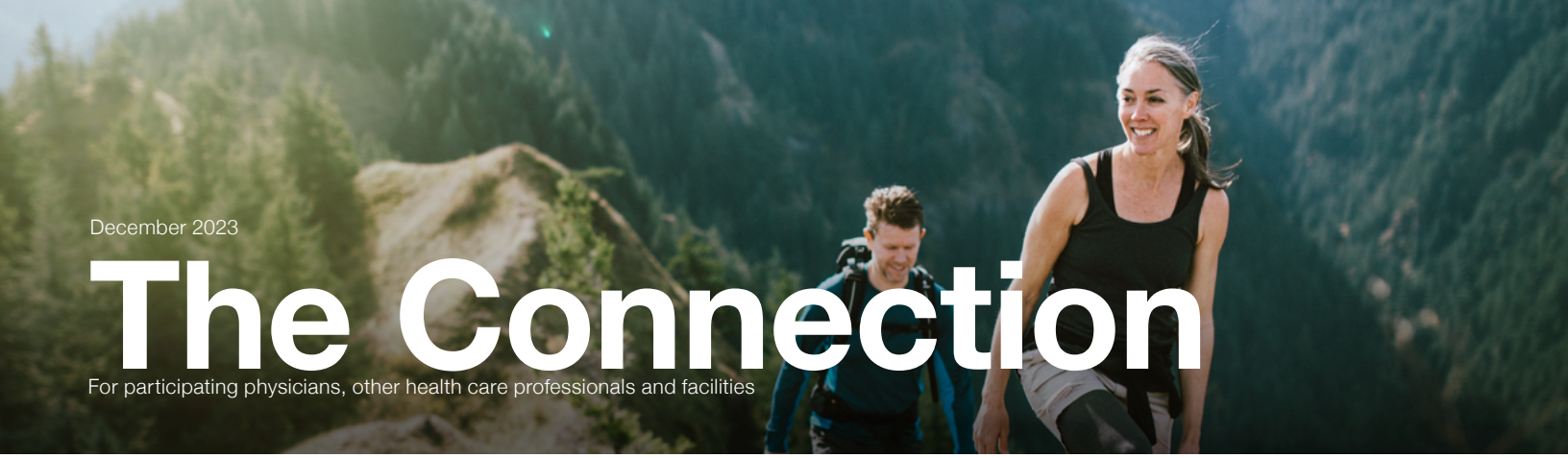

December 2023

The Connection

For participating physicians, other health care professionals and facilities

Updates and resources for the new year

Thank you for your tireless efforts to care for our members and the people in our community. As 2024 approaches, we want to keep you informed of upcoming changes and new resources for your practice.

Member ID card reminders

Many of your Asuris patients will receive new member cards in January. Ensure prompt and accurate claims processing by:

- Asking the member for their most current card at each visit. Since new member cards may be issued throughout the year, this will ensure that you have the most up-to-date information.
- Copying the front and back of the card. Use this information when submitting claims and share it with your billing staff.
- Verifying the member number submitted is exactly as it appears on the member card. This is critical for eligibility and benefit verification and claims processing.

Note: For new patients transitioning from another health plan, review with the member any outstanding pre-authorization requests that need to be resubmitted to Asuris.

More information about member ID cards can be found on our provider website: Claims & Payment>Identifying Members.

Resources to help you in the new year

As we start another year, we want to remind you of all the resources that are available to help and support you and your practice.

Continued on page 3

Easily find information

Did you know that you can search for words in this newsletter by holding down the **Ctrl** key on your keyboard and then the letter **F**? A pop-up window will appear asking if there's a word or phrase you need to find.

Subscribe today

Subscribe to receive email notifications when new issues of our publications are available.

Using our website

When you first visit **asuris.com**, you will be asked to select an audience type (individual, employer, producer or provider) and enter a ZIP code for your location. This allows our site to display content relevant to you.

Stay up to date

View the What's New section on the home page of our provider website for the latest news and updates.

ASURIS NORTHWEST HEALTH

Asuris Northwest Health

528 East Spokane Falls Blvd, Suite 301
Spokane, WA 99202

Contents

■ Critical article	We encourage you to read the other articles because they may apply to your specialty.
● Massage	
‡ Dental	
★ Star Ratings/Quality	

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.

Continued from page 1

Availity Essentials

You can use Availity Essentials to:

- Access most member eligibility, benefits and claims information
- Review pre-authorization requirements and submit requests online
- Use the Onboarding Tracker to view contracting status and more

Self-Service Tool

On our provider Self-Service Tool, you can find answers to more than 50 of the most frequently asked questions, including information about contracting and credentialing, claims, pre-authorization and tips for using Availity Essentials. You can launch our Self-Service Tool through the main menu on our provider website.

Provider Contact Center

Our Provider Contact Center is an excellent resource for information that cannot be served by Availity Essentials or our Self-Service Tool. Please be advised that the start of the new year is a busy time for the Provider Contact Center. Callers may experience extended wait times, and, during peak hours, we may temporarily pause the intake of calls, during which time callers will hear an automated message informing them of the high call volume and requesting they try contacting us as a later time. The message will be disabled as service representatives are able to resume receiving calls.

Provider toolkits

Did you know provider toolkits are available to help you and your practice? We have in-depth toolkits with tips, resources, links and information about topics including:

- Behavioral health
- Care options
- Coding
- COVID-19
- Cultural competency
- Pain management
- Quality improvement

Our provider Toolkits can be easily accessed on the homepage of our provider website.

Dental providers

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

Complete the office staff survey

The second wave of our 2023 Provider Office Staff Experience Survey will be emailed to some offices this month. If you receive the survey, we encourage you to share your feedback. Your responses will help us improve the services and tools we offer.

The online survey takes less than 10 minutes to complete and will be available until January 7, 2024.

Thank you in advance for sharing your feedback.

Do our publications meet your needs?

Take a few minutes to share your feedback about our newsletter and bulletin by completing this short survey before December 31, 2023.

SHARE YOUR FEEDBACK

Thank you in advance for your time and input!

Home health consolidated billing reviews

On March 1, 2024, we will begin post-payment reviews of home health services claims that are subject to consolidated billing. These reviews will include payments made separately from home health consolidated billing reimbursements for services provided during a covered home health service and within the state's timeliness rules.

The post-payment process will:

- Identify services that are subject to home health consolidated billing
- Validate that an authorized home health episode of care was in effect for the date of service
- Verify that any separate payments were appropriate

We will review commercial and Medicare Advantage claims.
We will adjust payments that we verify were separate from an applicable home health consolidated billing. Where allowed, we will request recoupment via adjustment of a future claim payment.

Additional information about home health billing is available in the Facility Guidelines section of our *Administrative Manual*, available on our provider website: Library>Administrative Manual.

Massage billing reminder

As a reminder, state licensing dictates which services a provider may practice. Massage therapists should use the existing, non-evaluation & management (E&M) CPT codes specific to their specialty and should bill only for services within their specialty's scope of practice.

Massage therapists are eligible to bill CPT 97110, 97112, 97124 and 97140.

All claims submitted are subject to provider contract and state licensing rules.

This standard is included in the Alternative Care section of our *Administrative Manual*, which is available on our provider website: Library> Administrative Manual.

Administrative Manual updates

The following updates were made to our manual on December 1, 2023:

Alternative Care

- Clarified services billable by licensed massage therapists (LMTs), as well as services that are not covered
- Clarified that osteopathic manipulation codes are only payable to MDs and DOs

Facility Guidelines

- Added information regarding consequences of failing to submit clinical records timely

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

Reconcile overpayments faster

If you receive a refund request letter or have a claim that needs to be adjusted, you can now email us to have the overpayment voucher deducted.

- Download a copy of the *Overpayment/Voucher Deduction Request* form, available on our provider website: Claims & Payment> Receiving Payment>Overpayment Recovery.
- Attach the completed form, along with any backup documentation that you have to expedite the process, and email the documents to us at **Overpayment_Recovery@asuris.com**.

