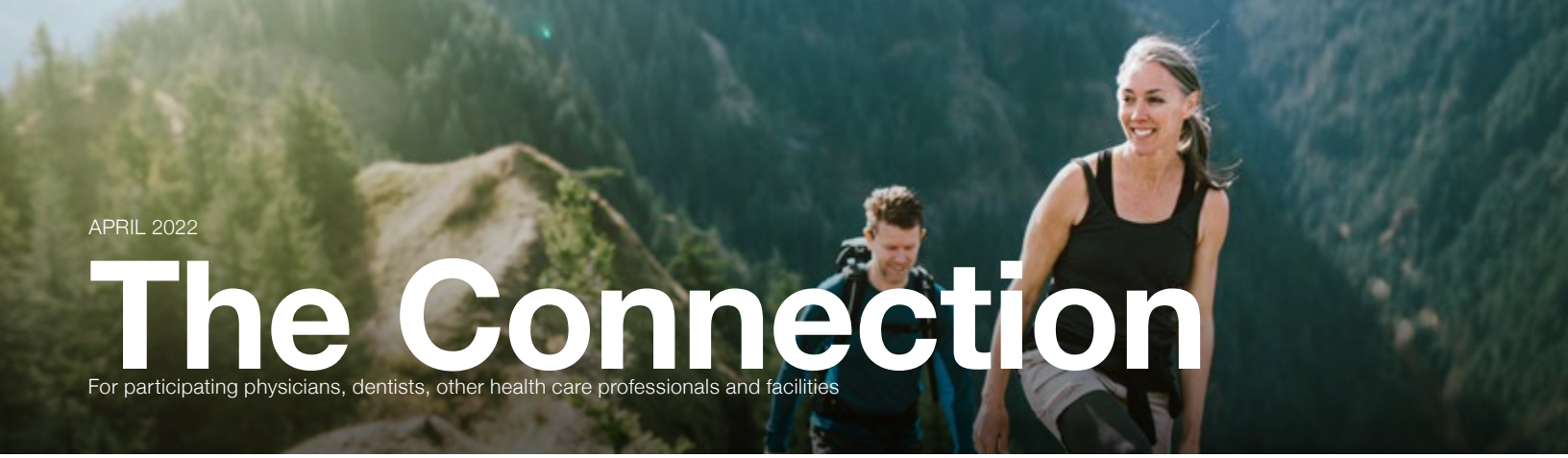

APRIL 2022

The Connection

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

National Healthcare Decisions Day

National Healthcare Decisions Day, observed annually on April 16, aims to inspire, educate and empower all of us to share our preferences for medical treatment should an unexpected illness occur.

The COVID-19 pandemic has collectively taught our communities that life, and our individual health, cannot always be predicted. Despite this fact, there are steps you can take to ensure your patients stay in control of their health at every stage of their care journey.

We encourage you to begin or continue advance care planning (ACP) conversations with all your patients as part of the preventive and treatment services you provide. We reimburse providers who bill for ACP conversations with members, regardless of age or health status, across all plans.

ACP conversations may include:

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

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

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

Continued on page 2

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
✶ Behavioral health must read
▲ Dental must read
‡ Physical medicine must read

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

Click on a title to read the article.

About *The Connection*

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

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

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

The Bulletin

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

Share your feedback

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

Continued from page 1

If you participate in our Medicare Quality Incentive Program (QIP), you can earn two additional incentives by:

- Having an ACP conversation with at least 20% of your Asuris Medicare Advantage patients and submitting claims with CPT 99497, CPTII 1123F, CPTII 1124F or CPTII 1158F
- Referring Medicare Advantage patients to specialty palliative care providers, who then submit a claim for a palliative care consult/encounter (ICD Z51.5)

Resources

- Our provider website: Programs>Medical Management>Personalized Care Support
- National POLST Paradigm: **polst.org**
- The Conversation Project: **theconversation project.org**
- Vital Talk: **vitaltalk.org**

Update your directory information

Accurate provider directories are essential for members to make informed health care decisions. When information is missing or inaccurate, members may be denied care or receive unexpected medical bills. The Consolidated Appropriations Act (CAA), 2021, requires health plans to establish a process to verify and update provider directory information no less frequently than every 90 days. Accurate provider directories are also a requirement for compliance with the Centers for Medicare & Medicaid Services (CMS), the Affordable Care Act (ACA) and your agreement as a network provider with Asuris.

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

- Providers to review to verify 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.

