several measures that are based on our members' experiences within the delivery system. Two measures we are monitoring concern how well providers follow up with test results and whether this is done in a timely manner.

Studies show that ineffective management of test results—because of not following up with test results or not following up in a timely manner—can lead to waste in health care by causing additional and unnecessary tests to be ordered, or by causing serious patient safety issues with missed diagnoses or the need for potential changes in patients' medications.

We know that many of our provider partners are currently hiring to fill open positions, which may include support staff to help with workflows related to following up with test results. We encourage you to consider these tips related to test result processes to ensure that follow up happens in a timely manner:

- Follow up on all test results, both normal and abnormal.
- Follow up using patients' preferred method of communication (mail, phone or email) to ensure they are notified of their results.
- Leverage your EMR to its highest potential for test tracking and follow up, to distinguish between abnormal and normal test results, and for communication between staff, as well as communication with patients through your patient portal.
- Communicating the standard process for following up with test results (e.g., within two to three business days), can help set expectations with patients, and improve the experience for patients and staff.

Consider test result follow up and following up timely as a quality improvement project for your 2022 or 2023 quality program year. Here are some resources that can help:

- The Institute for Health Improvement *Plan-Do-Study-Act (PDSA) Worksheet* can help guide almost any quality improvement project: **ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx**
- The Agency for Healthcare Research and Quality Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement may be helpful for improving processes and workflows within your practice: **ahrq.gov/hai/tools/ambulatory-care/lab-testing-toolkit.html**

In-home bone mineral density testing available for Medicare Advantage members

The Bone Health and Osteoporosis Foundation recommends that women ages 65 and older, or who are age 50 or older and have experienced a fracture, should be screened for osteoporosis. In-network bone mass measurements are preventive services covered at no cost to the qualifying patient every 24 months or more frequently if medically necessary.

Medicare Advantage members who need bone mineral density (BMD) testing can complete a test at home through our partner, Signify Health. You or your patient can call 1 (844) 857-3955 to schedule an in-home BMD test. Signify Health shares test results with both you and your patient.

Medicare QIP reminders

HCC EPB important dates

The Medicare Quality Incentive Program (QIP) 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:

1. Close 70% of your members' HCC gaps by 11:59 PM (PT) on August 31, 2022.
2. Close 80% of your members' HCC gaps by December 31, 2022.

Reminder: Gap closure means completely and accurately capturing the condition profile for the member, including both validating and invalidating conditions. This can completed via claim submission and medical record documentation.

You can submit HCC gap closures one of several ways:

- Claims
- Supplemental data files
- Care Gap Management Application (CGMA)

CGMA tips and tricks

Do you use the CGMA to manage your Medicare QIP work? Use these tips to get the most out of your CGMA user experience.

- **Stay active to avoid lockout**. CGMA accounts that are inactive for 120 calendar days are locked. It can take up to one week to reactivate and unlock your account.
- **Get your own CGMA user account**. When signing up for CGMA, every CGMA user agrees to have their own account and password. Accounts are free, and every user receives a practice-level weekly progress update on Monday mornings.
- **Gap comments section in the CGMA**. Whenever you work a gap in the CGMA, it is reviewed internally, and it may be returned to you if your submission doesn't meet certain criteria. When a gap is returned, the reason for the return is included in the Comments section on the gap closure dialog screens. Sometimes, the reviewers write notes to each other here, too. Providers may also use the Comments section, but please keep in mind that reviewers cannot use those notes as evidence to close a gap. Reviewers are restricted to considering only the content of patient chart notes that are submitted by you.

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

Resources for you

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

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