Using this form can save your office time because you will no longer need to write checks, print backup documentation and mail the overpayment. It also eliminates the possibility of your office sending in a check at the same time the overpayment is deducted from your voucher.

If you prefer, you can mail or fax a copy of the form and backup documentation to the address or fax number on the *Overpayment/Voucher Deduction Request* form.

Advantages of using CPT category II codes

CPT category II (CPT II) codes are supplemental tracking codes intended to facilitate data collection about care quality. CPT II codes describe components that are often included in an E&M service or test results that are part of a laboratory test or procedure. They provide more information about the care your patient received during a visit.

Why you should use CPT II codes

Submitting CPT II codes:

- Shares clinical data using claims
- Allows providers with alternative payment models (APMs) to provide us with more complete data
- Improves the data used for performance measurement, such as Healthcare Effectiveness Data and Information Set (HEDIS®) reporting
- Decreases the volume of record abstraction and chart review, which reduces providers' administrative burden
- Simplifies gap closure for many of our Medicare Advantage Quality Incentive Program (MA QIP) measures

If you use the Care Gap Management Application (CGMA) to track your QIP performance, CPT II codes provide an automated method for closing many gaps.

Resources

We have added common CPT category II coding information for blood pressure, dilated or retinal eye exams, hemoglobin A1c, medication reconciliation and prenatal and postpartum care on our provider website: Programs>Quality>HEDIS Reporting.

Our Quality Measures Guide is helpful for understanding which CPT II codes support performance measurement data and gap closure. It is available on our provider website: Library> Printed Material.

Related: See *Medicare Advantage Quality Incentive Program* on page 28.

Sign up now for HEDIS remote EMR service

Let us take on the responsibility of retrieving medical records for the upcoming annual HEDIS chart collection by signing up for our remote electronic medical record (EMR) access service.

Granting access to your EMR allows us to pull the required documentation for HEDIS. This aids your office in reaching compliance while reducing the time and resources associated with medical record retrieval.

Our EMR team is experienced with multiple EMR systems and extensively trained annually on HIPAA, EMR systems and HEDIS measure updates. We complete medical record retrieval based on minimum necessary guidelines:

- We only save to file; we do not physically print any personal health information.
- We only retrieve medical records that have claims evidence related to HEDIS measures.
- We only access medical records of members pulled into the HEDIS sample using specific demographic data.
- We access the least amount of information needed for use or disclosure, or we access only the specific medical records requested.

Getting started with remote EMR access

For the upcoming HEDIS chart collection beginning in February 2024, please contact Brenda Taylor or Kellee Mills.

- Brenda Taylor at (208) 798-2042 or **brenda.taylor@asuris.com**
- Kellee Mills at (208) 750-2758 or **kellee.mills@asuris.com**

Update your directory information

Accurate provider directories are essential to help members find providers who best meet their health care needs and individual preferences. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills.

The Consolidated Appropriations Act (CAA), 2021, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with CMS, the Affordable Care Act (ACA) and your agreement as a network provider with Asuris.

Our *Provider Directory Attestation Requirements for Providers* policy requires:

- Providers to review for accuracy and submit all updated information about their practice at least every 90 days
- Providers to continue to notify us promptly of changes to directory information
- All participating providers who are eligible to display in directories based on their specialty and current credentialing status to be displayed in our provider directories
- All participating providers to comply with our policies and procedures related to furnishing information necessary to ensure provider directories are up-to-date, accurate and complete pursuant to federal and state law, including 45 C.F.R. 156.230(b); this information includes, but is not limited to, accepting new patients, provider practice location, contact information, specialty, medical group and other institutional affiliations
- Providers to review, update and return roster validation requests

Please follow the instructions to verify your directory information on our provider website at least every 90 days: Contact Us>Update Your Information.

As part of your routine review of provider directory information, also review your National Provider Identifier (NPI) data in CMS' National Plan & Provider Enumeration System (NPPES). Visit NPPES help for more information: **nppes.cms.hhs.gov**.

Compliance program requirements

We want to remind you that all providers and their staff, including any board or trustee members, must meet our Government Programs compliance requirements, including monthly verification that they are not on an exclusion list, that standards of conduct and conflict of interest policies are being provided annually, and that they are completing annual trainings about compliance and fraud, waste and abuse (FWA).

We contract with the Centers for Medicare & Medicaid Services (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 (QHPs). 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, board members, contract/temporary workers and volunteers prior to hire and monthly thereafter. If an employee 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 and general compliance trainings 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.

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 and general compliance training 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* flyer: Library>Printed Material.
- *Administrative Manual*: Library> Administrative Manual
  - Qualified Health Plans
  - Medicare Advantage Compliance Requirements

Common reasons for upfront claims rejections

Claims received in our electronic data interchange (EDI) system may be rejected upfront because of various issues. When claims are rejected upfront, they do not enter our adjudication system, and an electronic report is sent to the submitter explaining the rejection. Please contact your claims clearinghouse to ensure you are receiving electronic reports. If a claim is rejected upfront, make the appropriate corrections per your report and resubmit electronically.

The following common reasons account for many upfront claims rejections.

Tax ID or National Provider Identifier (NPI) mismatch

Information submitted on the claim does not match our provider file system. For example:

- Rendering NPI is not associated with the tax ID
- Dates of service are not within the effective dates of the association

Ensure your rendering providers are associated with your tax ID and with the correct effective service dates. To associate an NPI to your tax ID, complete the *Provider Information Update Form* on our provider website: Contact Us>Update Your Information.

Corrected claims

Corrected claims must contain the original Asuris claim ID that is in a finalized status. The correct claim ID can be found on the last 835 ERA you received for the claim. **Note**: It must be the last ERA the claim was processed on.

Review corrected claims tips on our provider website: Claims & Payment>Claims Submission> Corrected Claims.

Sharing information about third-party billers

Third-party billers are business associates that create, receive, maintain or transmit personal information about patients on behalf of a provider.

If you use a third-party biller:

- They are required to have a business agreement with you in order to allow us to release protected information to them.
- You will need to provide them with the access they need to use Availity Essentials for eligibility and claims information.
- For information not available on Availity Essentials, they can call our Provider Contact Center. Our Provider Contact Center is required to ask on every call if the caller is a third-party company and to verify their identify and authority. We will then disclose only the minimum necessary information to answer their questions.

Note: To protect our members' privacy, we do not disclose protected information to automated software applications (bots).

Responding to documentation requests

If you receive a request for medical records or supporting documentation, please respond using the same format in which the request is received. If you receive a request via Availity Essentials, you must submit requested records using the Availity Attachments application.

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.

Learn more on our provider website: Claims & Payment>Claims Submission> Claims Attachments.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective November 1, 2023
Enteral and Oral Nutrition Therapy in the Home Setting (Allied Health #05)—*policy applies only to select Individual members*	- B4149, B4154 and S9434
Noninvasive Prenatal Testing to Determine Fetal Aneuploidies, Microdeletions, Single-Gene Disorders, and Twin Zygosity (Genetic Testing #44)	- 81408

Procedure/medical policy	Adding codes effective March 1, 2024

Surgical Site of Service – Hospital Outpatient
(Utilization Management #19)