Provider Data Management tool makes directory updates and attestation easy

You will soon be able to review, update and attest to your provider directory information for all participating payers, including Asuris, in Availity Essentials. The new provider data management (PDM) tool will allow you to update:

- Service locations
- Providers joining your organization
- Contact information
- Whether your office accepts new patients

When attesting that your information is correct in the PDM tool, all participating payers will receive your information. This eliminates the need for you to individually update or attest to directory information for each payer.

To allow your organization's users to update demographic information, you must assign the provider data management role to their profile.

See how it works

Learn more about the PDM tool, including how to assign the PDM role to user's profiles, on the Availity Essentials website: **https://apps.availity.com/availity/Demos/PDM/index.htm**.

Help and training

Access online help and training options from the Availity Essentials menu.

- Training: Help & Training>Get Trained
- Help: Help & Training>Find Help

Look for announcements about the PDM tool launch on our provider website and Availity Essentials.

Upcoming code pair edit

Effective for dates of service on and after July 1, 2022, we will implement Change Healthcare's bundling edits for outpatient facilities for all lines of business except Medicare Advantage. These outpatient code pairs will be used to supplement the CMS Outpatient Code Editor Correct Coding Initiative (OCE CCI) code pairs. These code pairs are proprietary to Change Healthcare and, therefore, we cannot publish details about them.

Read more about ClaimsXten-sourced edits on our provider website: Claims & Payment>Coding Toolkit.

Administrative Manual updates

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

Facility Guidelines

- Clarified that if a member under observation meets the inpatient level-of-care standard, the provider will be reimbursed for inpatient care for the entire length of stay
- Revised the treatment requirements for the chemical dependency intensive outpatient program (CDIOP) level of care

Medicare Advantage Compliance Requirements

- Updated regulatory references

Risk Adjustment

- Added information about provider education

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

Freestanding ASC Medicare Advantage modifier 50 billing

To align with CMS guidance, Asuris will begin denying Medicare Advantage ambulatory surgical center (ASC) claims submitted with modifier 50 effective for dates of service on or after July 1, 2022.

Bilateral procedures should be billed on two separate claim lines with one unit for each service.

Fragmented/split billing claim submission reminder

We require all professional services rendered by the same provider for the same date of service to be submitted on one claim form.

Exceptions:

- When a Medicare patient receives services that Medicare specifically requires to be submitted on separate claim forms
- Home infusion providers who bill for the initial and subsequent therapy administration code on the same day using modifier SH or SJ

We do not accept fragmented or split professional billing (i.e., services rendered by the same provider for the same date of service and submitted on multiple professional claim forms).

Dental timely claims filing reminder

Dental providers recently received a new provider agreement. It stated that claims for dental 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.

Note: Some member benefits also require 90 days timely claim filing. Verify member benefits on Availity Essentials.

Protect your Social Security number

The Transparency in Coverage (TIC) Final Rule, effective January 1, 2022, requires payers to provide members with a self-service cost-sharing estimator tool that displays personalized estimates based on the member's coverage. It also requires payers to publicly disclose, in machine-readable files:

- In-network negotiated rates for all covered items and services
- Allowed amounts for out-of-network providers and pharmacies
- Prescription drug pricing for in-network pharmacies

Under TIC, providers' billing identification must be disclosed. **If you are using your Social Security number (SSN) as your provider number for billing purposes, and do not have a National Provider Identifier (NPI), this information will be publicly available.**

We strongly encourage you to apply for a tax ID or employer identification number (EIN) and promptly send this information to us.

- Request a tax ID or EIN on the IRS website: **irs-gov-taxid.com**.
- Notify us of the change by submitting a *Provider Information Update Form* on our provider website: Contact Us>Update Your Information.

As a reminder, while Asuris must disclose negotiated reimbursement rates under this rule, our reimbursement schedules remain confidential and proprietary. Contracted providers should not disclose this information to others under the terms of our provider agreements.

Availity Essentials tips for estimating patient costs

Use the patient cost estimator (PCE) tool in Availity Essentials to quickly generate an estimate of professional medical and dental services for your patients. The PCE uses a combination of member eligibility, benefits and provider network pricing to create the estimate for a specific treatment or service for a specific member. You can access the patient cost estimator by submitting an eligibility and benefits request. On the results page, a Patient Cost Estimator button will display when the service is available for that member.

PCE button does not display

If you do not see the **Patient Cost Estimator** button, check the following:

- Your tax ID was included in the eligibility search.
- The current date was used in the **As of Date** box.
- Your patient is eligible for the treatment or service.