- 10060, 10061, 10080, 10081, 10120, 10121, 10140, 10160, 10180, 11000, 11010, 11012, 11042, 11044, 11200, 11310, 11402-11404, 11406, 11420-11424, 11426, 11440-11444, 11446, 11450, 11451, 11462, 11463, 11470, 11471, 11601-11604, 11606, 11620-11624, 11626, 11640-11644, 11646, 11730, 11750, 11760, 11765, 11770, 11772, 11900, 12001, 12002, 12011, 12020, 12031, 12032, 12034, 12035, 12037, 12041, 12042, 12051, 13120, 13121, 13131, 13132, 13151, 13152, 13160, 14020, 15120, 15220, 15240, 15760, 17000, 17110, 17111, 19020, 19101, 19110, 19112, 19120, 19125,
- 20200, 20205, 20220, 20225, 20240, 20526, 20600, 20604-20606, 20610-20912, 21011-21014, 21029-21031, 21040, 21046, 21048, 21315, 21320, 21325, 21330, 21335-21337, 21356, 21550, 21552, 21554-21557, 21920, 21930-21932, 22900-22903, 23030, 23071, 23075, 23140, 23150, 24000, 24006, 24065, 24066, 24071, 24073, 24075, 24076, 24101, 24110, 24120, 24130, 24147, 24200, 24201, 24366, 25071, 25073, 25075, 25076, 25085, 25109, 25120, 25130, 25350, 26070, 26105, 26110, 26111, 26113, 26115, 26180, 26200, 26210, 26357, 26432, 26433, 26500, 26530, 26542, 26841, 26862, 27006, 27043, 27045, 27047, 27048, 27062, 27093, 27095, 27310, 27323, 27324, 27327-27329, 27337, 27339, 27340, 27345, 27347, 27613, 27614, 27618, 27632, 27634, 27638, 27640, 27720, 28011, 28039, 28041, 28043, 28045, 28047, 28100, 28103, 28104, 28126, 28666, 29835, 29900, 29901,
- 30000, 30020, 30100, 30110, 30115, 30117, 30118, 30220, 30310, 30580, 30630, 30801, 30901, 30903, 30930, 31020, 31030, 31032, 31238, 31526, 31528-31530, 31535, 31536, 31540, 31541, 31545, 31570, 31571, 31575, 31576, 31578, 31611, 31622-31625, 31628, 31652, 31820, 36010, 36215, 36246, 36556, 36569, 36571, 36581, 36582, 36589, 36590, 37607, 38500, 38505, 38510, 38520, 38525, 38740, 38760,
- 40490, 40510, 40520, 40525, 40530, 40808, 40810, 40812, 40814, 40816, 41010, 41100, 41105, 41108, 41110, 41112, 41113, 41116, 42100, 42104, 42106, 42330, 42335, 42405, 42408, 42410, 42415, 42420, 42425, 42440, 42450, 42500, 42650, 42800, 42804, 42808, 42810, 42870, 43191, 43195, 43197, 43200, 43211-43217, 43220, 43226, 43227, 43229, 43231-43233, 43240, 43241, 43243, 43244, 43253, 43259, 43266, 43270, 43450, 43453, 44340, 44360, 44361, 44364, 44369, 44376, 44377, 44380-44382, 44385, 44386, 44388, 44389, 44391, 44392, 44394, 44408, 44705, 45100, 45171, 45172, 45190, 45305, 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350, 45382, 45388, 45389, 45391-45393, 45505, 45541, 45560, 45905, 45910, 45915, 45990, 46020, 46030, 46040, 46045, 46050, 46060, 46080, 46083, 46200, 46220, 46221, 46230, 46250, 46255, 46257, 46258, 46260-46262, 46270, 46275, 46280, 46285, 46288, 46320, 46606, 46610, 46612, 46615, 46700, 46750, 46910, 46917, 46922, 46924, 46930, 46940, 46945, 46946, 47000, 49083, 49500, 49505, 49507, 49520, 49521, 49525, 49550, 49553, 49650, 49651, 49900,
- 50435, 50575, 50590, 50688, 51040, 51102, 51600, 51610, 51702, 51710, 51720, 51726, 51728, 51729, 52000, 52005, 52007, 52204, 52214, 52224, 52234, 52240, 52260, 52265, 52275, 52276, 52281-52283, 52285, 52300, 52310, 52315, 52317, 52318, 52320, 52325, 52327, 52330, 52332, 52341, 52344, 52351-52354, 52356, 52500, 52601, 52630, 52640, 53020, 53200, 53230, 53260, 53265, 53270, 53440, 53450, 53500, 53605, 53665, 54001, 54055, 54057, 54060, 54065, 54100, 54110, 54512, 54530, 54600, 54620, 54640, 54700, 54830, 54860, 55000, 55060, 55100, 55110, 55120, 55250, 55400, 55500, 55520, 55540, 56405, 56420, 56440-56442, 56501, 56515, 56605, 56620, 56700, 56740, 56821, 57000, 57061,

Continued on page 10

Continued from page 9

Procedure/medical policy, continued	Adding codes effective March 1, 2024
Surgical Site of Service – Hospital Outpatient (Utilization Management #19) - *continued* - 57065, 57100, 57130, 57135, 57210, 57240, 57250, 57260, 57268, 57282, 57287, 57300, 57400, 57410, 57415, 57420,57421, 57425, 57452, 57454, 57456, 57461, 57500, 57505, 57510, 57513, 57520, 57522, 57530, 57700, 57720, 57800, 58100, 58120, 58558, 58560, 58561, 58565, 58662, 58670, 58671, 58700, 58925, 59200, - 64600, 64647, 64776, 64782, 64784, 64788, 64835, 65275, 65400, 65420, 65426, 65435, 65436, 65710, 65730, 65750, 65755, 65772, 65778, 65800, 65815, 65820, 65850, 65865, 65875, 65920, 66020, 66170, 66172, 66179, 66180, 66184, 66185, 66250, 66682, 66710, 66711, 66762, 66821, 66825, 66852, 66982-66988, 67005, 67010, 67015, 67025, 67031, 67036, 67039, 67040-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67120, 67121, 67141, 67145, 67210, 67220, 67221, 67228, 67311, 67312, 67314, 67316, 67318, 67345, 67400, 67412, 67414, 67420, 67445, 67550, 67560, 67700, 67800, 67801, 67805, 67808, 67810, 67825, 67840, 67875, 67935, 67961, 67966, 67971, 67973, 67975, 68100, 68110, 68115, 68135, 68440, 68530, 68700, 68720, 68750, 68761, 68801, 68811, 68815, 69000, 69100, 69110, 69140, 69145, 69205, 69222, 69310, 69320, 69421, 69424, 69433, 69436, 69440, 69450, 69502, 69505, 69550, 69602, 69610, 69620, 69631-69633, 69635, 69636, 69641-69646, 69650, 69660-69662, 69666, 69801, 69805, 69806, - G0104-G0106 and G0120-G0122	

Medicare Advantage

Procedure/medical policy	Adding codes effective January 1, 2024
Post-acute care facilities (SNF, LTAC, IPR)	- G0151-G0153, G1055-G1062, G0299, G0300 and G0493-G0496 - **Related**: See *Upcoming post-acute care changes* on page 13.

Our complete pre-authorization lists are available in the Pre-authorization section of our provider website. Please review the lists for all updates and pre-authorize services accordingly. You can submit standard medical pre-authorizations through the Availity Essentials Electronic Authorization application.

Changes to site-of-service reviews

In 2022, we began reviewing select services when performed in an outpatient hospital setting. In addition to our internal reviews, eviCore healthcare (eviCore) reviews select joint surgeries performed in an outpatient hospital setting.

Additional procedures at hospitals to require pre-authorization for commercial members

We are expanding these site-of-service pre-authorization requirements to include additional services where a lower level of care may be appropriate.

Effective March 1, 2024, select procedures affecting the following specialties will require pre-authorization for the site of service for commercial members when performed at an outpatient hospital surgical site:

- Cardiovascular
- Digestive
- Eye, ocular adnexa and ear
- Genitals (male and female)
- Hematologic and lymphatic
- Integumentary
- Musculoskeletal
- Nervous
- Respiratory
- Urinary

The sites of service will not require pre-authorization when performed at an ambulatory surgical center (ASC) or physician office. We consider an individual's health status, facility and geographic availability, specialty requirements, physician privileges and other factors when determining the appropriate site of service.

Related: View the list of codes in our *Pre-authorization updates* on pages 9-10.

Save time and effort with Availity

For the fastest review, submit requests through Availity Essentials' Electronic Authorization application. Some requests will receive automated approvals. The Availity process incorporates additional questions related to site of service, so you don't need to fill out and submit the *Surgical Site of Service Additional Information Form*.