Error messages

Message	Reason for error
We cannot provide an automated cost estimate for the information entered. This service requires review upon claim submission. For additional information prior to claims processing, please refer to your fee schedule and/or the member's benefits.	One or more of the procedure codes you entered triggers a pend flag in our claims system. When that happens, it means the claim would normally be pended for manual review, so a real-time estimate cannot be returned.
Patient Cost Estimates are not currently available due to a technical issue with the payer. Please try again later.	You may have encountered a service disruption or a timeout issue when you ran the transaction. Retry the transaction after an hour.
We are unable to reach the payer at this time. Please try again later. Response ID:	

Other errors troubleshooting tips

- Check whether the combination of POS, procedure codes and modifiers are being submitted correctly. Correct billing guidelines are available on our provider website: Claims & Payment> Claims Submission.
- If you are submitting a dental PCE, you must include the specific tooth or an oral cavity (OC) code, which is determined by the procedure code. The PCE screen includes a document of procedure codes that require an OC code.
- If you receive an Authorization Required or Authorization Unknown message in the PCE results, click the **Request Authorization** button to be routed to the authorization tool. Patient information from the PCE will be prepopulated in the authorization form.

Get trained for free

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

Learn more about the PCE on our provider website: Programs>Cost & Quality>Member Tools.

Look for the next *Availity Essentials tips for reimbursement schedules* article in our June 2022 newsletter.

Submit claims appeals in Availity Essentials starting in May

Beginning in May 2022, you will be able to use the new appeals tool in Availity Essentials to submit appeals.

- The new tool will streamline the appeals process, making it faster and easier to submit appeals directly from Availity Essentials.
- Instead of having to manually complete and submit a separate *Provider Appeal Form*, portal users will be able to submit an appeal with required documentation directly from the Claim Status screen, receive immediate confirmation of submission and review the progress of their appeal all in one place.

The appeals dashboard will show the status of submitted appeals. Access it from Availity Essentials: Claims & Payments>Appeals.

Get trained for free

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

Look for announcements about the appeals tool launch on our provider website and Availity Essentials.

Leading the way in pre-authorization transformation

Pre-authorization is a process that examines the safety, efficacy, quality and cost-efficiency of proposed services or treatments, helping to ensure members receive evidence-based and necessary care. Intended as a safety and cost-saving measure, the process increases treatment wait times for our members and administrative burden for providers.

This year, we seek to fundamentally transform the pre-authorization process. By integrating technology, provider partnerships and data automation, our goal is to reduce costs and administrative burden for providers while increasing transparency to promote timely care for our members. We will be able to selectively apply pre-authorization requirements for services—and remove requirements for services that are always approved.

We strive to be the industry leader of pre-authorization transformation by using technology and several responsive pre-authorization and auto-authorization programs to improve the experience for our members and providers, including:

- Transitioning from fax to electronic medical records (EMRs)
- Workflow automation
- Artificial intelligence (AI) predictive power to reduce administrative burden and make faster decisions based on prior services rendered

Fax to EMR

Our goal is to shift from the traditional way of submitting pre-authorization requests using fax to electronic tools for submission and authorization, including those we currently offer providers through Availity Essentials: Real-time, electronic pre-authorization (eAuth) and automated pre-authorization via MCG Health's (MCG) Cite AutoAuth. Fax to EMR-based pre-authorization submissions will significantly improve the efficiency, efficacy and timeliness of the pre-authorization process.

Workflow automation

Later this year we will implement workflow automation to improve pre-authorization approval times through providers' EMRs. EMR integration uses the providers' current workflows so they don't have to access a separate tool for pre-authorization submissions. Additionally, EMR integration allows auto population of fields and clinical requirements for streamlined submissions and reviews resulting in faster pre-authorization determinations. Pre-authorization determinations can be displayed on a dashboard available in the EMR.

Artificial intelligence (AI) predictive power

We are using AI to determine whether a pre-authorization request should be automatically approved with little or no human interaction for medical treatments.

We developed machine-learning models and automated business rules (ABRE) from thousands of historical pre-authorization cases to identify patterns in required criteria for approval, evaluate those patterns in the current request, and predict the appropriateness for a future requested services when a pre-authorization request is received, yielding an automatic decision. When criteria are met, the models predict whether a request should be approved and can return a decision to providers in minutes. AI allows for faster pre-authorization approval because it no longer needs a clinician to review each request: If the workflow determines the criteria are met, the request is approved immediately. **Note**: AI will never deny a request; if medical criteria are not met in the workflow, the request is pended for clinician review.

Our AI assistant is now providing a suggested determination (approve or pend) for the first of our medical policies to go through this process:

- *Oxygen Concentrators* (#DME91)
- *Transcranial Magnetic Stimulation as a Treatment of Depression and Other Disorders* (#MED148)
- *Endometrial Ablation* (#SUR01)
- *Genetic Testing for Hereditary Breast and Ovarian Cancer and Li-Fraumeni Syndrome* (#GT02)

You can take advantage of our AI-powered predictive pre-authorization now when you request authorization for these services through Availity Essentials' electronic authorization tool or MCG Health's (MCG) Cite AutoAuth. More medical policies will be added to the AI model over the coming months.

We believe that by being leaders in pre-authorization transformation, we will be the pre-authorization payer of choice for members and providers, further strengthening our value-based agreements (VBAs).

If you do not already have an Availity Essentials account, register today to start taking advantage of improved pre-authorization turnaround time and reduced administrative burden. Look for more information about our pre-authorization transformation efforts in future issues of this newsletter.

Pre-authorization updates

Commercial Pre-authorization List updates

Procedure/medical policy	Added codes effective March 1, 2022
Evaluating the Utility of Genetic Panels (#GT64)	- 81440, 81460, 81465
Genetic Testing; Primary Mitochondrial Disorders (#GT54)	- 81401, 81403-80415, 81440, 81460, 81465
Procedure/medical policy	**Added codes effective April 1, 2022**
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (#MED170)	- A4100
Digital Health Products (#MED175)	- A9291
Digital Health Products for Attention Deficit Hyperactivity Disorder (#MED175.01)	- A9291
Digital Health Products for Substance Use Disorders (#MED175.02)	- A9291
Procedure/medical policy	**Adding codes effective June 1, 2022**
Wireless Capsule Endoscopy for Gastrointestinal (GI) Disorders (#RAD38)	- 0651T, 91110, 91111, 91113

Medicare Pre-authorization List updates

Procedure/medical policy	Added codes effective April 1, 2022
External Insulin Infusion Pumps (#M-DME86)	- A4238
Genetic and Molecular Diagnostics – Next Generation	- 0306U, 0307U, 0311U
Sequencing and Genetic Panel Testing (#M-GT64)	- C9782
Orthopedic Applications of Stem Cell Therapy, Including Bone Substitutes Used with Autologous Bone Marrow (M-MED#142)	- C9782
Transplants - Stem Cell and Bone Marrow (Medicare Advantage—Transplants #45)	**Added codes effective May 1, 2022**
Power Wheelchairs-Group 2 and Group 3 (PWC) (#M-DME37)	- K0820-K0829, K0835-K0843

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

The Bulletin recap

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

Medical policy updates

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

- *Autologous Blood-Derived Growth Factors as a Treatment for Wound Healing and Other Miscellaneous Conditions* - (#M-MED77)
- *Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia* (#TRA45.36)
- *Power Wheelchairs – Group 2 and Group 3* - Medicare Advantage (#M-DME37)

We provided 90-day notice in the March 2022 issue of *The Bulletin* about the new *Wireless Capsule Endoscopy for Gastrointestinal (GI) Disorders* (#RAD38) medical policy, which is effective June 1, 2022.

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 February 2022 issue of *The Bulletin* about changes to the *Drugs, Immunizations/Vaccines, Radiopharmaceuticals, and Skin Substitutes Reimbursed Under Medical Coverage* (Medicine #104) commercial and Medicare Advantage reimbursement policies, which are effective May 1, 2022.

We provided 90-day notice in the March 2022 issue of *The Bulletin* about changes to the *Cellular and Gene Therapy Products* (Medicine #112) reimbursement policy, which are effective June 1, 2022.

Our reimbursement policies are reviewed on an annual basis.

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

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

Reminder: CAM services no longer require pre-authorization

Chiropractic, acupuncture and massage (CAM) services no longer require pre-authorization.

Use Availity Essentials to check whether a service requires pre-authorization.

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.

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

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

Some behavioral health cases to require review by phone

Our behavioral health utilization management team will complete telephonic concurrent and discharge reviews for some services delivered on or after July 1, 2022.

We will require telephonic reviews for cases involving 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)

After a provider submits the inpatient form—required beginning May 1, 2022—our staff will contact the requestor to schedule a review. **Related**:
See *Reminder: Inpatient behavioral health forms* on page 11.

Improving provider experience and patient outcomes

These types of cases are typically more complex and have more treatment and discharge needs. Discussing these cases by phone allows for thorough conversations in which all relevant clinical information can be provided and all questions answered. Telephonic reviews result in more productive utilization reviews and outcomes.