If you're faxing a pre-authorization request, you will need to submit the *Surgical Site of Service Additional Information Form* to provide attestation-based supporting documentation. **Failure to submit a completed and signed form will delay review.**

Additional information

The complete list of codes requiring pre-authorization and the *Surgical Site of Service Additional Information Form* for faxed requests are available on our provider website: Pre-authorization>Commercial. In addition to the site of service, the services performed may require pre-authorization.

View the *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19) medical policy on our provider website: Library>Policies & Guidelines>Medical Policy.

Site-of-service reviews ending for Medicare Advantage members

Effective December 1, 2023: We no longer require site-of-service reviews for our Medicare Advantage members for the following types of services:

- Digestive
- Genitals (male and female)
- Gastrointestinal (colonoscopy and endoscopy)
- Hematologic and lymphatic
- Integumentary
- Nervous
- Ophthalmologic procedures
- Respiratory
- Urinary

The *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19) Medicare Advantage medical policy has been archived. We announced this change in the December 1, 2023, issue of *The Bulletin*.

Effective January 1, 2024: eviCore will no longer review the site of service for joint surgeries for Medicare Advantage members. For surgeries planned for Medicare Advantage members in December 2023, please submit a pre-authorization request to eviCore.

Carelon revising radiology and cardiology clinical guidelines

Effective March 17, 2024, Carelon Medical Benefits Management (Carelon) will revise the following cardiology guidelines:

- Cardiac Resynchronization Therapy
- Implantable Cardioverter Defibrillators
- Permanent Implantable Pacemakers
  - **Note:** Dual chamber leadless pacemakers remain investigational. Effective January 1, 2024, Carelon will apply our *Leadless Cardiac Pacemakers* (Surgery #217) medical policy as part of our cardiology program expansion. The policy is available on our provider website: Library>Policies & Guidelines>Medical Policy.

Effective April 14, 2024, Carelon will revise the following radiology guidelines:

- Imaging of the Abdomen and Pelvis
- Imaging of the Brain
- Imaging of the Chest
- Imaging of the Head and Neck
- Imaging of the Heart
- Oncologic Imaging

Visit Carelon's website to view the revised guidelines: **guidelines.carelonmedicalbenefitsmanagement.com/category/coming-soon**.

Editor's note (12/28/23): Added Medicare Advantage members to the population for which Carelon may request additional supporting documentation.

Reminder: Cardiology program changes

Effective January 1, 2024, our cardiology program will include:

- Pre-service medical necessity review for implantable cardiac devices
- ASO groups that purchase the program
- Requests for supporting documentation for select procedures when certain clinical indications are present for commercial and Medicare Advantage members

About the program

Carelon administers our program, which reviews non-emergent outpatient cardiovascular tests and procedures, as well as most implantable cardiac devices.

Providers can contact Carelon to request pre-authorization for these additional services and/or members beginning December 18, 2023:

- **Online**: The Carelon ProviderPortal, **providerportal.com**, is available 24/7.
- **By phone**: (877) 291-0509, Monday through Friday, 8 a.m.-5 p.m. (PT).

Learn more about the program on our provider website: Programs>Medical Management>Cardiology.

Upcoming post-acute care changes

In the October issue of this newsletter, we announced upcoming changes to the post-acute care (PAC) pre-authorization process for Medicare Advantage members.

Home health

For services delivered on or after January 1, 2024, **home health agencies will need to request pre-authorization through Carelon Post Acute Solutions (Carelon PAS) to begin care**. This is a change to both the date services require authorization (day one) and the process for requesting authorization.

Authorizations are specific to a number of visits in a given period; visits beyond this quantity or past the authorized period require a new physician order and reauthorization. Carelon PAS will handle all authorizations for home health services.

Requests must include:

- Visit notes and an updated treatment plan upon each reauthorization
- The Outcome and Assessment Information Set (OASIS) for the initial certification period
- **Note:** An OASIS must be resubmitted to Carelon PAS for each additional reauthorization request that is for a new 60-day certification period.

Beginning December 18, 2023, providers can submit requests for home health services to be delivered on or after January 1, 2024. Carelon PAS will honor existing authorizations that crossover January 1, 2024.

PAC facilities

PAC facilities will need to submit authorization requests to Carelon PAS for services delivered on or after February 1, 2024. **This is a one-month delay from what was previously announced**.

Pre-authorization and reauthorization (concurrent review) requests for the following types of PAC will need to be sent to Carelon PAS:

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

Beginning January 29, 2024, PAC facilities can submit requests for stays occurring on or after February 1, 2024. Carelon PAS will honor existing authorizations that crossover February 1, 2024.

How to request an authorization

Before submitting an authorization request, register for Carelon's PAS provider portal: **providers.carelonmedicalbenefitsmanagement.com/postacute**.

You can submit a request or check authorization status online or by calling 1 (844) 411-9622, 8 a.m.-5 p.m. (PT) Monday through Friday.

Attend an orientation session

We encourage providers to join a Carelon PAS orientation session designed to familiarize you and your staff with the authorization portal and process. Register for an orientation session: **providers.carelonmedicalbenefitsmanagement.com/postacute/provider-materials/asuris**.

Reminder: Facility records requirements

Effective January 1, 2024, failure to notify of medical or behavioral health inpatient admissions or provide requested clinical documentation for continued stay within the allowed time may result in administrative denial.

Note: This announcement concerns only the enforcement of clinical records requirements; current admission and discharge notification requirements are not changing.

Upon receiving notification of admission, we will fax an acknowledgement that includes the date we require updated clinical information for concurrent review.

Concurrent review

Facilities are required to provide clinical records, which may include:

- Medical records
  - Labs
  - Medications
  - Diagnosis
  - Imaging
- Progress notes
- Physician orders
- Therapy notes
- Case management and discharge planning

Days that have not been authorized through pre-authorization, administrative approval or concurrent review approval will be administratively denied as provider liability.

- If a facility does not submit timely clinical records, it will not receive concurrent review approval for those days.
- Providing incomplete information will not result in authorization.

Submission options

- **EMR access**: Compliance requires full access, and all clinical records must be available for download.
- **Fax**: Compliance requires all clinical records; the face sheet and/or admission diagnosis alone are not sufficient.
- **Note**: Availity Essentials is not available for concurrent review submissions.

Exceptions

We recognize that extenuating circumstances may prevent you or facility from submitting clinical records within the allowed timeframe. We allow exceptions under our *Extenuating Circumstances* policy, available in the Pre-authorization section of our provider website. The policy includes information about how to notify us of an extenuating circumstance prior to claim submission. If you do not notify us prior to claim submission, you may appeal the administrative denial.

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 October 1, 2023, issue of *The Bulletin* about changes to the following medical policies, which are effective January 1, 2024:

- *Hypoglossal Nerve Stimulation* (Surgery #215)
- *Radiofrequency Ablation and Injection of Sacroiliac Joint Nerves* (Surgery #231)—new policy
- *Surgical Site of Service – Hospital Outpatient* (Utilization Management #19)

No medical policies in the November 1, 2023, issue of *The Bulletin* required 90-day notice.

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

Reimbursement policy updates

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

- *Emergency Room Visit: Level of Care* (Facility #110)
- *Implants, Implant Components, Medical and Surgical Supplies for All Procedures* (Facility #125)
- *Inpatient Hospital Readmissions* (Administrative #111)—commercial and Medicare Advantage
- *Reimbursement of Room and Board* (Facility #103)

No reimbursement policies in the November 1, 2023, issue of *The Bulletin* required 90-day notice.

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

Medication policy updates

Listed below is a summary of medication policy additions and changes. Links to all medication policies, medication lists and pre-authorization information for our members, including real-time deletions from our pre-authorization lists, are available on our provider website: Programs>Pharmacy. **Note**: Policies are available online and pre-authorization requests can be submitted on the effective date of the addition or change, but not before.

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

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

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

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

Effective October 15, 2023	Description
New policies	
Vyjuvek, beremagene geperpavec-svdt, dru759	- Limited coverage to treatment of recessive dystrophic epidermolysis bullosa when diagnosed by a specialist (dermatologist), with documentation of gene mutation, failure of standard of care interventions (wound care), and no target wound infection or squamous cell cancer; the non-diagnostic criteria are more restrictive than label but supported by clinical trial design - Added this medication to the Site of Care Program; when administered by a health care provider, this medication must be given at an approved site of care location
Bispecific T-cell engager (BiTE) Therapies for Diffuse Large B-cell Lymphoma (DLBCL), dru761	- Limited coverage of Epkinly (epcoritamab-bysp) to patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) who have received at least two prior systemic therapies when used as monotherapy and when there has been no prior use of CD20-directed BiTE therapy; monotherapy and no prior BiTE therapy requirements are more restrictive than label but supported by clinical trial design - Limited coverage of Columvi (glofitamab) to patients with relapsed or refractory diffuse large B-cell lymphoma, not otherwise specified (DLBCL, NOS), or large B-cell lymphoma (LBCL) arising from follicular lymphoma (FL) who have received at least two prior systemic therapies when used as monotherapy and when there has been no prior use of CD20-directed BiTE therapy; monotherapy and no prior BiTE therapy requirements are more restrictive than label but supported by clinical trial design
Revised policies	
Medications for Amyotrophic Lateral Sclerosis (ALS), dru734	- Added newly FDA-approved medication Qalsody (tofersen) to policy, with use considered investigational (and therefore not covered) in the treatment of all conditions, including amyotrophic lateral sclerosis (ALS), due to lack of high-quality evidence of clinically meaningful health benefit

Continued on page 16

Continued from page 15

Revised policies, continued	
Keytruda, pembrolizumab, dru367	- Added coverage criteria for use in locally advanced or metastatic urothelial carcinoma, a newly FDA-approved indication, when used in combination with Padcev as a front-line therapy for patients who are not eligible for cisplatin-containing chemotherapy
Padcev, enfortumab vedotin-ejfv, dru622	- Added coverage criteria for use in locally advanced or metastatic urothelial carcinoma, a newly FDA-approved indication, when used in combination with Keytruda as a front-line therapy for patients who are not eligible for cisplatin-containing chemotherapy
Gazyva, obinutuzumab, dru327	- Added coverage for use as a one-time dose prior to initiation of Columvi as indicated in the Columvi FDA prescribing information

Effective December 1, 2023	Description
New policies	
Joenja, leniolisib, dru758	- Use of Joenja is considered investigational (and therefore not covered) in the treatment of all conditions, including activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS), due to lack of high-quality evidence of clinically meaningful health benefit
Skyclarys, omaveloxolone, dru756	- Use of Skyclarys is considered investigational (and therefore not covered) in the treatment of all conditions, including Friedrich ataxia, due to lack of high-quality evidence of clinically meaningful health benefit
Revised policies	
Medications for recurrent Clostridioides difficile infection (rCDI), dru741	- Use of Vowst (fecal microbiota spores, live-brpk) for recurrent clostridioides difficile infection is considered not medically necessary (and therefore not covered) due to the lack of proven additional benefit versus lower-cost standard of care, such as fecal microbiota transplant sourced from different independent distributers
Medications for urea cycle disorders, dru312	- Added newly FDA-approved Olpruva (sodium phenylbutyrate) to policy
Drugs for chronic inflammatory diseases, dru444	- Added newly FDA-approved Humira biosimilar Yuflyma to policy as a non-preferred self-administered treatment option
Growth Hormone, dru015	- Added newly FDA-approved long-acting product Ngenla (somatrogon) to policy as a non-preferred treatment option
Efgartigimod-containing medications, dru696	- Added newly FDA-approved Vyvgart Hytrulo (efgartigimod hyaluronidase-qvfc) to policy - This medication was also added to the Site of Care Program; when administered by a health care provider, this medication must be given at an approved site of care location
High-cost medications for chronic constipation, dru519	- Added coverage criteria for Linzess (linaclotide) when used for pediatric functional constipation, a newly FDA-approved indication - Limited coverage to when less costly, standard of care therapies have been ineffective (such as polyethylene glycol, bisacodyl and docusate)

Continued on page 17

Continued from page 16

Effective December 1, 2023	Description
Revised policies, continued	
Polivy, polatuzumab vedotin-piiq, dru600	- Added coverage criteria for diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS), a newly FDA-approved indication, when used in combination with R-CHP (rituximab, cyclophosphamide, doxorubicin and prednisone) and the International Prognostic Index (IPI) score is at least 2 - Added use in high grade B-cell lymphoma (HGBL), a newly FDA-approved indication as investigational (and therefore not covered), due to lack of high-quality evidence of clinically meaningful health benefit
Tyrosine kinase inhibitors (TKIs) for gastrointestinal stromal tumors (GIST), dru725	- Added coverage criteria for Ayvakit (avapritinib) when used for indolent systemic mastocytosis, a newly FDA-approved indication
Talzenna, talazoparib, dru566	- Added coverage criteria for homologous recombination repair gene-mutated metastatic castration-resistant prostate cancer (mCRPC), a newly FDA-approved indication, when used in combination with Xtandi - Added requirement of no prior systemic therapy in the castration-resistant setting (i.e., front-line therapy) based on trial criteria
Lynparza, laparib, dru389	- Added coverage criteria BRCA gene-mutated metastatic castration-resistant prostate cancer, a newly FDA-approved indication, when used in combination with Zytiga plus prednisone - Added requirement of concomitant use of androgen deprivation therapy (ADT) based on trial criteria
Enjaymo, sutimlimab-jome, dru716	- Added that use of Enjaymo for cold agglutinin disease without a recent transfusion is considered not medically necessary (and therefore not covered) - **Note**: Enjaymo has coverage criteria for patients with recent transfusion(s)
Pituitary Disorder Therapies, dru488	- Added that use of Sandostatin LAR (octreotide LAR) for chemotherapy-induced diarrhea is considered not medically necessary (and therefore not covered), due to the lack of proven additional benefit versus lower-cost standard of care, such as generic octreotide

Note: In the October 2023 issue of this newsletter, we announced a new policy, *Asuris EquaPathRx*™, dru764, effective January 1, 2024. The name of this policy has been updated to *Provider-Administered Specialty Drugs*, dru764. **Related**: See *Update to Asuris EquaPathRx*™ *program* on page 18.

Updates to Asuris EquaPathRx™ program

As the cost of health care continues to rise, our employer group customers continually explore ways to lower costs for the financial health of their own businesses and the benefit of their employees. Increasingly high costs for provider-administered specialty medications have pushed employers to forced white-bagging options through third-party PBMs to solve for affordability.

We have created a different approach that continues to pay designated providers to procure and administer specialty medications. This approach keeps the provider-patient relationship intact and delivers predictable costs for members and employer groups. Based on your feedback, claims submission and processing remain unchanged under this program.

Asuris EquaPathRx is effective January 1, 2024, for fully insured group and Individual plan members, through a filed Provider Administered Specialty Medication benefit. We'd like to extend our thanks to providers who have completed the contracting process with Prime Therapeutics (Prime) as implementation will continue throughout 2024. Medicare Advantage and Administrative Services Only (ASO) members will not have this new benefit in 2024.

Here's what this means for you:

- **From January 1, 2024, to June 30, 2024**: As we work with providers to contract with the Prime IntegratedRx - Medical® network and become a designed provider for this program, from January 1, 2024, to June 30, 2024, all Asuris network providers are designated as eligible to provide medications included in the Asuris EquaPathRx program (subject to otherwise applicable conditions) to members with this benefit. This means that members can continue to receive medications from you as they do today, and claims for medications included in this program will be processed based on your existing contract terms with us.
  - Medications included in this program must be pre-authorized according to our medication policies, including the new Provider-Administered Specialty Drugs (dru764) policy, effective January 1, 2024.
- **Effective July 1, 2024**: We expect providers to be contracted with the IntegratedRx - Medical network to be reimbursed for administering medications included in the Asuris EquaPathRx program to members with this benefit.
  - The medication portion of the claim will be adjudicated under the terms and rates of the agreement you have with Prime.
  - Medications included in this program must be pre-authorized according to our medication policies and require administration by a participating IntegratedRx - Medical provider to be covered under the member's benefits.
  - If you have not contracted with Prime by July 1, 2024, coverage for provider-administered medications covered under the Asuris EquaPathRx program will not be covered for members with that benefit. There will be no change in reimbursement or experience for members who do not have this benefit.