After processing an initial review, our staff will notify the requestor when the next concurrent or discharge review is due, and a telephonic review can be scheduled. Alternatively, the requestor can call our staff to complete the review the day it is due.

Excluded services: Applied behavior analysis (ABA) and transcranial magnetic stimulation (TMS) services are excluded from the telephonic review requirement.

Look for additional information in the June 2022 issue of this newsletter.

ABA reimbursement reminder

Reimbursement rates for ABA services provided to our commercial members (group and Individual products) will change effective May 1, 2022. You can check rates on Availity Essentials: Claims & Payment>Fee Schedule Listing>Fee Schedules.

Behavioral health corner

Telehealth support for post-discharge behavioral health care

To improve our members' outcomes and to reduce or avoid readmissions, it is important that patients are seen by a behavioral health provider within seven days of discharge. Telehealth appointments can help meet that need.

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

Measuring success

The Healthcare Effectiveness Data and Information Set (HEDIS®) measure Follow-Up After Hospitalization for Mental Illness (FUH) tracks post-discharge care. To meet the measure's standard, behavioral health clinicians should provide the following types of services within seven days of discharge:

Qualifying provider types

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

Qualifying services

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

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

Telehealth options

We encourage you to share the following telehealth options with your patients to help them receive needed post-discharge care.

Telehealth providers

- **Talkspace:** Virtual mental health counseling available 24/7/365 via text, audio or video messaging
  - **talkspace.com/partnerinsurance**
- **NoCD**: Specialized virtual care for obsessive compulsive disorder (OCD) using exposure and response prevention (ERP)
  - **treatmyocd.com**

Learn more about telehealth

Telehealth visits allow members to receive care using a computer, phone and/or tablet.

All of our members have access to expanded telehealth services. In addition, most members have standard telehealth benefits. Learn more about telehealth on our provider website: COVID-19 Updates & Resources>Telehealth Visits.

We continue to add virtual care options to increase access to outpatient professional appointments.

Check eligibility and benefits

Check telehealth benefits in Availity Essentials by performing an eligibility and benefits inquiry:

- Select the Professional (Physician) Visit – Office benefit service type (BST).
- Scroll down to Professional (Physician) Visit – Home to view eligibility and benefits results.

You may also need to view the benefit booklet for additional details.

You can view standard telehealth benefits when performing an eligibility and benefits inquiry in Availity Essentials.

Reminder: Inpatient behavioral health forms

To reduce turnaround times for reviews and approvals, we will require facilities to submit behavioral health intake forms for services rendered May 1, 2022, and later.

The following forms will be required:

- *Initial Request Form* (This form can be attached to new initial pre-authorization requests in Availity Essentials)
- *Concurrent Request Form*
- *Stepdown Request Form*
- *Discharge Notification Form*

The forms will be available on our provider website April 4, 2022:

- Quick Links>Behavioral Health Facilities
- Library>Forms

Medication policy updates

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

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

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

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

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

Effective March 1, 2022	Description
Revised medication policy	
High-cost medications for dry eye disease, dru472	- Added the newly available generic for Restasis single-dose vials to policy - Coverage of the generic is limited to when there is documentation of an intolerance or contraindication to an inactive ingredient in branded Restasis single-dose vials - Restasis multidose-vials are considered not medically necessary and therefore not covered

Effective March 13, 2022	Description
Revised medication policies	
Drugs for chronic inflammatory diseases, dru444	- Added coverage criteria for newly FDA-approved indications: • Psoriatic arthritis (PsA) - Added Rinvoq as a level 2 option - Added Skyrizi as a level 1 option • Ankylosing spondylitis (AS) - Added Xeljanz/ Xeljanz XR as a level 2 option - Cimzia syringes, Simponi, and Taltz were moved to level 3 • Rinvoq in atopic dermatitis (AD) • Intravenous Orencia in the prophylaxis of graft versus host disease (GVHD) • Cosentyx for enthesitis-related arthritis (ERA) - Added adalimumab-aqvh (Yusimry) added to policy as a non-preferred adalimumab product