We will continue to reach out to remind you to contract with Prime for this program. If you have not already, please reach out to your Prime contact now to complete the process of credentialing and contracting for the IntegratedRx - Medical Network.

If you have not yet contracted with Prime by July 1, 2024, we will work closely with you and our members to ensure they continue to have uninterrupted access to their treatment.

Find more information about Asuris EquaPathRx, including the list of medications included, is on our provider website: Programs> Medical Management>Pharmacy.

Behavioral health corner

About behavioral health corner

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

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

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

New provider types will be eligible to serve Medicare members

In an effort to expand access to behavioral health care, CMS is broadening the types of providers eligible to serve Medicare members in 2024.

As a result, we will add mental health counselors and marriage and family therapists to our Medicare Advantage networks.

Joining our Medicare Advantage network(s)

- Providers with a tax ID that has a Medicare Advantage agreement with us will automatically be added to our Medicare Advantage network(s) effective January 1, 2024, and can begin providing services to these members that day.
- We are sending non-signatory amendments to providers with whom we don't have a Medicare Advantage agreement. Each provider will receive a *Provider Network Addendum* (PNA) that lists the networks in which they currently participate, as well as their future participation in our Medicare Advantage network(s).
  - The mailing will include the date your Medicare Advantage network participation begins.
  - If you want to be added to our network earlier, you may call our Provider Contact Center in January to request a Medicare Advantage contract, which you will need to sign and return.

Note: Members with a Medicare Advantage HMO plan do not require a referral for behavioral health services.

Behavioral health corner

Help members begin and continue their journey with you

Employee assistance programs (EAPs, sometimes also called individual assistance programs, or IAPs) support members in navigating stressors by offering self-serve tools, professional services and crisis intervention.

When a member begins behavioral health counseling with an EAP provider, that relationship often ends when the EAP-covered counseling sessions conclude.

ComPsych, the world's largest provider of mental health services, will become our EAP partner January 1, 2024. As our new EAP partner, ComPsych wants to ensure those trusted relationships can continue beyond their program, providing our members with a seamless transition from the EAP to ongoing care with our network providers.

ComPsych would like to invite Asuris providers to join their network. To learn more about ComPsych or get started, fill out the *Provider Interest Form* at **compsych.com/providers/interestForm/interestForm.xhtml**.

Through the program, members or those in their household can receive four to eight counseling sessions (depending on their employer/plan) at no cost per calendar year or incident. In addition to counseling sessions, the EAP also offers unlimited consultations with in-house legal and financial experts, as well as other services.

New virtual provider and easier search

Because timely behavioral health care is integral to patients' overall well-being, we continue to improve access by expanding the types of specialized virtual behavioral health providers in our networks. These providers' diverse areas of focus include eating disorders, obsessive compulsive disorder (OCD), substance use disorder (SUD) and comprehensive therapy programs to treat a variety of age ranges, from age 6 through adulthood.

Array joins networks

Array Behavioral Care (Array) will become an in-network provider on December 15, 2023. Array is one of the largest telepsychiatry providers in the country, employing psychiatry and behavioral health clinicians with diverse specialties. Learn more at **arraybc.com**.

Contact information on our provider website

- Find an up-to-date list of these providers in the Telehealth section of our Behavioral Health Toolkit: Behavioral Health>Behavioral Health Toolkit.
- Learn about additional national behavioral health vendors available to some members: Care Options>Telehealth.

It's now easier to connect members to care

We've improved how members find virtual behavioral health providers. Online search results include groups' specialties and areas of focus, such as mental health, SUD or eating disorder treatment.

Members have several options to find virtual providers:

- **Improved provider search**: After logging in to our member website, **asuris.com**, members can easily narrow their search to find the type of virtual care most convenient to them: Behavioral Health> In-Network Virtual Care.
  - To view providers who offer only virtual services, choose the **Remote Services** tab. These virtual-only providers are listed in our Behavioral Health Toolkit.
  - To view providers who offer the choice of in-person or virtual care, select the **In-Person Care** tab.
- **Find a Doctor**: You can still use this tool on our member website to broaden your search or use Places by Name to find a provider group.
- **Customer Service**: Find a provider group and verify their network status.
  - Call number on the back of their ID card
  - Chat online

Behavioral health corner

Get reimbursed for integrated care

PCPs often care for patients who need behavioral health services, and any patients with mild to moderate behavioral health needs can be treated in a rapid and effective manner within the primary care setting. But PCPs may lack the clinical expertise and/or clinical resources to provide effective behavioral health treatment for some patients. Integrating behavioral health providers in primary care settings can help support the work of PCPs and improve patient outcomes.

We recognize the value of behavioral health integration (BHI) and encourage providers to participate in the Collaborative Care Model (CoCM) approach to treat and support members with complex needs.

According to the American Psychiatric Association (APA), among the BHI models, the CoCM has the most evidence demonstrating "effective and efficient integration in terms of controlling costs, improving access, improving clinical outcomes and increasing patient satisfaction in a variety of primary care settings—rural, urban and among veterans."

The model consists of a team of three individuals delivering care: A PCP, a behavioral health care manager and a psychiatric consultant. Its integrated behavioral health services include the following types of care:

- Counseling
- Medication support
- Care planning for behavioral health conditions
- Ongoing assessment of the patient's condition
- Other recommended treatment, if needed

This is accomplished through three core elements:

- Care coordination and management provided by a behavioral health care manager or psychiatric consultant working closely with the PCP
- Regular treatment and monitoring with standardized outcome measures/rating scales based on targeted quality outcomes
- Regular caseload review with a psychiatrist and/or psychiatric-trained nurse practitioner/physician assistant whose primary responsibility is to make treatment recommendations

We encourage integration of behavioral health providers into primary care settings and reimburse:

- Behavioral health services provided in the primary care setting
- CoCM codes CPT 99492-99494 and HCPCS G2214

Resources

- Review our *Collaborative Care Codes* (Behavioral Health #100) reimbursement policy on our provider website: Library>Policies & Guidelines>Reimbursement Policy.
- The *Behavioral Health Integration Services* booklet from CMS discusses the roles of care team members and CoCM service components, as well as providing full code descriptors: **cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf**
- The APA has information about the CoCM and reducing inequities in care, as well as providing CoCM training for PCPs, behavioral health care managers and psychiatrists: **psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn**

Behavioral health corner

Peer support program now available for adult Medicare Advantage members

We're excited to announce our peer support program is now open to Medicare Advantage members 18 and older.

The advantages of peer support

Peer support offers acceptance and validation to people recovering from mental health conditions and/or substance use disorders (SUD). It allows people with lived experience to help others develop goals and strategies through non-clinical, strengths-based support. Peer support is evidence-based, demonstrating specific improvements in patient engagement and treatment retention.

Peer support specialists help members address mental health and/or SUD challenges while advocating for the members as part of their care team. They share their lived experience, creating a safe environment to meet and provide mutual support.

The peer support program empowers individuals to direct their own recovery process. Because it is unique to the individual's needs, it considers the member's level of functioning, co-morbid conditions and other life factors to address:

- Self-advocacy skills
- Employment readiness
- Peer counseling and role modeling
- Connection and referral to other community resources
- Development of a Wellness Recovery Action Plan (WRAP)
- Education (nutrition, exercise, household tasks, community safety, mental illness, etc.)

Identify candidates for peer support

There isn't a single set of guidelines to determine who can benefit from peer support, but in general, members who struggle to stay engaged in their treatment and with their health and self-care are good candidates. Additionally, members who have previously declined care management might respond more positively to working with a peer.