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Effective April 15, 2022	Description
New medication policies	
Betibeglogene autotemcel, dru698	- Will limit coverage to patients with transfusion-dependent beta-thalassemia with a non-β0/β0 genotype when standard of care (red blood cell transfusions/iron chelation therapy) has been ineffective and for whom a hematopoietic stem cell transplantation (HSCT) is appropriate, but a matched donor is not available
Tivdak, tisotumab vedotin, dru690	- Will limit coverage as monotherapy for patients with recurrent or metastatic cervical cancer when there has been progression of disease on or after at least one prior chemotherapy doublet and, if the tumor expressed PD-L1 (CPS > 1), pembrolizumab unless contraindicated or not tolerated
Vyvgart, efgartigimod alfa, dru696	- Will limit coverage to patients with AChR-antibody positive generalized Myasthenia Gravis with severe disease when managed by a specialist and lower cost therapies were ineffective or not tolerated
Xipere, triamcinolone, dru702	- Will limit coverage to when lower cost forms of corticosteroids were ineffective, including oral, ophthalmic drops and injectable Triesence
Revised medication policies	
Complement Inhibitors, dru385	- Adding Tavneos (avacopan) to policy - Will limit coverage to patients with severe active ANCA-AV as adjunctive therapy with standard of care including glucocorticoids, when managed by a specialist and previous standard of care therapies (rituximab, cyclophosphamide, glucocorticoids, MTX, AZA and MMF) were ineffective at inducing or maintaining remission
Keytruda, pembrolizumab, dru367	- Will add coverage criteria for early TNBC in the neoadjuvant/adjuvant treatment setting; this indication was previously considered not medically necessary
Opdivo, nivolumab, dru390	- Will add coverage criteria for the use of Opdivo for urothelial carcinoma in the adjuvant setting for patients at high risk of recurrence, a newly FDA-approved indication
Tecentriq, atezolizumab, dru463	- Will add coverage criteria for the use of Tecentriq for early non-small-cell lung cancer (NSCLC) in the adjuvant setting, a newly FDA-approved indication

Effective June 1, 2022	Description
New medication policies	
Besremi, ropeginterferon alfa-2b-NJFT, dru703	- Will limit coverage to patients with polycythemia vera when hydroxyurea and peginterferon alfa-2a have not been effective
Exkivity, mobocertinib, dru686	- Will limit coverage to patients with advanced NSCLC when there has been progression of disease on or after front-line therapy with cytotoxic chemotherapy when the tumor harbors an EGFR exon 20 insertion mutation; use in the front-line setting is considered investigational

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New medication policies, continued	
Ileal Bile Acid Transporter (IBAT) Inhibitors, dru699	- Will limit coverage of odevixibat (Bylvay) to patients with pruritis due to progressive familial intrahepatic cholestasis when standard therapies have been ineffective - Will limit coverage of maralixibat (Livmarli) to patients with Alagille syndrome when diagnosed by a specialist with genetic confirmation, when standard therapies have been ineffective, and activities of daily living (ADLs) are affected
PCSK9 Inhibitors, dru697	- New combination policy replacing individual policies for Praluent and Repatha (dru406 and dru407) - Will add newly FDA-approved product, Leqvio (inclisiran), to policy
Rezurock, belumosudil, dru684	- Will limit coverage to patients with chronic GVHD after autologous bone marrow transplant (BMT) or HSCT when at least two prior cGVHD therapies have failed or were not tolerated
Scemblix, asciminib, dru692	- Will limit coverage to patients with Ph+ CML after at least two prior tyrosine kinase inhibitors (TKIs) (in alignment with labeling), or when there is documentation of a T315I mutation and ponatinib was ineffective, was not tolerated, or is contraindicated (aligned with label plus step therapy with a lower-cost alternative)
Welireg, belzutifan, dru685	- Will limit coverage to a specific subset of VHL-associated tumors (RCC, CNS hemangioblastomas and pNETs) when the disease is not metastatic, and tumors do not require immediate resection
Revised medication policies	
Brukinsa, zanubrutinib, dru691	- Will move to new combination policy: Bruton's tyrosine kinase (BTK) inhibitors, dru691 - Will add coverage criteria for Waldenstrom's macroglobulinemia (WM) and marginal zone lymphoma (MZL), two newly FDA-approved indications
cabozantinib-containing medications, dru290	- Will add coverage for use of Cabometyx in differentiated thyroid cancer (DTC), a newly FDA-approved indication
CDK4/6 Inhibitors for Breast Cancer	- Will add coverage criteria for Verzenio (abemaciclib) as adjuvant therapy for early breast cancer (BC), a newly FDA-approved indication
Copiktra, duvelisib, dru573	- Will move to new combination policy: PI3K Inhibitors, dru706 - Will remove coverage criteria for follicular b-cell non-Hodgkin lymphoma (FL); indication withdrawn by the FDA
High-cost medications for dry eye disease, dru472	- Will add newly FDA-approved Tyrvaya (varenicline solution) nasal spray to policy
Istodax, romidepsin, dru198	- Will move to new combination policy: Medications for T-cell lymphoma, dru705 - Will remove coverage criteria for peripheral t-cell lymphoma (PTCL); indication withdrawn by the FDA
Jakafi, ruxolitinib, dru268	- Will add coverage criteria for chronic GVHD, a newly FDA-approved indication