Members who've recently experienced increased health care needs may be particularly vulnerable. Consider a referral if a member has:

- Had two or more mental health inpatient admissions in a six-month period
- Had two or more emergency department visits in a six-month period
- Been readmitted to a mental health inpatient facility within 30 days

A referral may also be appropriate if these members:

- Lack a social support system
- Need support accessing resources related to social determinants of health (e.g., food, transportation, housing, etc.)
- Need assistance identifying or connecting with community-based supportive resources to improve treatment and recovery outcomes

Example scenarios

- A member with a history of alcohol dependency begins dialysis and later stops treatment, slipping into depression. The provider refers the member for behavioral health care, but the member needs additional support. The peer support specialist can build trust with the member by providing advocacy and support.
- A member is recently diagnosed with a behavioral health condition that will require significant intervention. The member declines case management because they have trust issues with providers. The peer support specialist can build trust with the member by providing advocacy and support.

The referral process

We encourage providers to consider referring their eligible patients to this supportive program.

You can identify Medicare Advantage members by the "MedAdv" in the top right corner of the front of their member ID card. Refer a member to our Case Management team by:

- Calling our Provider Contact Center at 1 (888) 349-6558
- Calling the Customer Service number on the back the member's ID card

Help patients plan ahead for care

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

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

Best practices to help your patients plan ahead for care

Pre-recorded, on-hold messaging

- Include information about when to go to the ED or call 911. A list of symptoms may include crushing chest pain; severe shortness of breath; debilitating headache; facial weakness, drooping, numbness, weakness on one side of your body, inability to talk or use limbs; suicidal or homicidal thoughts.
- Share your specific office hours, noting evening or weekend availability. If you offer virtual appointments, include information about the symptoms that can be treated virtually (e.g., allergies, cold and flu, urinary tract infections) and how to schedule an appointment.
- Direct patients to on-call providers or a 24-hour nurse line for support.

Patient outreach

Identify patients who may be overutilizing the ED:

- Send them a follow-up letter with information about their care options (when to seek services from their PCP, urgent care clinic or ED and the estimated out-of-pocket costs for the different sites of service). Include the hours of operation and contact information for their PCP and the nearest urgent care options.
- You may also include a survey to ask them the reason for the ED visit, if they called the clinic before going to the ED and how your office may help support them in avoiding unnecessary trips to the ED.
- Review the patient's utilization during the next three to six months to monitor behavior change.

Resources

Educate patients during and after their visit, using the following resources included the Care Options Toolkit, available on the home page of our provider website:

- View the *Help Patients Plan Ahead for Care* flyer for:
  - More information about the best practices included above, including an example patient follow-up letter and survey
  - An example educational flyer your office can create to share with patients during their visit that includes information about when to seek services from their PCP, urgent care or ED; the estimated out-of-pocket costs for the different sites of service; and contact information about the locations nearest the patient
- Share the Asuris *Know Where to Go for Care* or *Know Your Behavioral Health Options or the Healthwise Your Health: Using the Emergency Room Wisely* flyers with patients during their visit. The flyers are available in English and Spanish.
- Include copies of the flyers or information in the office visit summary about when to seek services from their PCP, urgent care or ED.
- Members can also login to their **asuris.com** account or call the number on the back of their member ID card to learn about their care options.

We have been educating our members about their care options through content on our public and authenticated member websites, blogs, social media and email campaigns. In addition, our care managers contact members who have had several ED visits to help educate them about their care options.

In-home urgent care

DispatchHealth can treat urgent illness and injuries (e.g., urinary concerns, extremity injuries, swelling, confusion, weakness, vomiting, rash, cellulitis, abscesses and more) and perform a range of procedures (e.g., lab tests, administering IVs and changing catheters). They are available from 8 a.m. to 10 p.m. in the Spokane, Washington, area.

Learn about their services and how to make an appointment in the Care Options Toolkit, available from the homepage of our provider website.

Talking to your patients about diabetes

According to the Centers for Disease Control and Prevention (CDC), more than 133 million Americans are living with diabetes (37.3 million) or prediabetes (96 million), and more than 8 in 10 of them don't know they have it. The U.S. Preventive Services Task Force (USPSTF) recommends that providers consider screening non-pregnant patients ages 35 to 70 who are overweight or obese and have no current symptoms of diabetes.

Disparities in diabetes prevalence disproportionately affect some racial and ethnic minority groups and groups with lower socioeconomic status and, therefore, clinicians should consider screening at an earlier age or lower BMI for these patients as appropriate. For valuable information to help support health equity in your practice, read the USPSTF's *Prediabetes and Type 2 Diabetes: Screening*, available at **uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes#bootstrap-panel--6**.

In addition to diagnosing diabetes, providers play an important role in helping their patients manage their diabetes—whether their patients are newly diagnosed or have been living with diabetes for a while. We encourage you to discuss the importance of diabetes management with your patients, including eating well, getting regular exercise, controlling blood sugar levels, scheduling eye exams and discussing ways to keep their feet healthy.

Best practices for diabetes management in the primary care office

- Leverage your EMR and use registries and prompts to alert providers and staff when it's time to order recommended diabetic screenings and tests (e.g., A1c, urine microalbumin, lipid panel, eye exam, foot exam).
- Consider using support staff to help you reach out to patients who are due for diabetic screenings and tests.
- Complete screenings and order diabetic labs during the office visit to ensure that patients due for screenings or tests get the care they need.
- Use clinical pharmacists to help manage patients who may need more support managing their diabetes.
- Consider additional resources that patients may need to help manage their diabetes (e.g., health coaches, diabetic specialists, nutritionists).

Resources

The Healthwise Knowledgebase has several helpful resources in English and Spanish for you and your patients:

- *Diabetes Care Plan*: This can be shared with your patients and includes a list of what to bring to every appointment; current measurements for weight and blood pressure; home blood glucose testing goals; recent test results (e.g., A1c and cholesterol); and tests to schedule (e.g., foot exams and eye exams).
- *Taking Medicines as Prescribed*: This content can help you discuss the importance of medication adherence with your patients.
- *Dilated Eye Exam*: This content includes information about the exam (i.e., how it is performed and what to expect after the test).

Our Quality Improvement Toolkit, available on the homepage of our provider website, has a link to the Healthwise Knowledgebase and other helpful tools.

Diabetes prevention and management programs

We are committed to ensuring that our members who are living with diabetes receive the best care, treatment and information about how to manage their chronic condition. Learn about the programs we offer on our provider website: Programs> Medical Management>Diabetes Management.

Help patients manage their weight

As a provider, you play a vital role in helping patients better understand how maintaining a healthy weight can reduce the risk of diseases and health conditions, including type 2 diabetes, heart disease, high blood pressure, arthritis, sleep apnea and stroke.

Patients may have a hard time talking about their weight. You may want to start with mentioning the health risks associated with obesity and being overweight and ask if you could talk to them about how weight impacts their overall health.

Mental and emotional health are also factors in maintaining a healthy weight. Consider connecting patients to in-network behavioral health providers. Members can find in-network behavioral health providers and vendors that offer virtual care services by logging in to their member account on **asuris.com**. **Related**: See *New virtual provider and easier search* on page 20.

Measuring your patients' body mass index (BMI) regularly may help you identify who may benefit from weight loss information and counseling. Your electronic medical record system may include an alert that will automatically calculate the BMI. When coding for obesity, code for both the obesity diagnosis (e.g., ICD-10 E666.1-E666.3, E666.8 or E66.9), as well as the BMI Z codes.

The Healthwise Knowledgebase has several helpful resources in English and Spanish for you and your patients. Our Quality Improvement Toolkit, available on the homepage of our provider website, has a link to the Healthwise Knowledgebase and other helpful tools.

Avoid antibiotics for acute bronchitis and bronchiolitis

Over-prescribing antibiotics can have detrimental effects on the overall population and individuals, resulting in an increase of antibiotic-resistant infections and exposing people to avoidable adverse events. The CDC reports that more than 2.8 million antibiotic-resistant infections occur in the U.S. each year, and more than 35,000 people die as a result.

Acute bronchitis/bronchiolitis is a common condition that is generally self-limiting yet is often inappropriately treated with antibiotics.