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Revised medication policies, continued	
Medications for pulmonary arterial hypertension, dru633	- Will remove treprostinil injection (generic Remodulin) from policy; this product will no longer require pre-authorization - Will add step therapy requirements with generic bosentan and generic ambrisentan to Adempas, Orenitram, and Uptravi when used for WHO Group 1 pulmonary arterial hypertension - Will add intravenous Uptravi to policy; its use will be considered not medically necessary and therefore not covered
metyrosine (generics, Demser), dru405	- Will revise step therapy criteria to include dihydropyridine calcium channel blockers
Sodium oxybate-containing medications, dru093	- Will add coverage criteria for Xywav for idiopathic hypersomnia, a newly FDA-approved indication
Revised medication policies, continued	
Tibsovo, ivosidenib, dru558	- Will add coverage criteria for relapsed or refractory IDH1-mutated cholangiocarcinoma (CCA), a newly FDA-approved indication
Zydelig, idelalisib, dru363	- Will move to new combination policy: PI3K Inhibitors, dru706 - Will remove coverage criteria for FL and small lymphocytic lymphoma (SLL); indications withdrawn by the FDA
Archived medication policies	
everolimus-containing-medications, dru178	- Afinitor products will no longer require pre-authorization
Sutent, sunitinib, dru128	- Sutent will no longer require pre-authorization

Effective July 1, 2022	Description
Archived medication policies	
High-Cost Epinephrine Autoinjectors, dru484	- Auvi-Q will no longer require pre-authorization

Cancer screenings

An estimated 30% to 50% of all cancers are preventable. According to the Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in the U.S.

We cover a variety of preventive services at no cost (no copay and no deductible) to our members. Preventive services can help detect the following cancers before symptoms appear and when treatment is more likely to be successful. Your patients may have avoided cancer screenings during the COVID-19 pandemic and may be overdue for them.

Screening coverage for commercial members

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

Member reminders

Eligible members—including Medicare Advantage, fully insured group and Individual, and ASO members—are receiving opt-in texts asking whether they agree to receive preventive screening reminders. If the member agrees, they will receive a text message reminding them of the importance of the screening and that they might be due to schedule theirs. The text will also include a link to an educational video about the importance of the missing screening. The member can respond to the text with a request for help scheduling an appointment, which will trigger a call from a Asuris care advocate. The text also allows the member to indicate barriers preventing them from being screened, which a care advocate can help address.

Preventive vs. diagnostic care

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

View our preventive care lists

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

Educational flyers

We have flyers available for you to share with patients that address the importance of breast, colorectal and cervical screenings on our provider website: Programs>Cost and Quality>Provider Quality Resources.

You can also email us to request copies of the flyers at **Quality@asuris.com**.

Monitoring physical activity and improving quality

The Monitoring Physical Activity Medicare Star Ratings measure continues to be an opportunity of improvement for us.

As a health care provider, you understand the importance of exercise in reducing the risk of many chronic diseases and cancers, as well as managing and improving the health of patients already diagnosed with a chronic condition. You can encourage and motivate your patients to become or stay active when you assess their level of physical activity and fitness during a visit.

Tips for making the Monitoring Physical Activity measure a part of your workflow:

- Share information about regular physical activity, including endurance, muscle strengthening, and balance and flexibility exercises, which are essential for healthy aging and fall risk reduction.
- Implement exercise or physical activity as a Vital Sign into your rooming process and electronic medical record (EMR). There are several simple screening tools that can begin with clinical support staff and then be handed off to the provider. Learn more: **cdc.gov/pcd/issues/2017/17_0030.htm**.
- Include physical activity in your patient's care plan. Help them develop an exercise plan that includes realistic goals and discuss any potential barriers they may have to becoming or staying active.
- Involve members of your team—such as a health coach, patient navigator, care manager, case manager or anyone trained in motivational interviewing—in the process to help encourage patients to stay physically active.
- Consider ways to encourage social support that is safe during the COVID-19 pandemic. Social support from family and friends has been consistently and positively related to sustaining regular physical activity.
- Talk to patients about Silver&Fit, a benefit of their Asuris Medicare Advantage or Medigap plan. Silver&Fit is designed to offer healthy activities, information and support for everyone. Whether working out at one of more than 20,000 fitness clubs and exercise centers or from the comfort of home, our Medicare members can enjoy healthier, more active lives. Visit **silverandfit.com** to learn more about the program.
  - Additional benefits associated with the Silver&Fit program include:
    - **Home fitness program**: Choose up to two home fitness kits each year to promote staying active.
    - **Resource library**: Members can browse a library of online classes, healthy aging videos, articles and *The Silver Slate Newsletter*.
    - **Silver&Fit Connected!**: Members can track their exercise using a fitness device or app.
    - **Rewards program**: Members are rewarded for being active.