A HEDIS measure was created to monitor the antibiotic prescribing rate for acute bronchitis/bronchiolitis. This measure reports the percentage of members three months and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription on the date of diagnosis or within three days of diagnosis. A higher rate indicates appropriate treatment for the condition (i.e., the percentage of episodes that were not prescribed an antibiotic).

Our providers rate well on the HEDIS measure for treating upper respiratory infections, but there is opportunity to improve rates for treatment of acute bronchitis and bronchiolitis. Our data indicates that more than 40% of acute bronchitis and bronchiolitis cases are not treated appropriately. Please consider this in your approach to treating acute bronchitis and bronchiolitis. Here are a few best practices to follow:

- Help patients and caretakers understand the difference between bacterial and viral infections.
- Educate patients and caretakers on home treatment to relieve acute bronchitis/bronchiolitis symptoms.
- For patients with a comorbid condition requiring an antibiotic prescription, be sure that documentation and coding accurately reflect the diagnosis code for the comorbid condition (or bacterial infection). Some examples of comorbid conditions include HIV, malignant neoplasm, emphysema, chronic obstructive pulmonary disorder (COPD) and immune system disorders.

If you would like copies of our *Using Antibiotics Wisely and Treatment for Acute Bronchitis/Bronchiolitis* flyers, available in English and Spanish, email us at **Quality@asuris.com**.

Tobacco cessation resources

Tobacco use is the leading cause of preventable disease, disability and death in the U.S., accounting for more than 480,000 deaths per year, according to the CDC. Cigarette smoking is linked to diseases of nearly all organs of the body, particularly cardiovascular, metabolic and pulmonary diseases.

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

A team approach is the best way to treat tobacco use and dependence. Integrating treatment into the routine clinical workflow and engaging the entire health care team in treatment delivery can make a difference. Here are some suggestions:

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

Resources

Healthwise Knowledgebase flyers

Our Quality Improvement Toolkit, available on the homepage of our provider website, includes the following Healthwise Knowledgebase flyers in English and Spanish for you to share with your patients:

- *Smoking: How to Quit*
- *Quitting Smoking: My Quit Plan*
- *Quitting Smoking: Track Your Triggers*
- *Quitting Smoking: My Reasons to Stop*
- *Quitting Smoking: When Do You Use It?*
- *Smoking: Should I Take Medicine to Quit*
- *Smoking: Should I Use Nicotine Replacement to Quit?*

CDC website

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

Tobacco cessation resources

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

$0 medication copays for Medicare Advantage members

Tier 1 medications on our formulary have a $0 copay for Medicare Advantage members. This applies when medications are filled through home delivery or a preferred retail pharmacy with up to a 100-day supply. Note: The $0 copay applies prior to the coverage gap (during the initial coverage phase).

Switching your patient to a Tier 1 medication can reduce financial barriers and improve medication adherence. You may also want to consider combination products in Tier 1 to reduce pill burden. For your convenience, here are the Tier 1 medications for the Medication Adherence Star Rating measures:

Star rating measure	Tier 1 medication
Medication adherence for diabetes medications	- Glimepiride, glipizide, glipizide ER/XL - Glipizide/metformin - Metformin, metformin ER (generic Glucophage XR only; not generic Fortamet or generic Glumetza) - Pioglitazone - Nateglinide, repaglinide
Medication adherence for hypertension (RAS antagonists)	- Amlodipine/ benazepril, amlodipine/valsartan - Benazepril, enalapril, fosinopril, lisinopril, quinapril, ramipril, trandolapril - Enalapril/HCTZ, lisinopril/ HCTZ - Irbesartan, losartan, olmesartan, valsartan - Irbesartan/HCTZ, losartan/HCT, olmesartan/HCTZ, valsartan/HCTZ
Medication adherence for cholesterol (statins)	- Atorvastatin - Lovastatin - Pravastatin - Rosuvastatin - Simvastatin

Medicare Advantage Quality Incentive Program

Our 2024 Medicare Advantage Quality Incentive Program (MA QIP) remains focused on rewarding PCPs who meet specific goals to improve health outcomes for our Medicare Advantage members. Our goal for 2024 is to simplify the program. **One key change for the 2024 program is that you must sign in to the CGMA by October 1, 2024, to opt in and be eligible to earn incentives**.

The following updates in each of our incentive categories will be made for 2024.

Medicare Star Rating measures

- The Medicare Star Rating measures will remain the same in 2024:
  - Breast cancer screening (BCS)
  - Colorectal cancer screening (COL)
  - Controlling blood pressure (CBP)
  - Eye exam for patients with diabetes (EED)
  - Follow-up after emergency dept visit for people with multiple high-risk chronic conditions (FMC)
  - Hemoglobulin A1c control for patients with diabetes (HBD)
  - Kidney health evaluation for patients with diabetes (KED)
  - Medication adherence: Cholesterol (MAC)
  - Medication adherence: Diabetes (MAD)
  - Medication adherence: Hypertension (MAH)
  - Osteoporosis management in women who have had a fracture (OMW)
  - Plan all-cause readmission (PCR)
  - Statin therapy for patients with cardiovascular disease (SPC)
  - Statin use in persons with diabetes (SPD)
  - Transitions of care: Medication reconciliation post-discharge (MRP)
  - Transitions of care: Notification of inpatient admission (NIA)
  - Transitions of care: Patient engagement after inpatient discharge (EAD)
  - Transitions of care: Receipt of discharge information (RDI)
- We are focusing on reaching 4- and 5-Star performance and have removed or lowered incentive amounts for 1-, 2- and 3-Star performance.

Risk adjustment

- The incentive for assessing risk adjustment gaps will be simplified into five earning tiers.
- We are removing the early performance bonus.
- We are removing the performance improvement incentive.

Member experience measure

- We are removing fall risk management and management of urinary incontinence.
- Annual flu vaccine will continue to be a member experience measure.

Notes:

- This gap requires interaction between the member and the PCP. It can be closed when the provider submits a claim for administering the vaccination or reports on a claim that the member received their vaccine elsewhere.

Personalized care support

- We've created a tiered incentive structure for advance care planning (ACP).
- We will remove Encounter for Palliative Care.

Preventive care visits (PCV)

- We've created a tiered incentive structure for PCV.
- An early performance bonus will be available for groups that complete PCVs for 40% of their members by June 30, 2024, and 70% by December 31, 2024.
- The performance improvement incentive will be removed.

Structured supplemental data submission incentive

- This incentive has been redesigned as a per member incentive.
- To earn any incentive, groups must submit at least 10 months of data for at least 80% of their members.
- If groups submit all six Tier 1 measures, the incentive is $20/member.
- If groups submit all nine Tier 2 measures, the incentive is $30/member.

Continued on page 29

Continued from page 28

Measure	Tier 1	Tier 2
Annual flu vaccine (AFV)		X
Breast cancer screening (BCS)	X	X
Colorectal cancer screening (COL)	X	X
Controlling blood pressure (CBP)	X	X
Eye exam for patients with diabetes (EED)	X	X
Hemoglobin A1c control for patients with diabetes (HBD)	X	X
Transitions of care: Medication reconciliation post-discharge (MRP)		X
Transitions of care: Receipt of discharge information (RDI)		X

The *2024 MA QIP overview* (PDF) is available on our provider website: Programs>Medicare Advantage Quality Incentive Program. By January 16, 2024, we will update the rest of the 2024 program information on our provider website and the personalized care support page: Programs>Medical Management>Personalized Care Support.

If you have questions, please email us at **QIPQuestions@asuris.com**.

We'd like to remind you of the following program deadlines to close gaps for the 2023 program:

- **December 31, 2023**—Last day to perform services
- **February 28, 2024**—Last day to submit supplemental data
- **February 28, 2024**—Last day to work in the CGMA
- **March 31, 2024**—Last day to submit medical or pharmacy claims
- **January 31, 2024** - Last day to submit evidence to close gaps for MA Coordination of Care members

The CGMA will continue to display 2023 data through June 2024 to allow you to monitor your 2023 performance up to payout.

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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