We can help facilitate conversations with flyers that address topics such as fitness and physical activity. The flyers are available in English and Spanish, and include:

- *Exercise: How to Start*
- *Exercise: Stay Motivated*
- *Fitness: What's Getting in Your Way*
- *Exercise: Setting Goals to Get Active*
- *Exercise: Finding Activities That Work for You*

The flyers are designed to reinforce learning objectives after a coaching encounter or to review in the waiting room before an appointment. They use motivational interviewing and behavioral science techniques to help members make the best decision.

If you would like copies of these flyers, please email a request to us at **Quality@asuris.com**.

New kidney health measure for Medicare Quality Incentive Program

We are changing one of the quality measures in our 2022 Medicare Quality Incentive Program.

In accordance with HEDIS changes and CMS guidance, we are replacing the *Diabetes care–Medical attention for nephropathy* measure with the *Kidney evaluation for patients with diabetes (KED)* measure.

Specifications for the new measure are as follows:

Measure description:

The percentage of members ages 18-85 with diabetes (type 1 and type 2) who received a kidney health evaluation.

Numerator:

Members who received both of the following during the measurement year on the same or different dates of service:

- At least one estimated glomerular filtration rate (eGFR)
- At least one urine albumin-creatinine ratio (uACR)

Note: The uACR is identified by the member having both a quantitative urine albumin test and a urine creatinine test with service dates four or fewer days apart.

Gaps for this measure will be displayed in the Care Gap Management Application for your patients. The only way to close these gaps is through claims submission.

The incentive amount for gap closure remains the same as the previous measure at $10 per compliant member, and the cut points for earning the potential 4- and 5-Star bonuses remain the same as well. Information about this measure is also included in the *Quality Measures Guide*.

More information about the incentive program, cut points and the *Quality Measures Guide* is available on our provider website: Programs>Medicare Quality Incentive Program.

$35 copay for insulins for Medicare Advantage members

Formulary insulins have a $35 copay for Medicare Advantage members in 2022. This copay is for a one-month supply and is not subject to the deductible or pharmacy coverage gap. Some members may also pay two and a half copays for a three-month supply depending on their benefits.

Switching your patient to a formulary insulin can reduce financial barriers, improve medication adherence and improve diabetes management. Our current Medicare Advantage formulary insulins are:

- Basaglar
- Humalog
- Humalog mix
- Humulin 70/30
- Humulin N
- Humulin R
- Lantus
- Levemir
- Lyumjev
- Toujeo
- Tresiba
- Tresiba

Statin use for diabetes or cardiovascular disease

Statin use in persons with diabetes (SUPD) and Statin therapy for patients with cardiovascular disease (SPC) are part of the Medicare Star Ratings program and included in our Medicare Quality Incentive Program.

SUPD focuses on patients ages 40 to 75 who were dispensed at least two diabetes medication fills and were also dispensed at least one statin medication.

SPC focuses on males ages 21 to 75 and females ages 40 to 75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication.

While these measures are supported by the 2013 American College of Cardiology and American Heart Association blood cholesterol guidelines, as well as the 2017 American Diabetes Association guidelines, sometimes statins are not clinically appropriate. There are several clinical reasons why a statin may not be appropriate for your patient. If your patient has or had any of the following, they can be excluded from these quality measures.

Exclusion conditions	ICD-10 codes
End-stage renal disease	- I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2
Lactation	- O91.03, O91.13, O91.23, O92.03, O92.13, O92.5, O92.70, O92.79, Z39.1
Liver disease	- Numerous codes (>60 codes)
Polycystic ovarian syndrome (SUPD only)	- E28.2
Prediabetes (SUPD only)	- R73.03, R73.09
Pregnancy	- Numerous codes (>1700 codes)
Rhabdomyolysis, myopathy, myositis	- G72.0, G72.89, G72.9, M60.80, M60.9, M62.82, T46.6X5A

Notes:

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

During an office visit, be sure to discuss statin therapy with your patient. If your patient has a condition that would exclude them from these measures and you find statin therapy to be inappropriate for that patient, be sure to document in the patient's medical record and submit the appropriate diagnosis code(s) on a claim.

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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