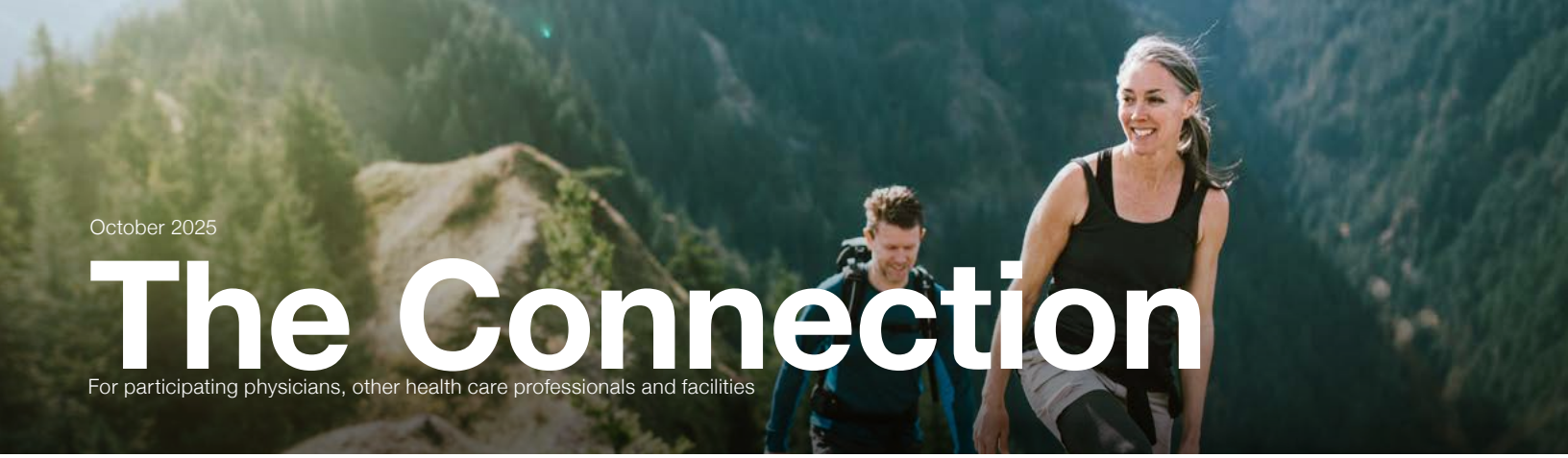

October 2025

The Connection

For participating physicians, other health care professionals and facilities

In this issue

2026 product and network updates

Each year, we conduct a comprehensive review of our provider networks and product offerings to ensure we serve our members' diverse health care needs and deliver high-quality, cost-effective health care solutions.

2026 brings code changes for services and supplies

Please remember to review your 2026 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

Enforcement of deadlines for requested records

Our *Timely Receipt of Medical Records* (Administrative #145) reimbursement policy will be updated clarify that incomplete requests and records received after the 90-day period will not be accepted and will not change the adjudication of the claim. Providers will need to follow the dispute process to have records reviewed after the 90-day deadline.

Change to colonoscopy site-of-care exceptions

Effective January 1, 2026, providers will no longer be able to cite a lack of ambulatory surgical center (ASC) privileges when requesting to perform a screening or surveillance colonoscopy in an outpatient hospital setting. These reviews will be subject to our new *Surgical Site of Care – Colonoscopy* (Utilization Management #20) commercial medical policy.

Contents

■ Critical article ▲ DME ★ Star Ratings/Quality

ASURIS NORTHWEST HEALTH

Asuris Northwest Health

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

Get the latest news

We publish the latest news and updates in the What's New section on the homepage of our provider website.

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

The Connection

This publication includes important news, as well as notices we are contractually required to communicate to you.

In the table of contents on page 1, this symbol indicates articles that include critical updates: ■. Click on article titles to go directly to that page, and return to the table of contents by clicking the link at the bottom of each page.

We publish issues of *The Connection* on the first of February, April, June, August, October and December.

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

The Bulletin

Published monthly, *The Bulletin* summarizes updates to medical and reimbursement policies, including policy changes we are contractually required to communicate to you.

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.

Maximize your clinical impact with PRIA's enhanced ED analytics

Transform how your clinical team identifies and manages high-risk patients with the Provider Reporting Insights & Analytics (PRIA) platform. Our enhanced tools help you pinpoint members with high emergency department (ED) risk, high ED utilization, and potentially avoidable ED visits—enabling smarter resource allocation and better patient outcomes.

- **Focus limited clinical resources**: Direct specialized staff toward patients who will benefit most from intervention.
- **Reduce wasted outreach efforts**: Eliminate time spent on patients unlikely to need or benefit from intensive management.
- **Increase return on staff investment**: Generate better outcomes with existing staffing through targeted interventions.
- **Optimize caseloads**: Structure case manager workloads based on patient complexity and intervention potential.

Powerful tools to drive clinical excellence

ER Utilizers report: Identify high-risk members

Quickly identify your top ED utilizers and high-risk members with comprehensive, member-level insights, including:

- Two-year ED utilization summary with primary diagnoses
- Inpatient hospitalization history and medications
- Provider network (including specialists)
- Complete expense breakdown (medical and pharmacy)

Identify members with potentially avoidable ED visits

Compare costs and identify intervention opportunities by analyzing:

- Members with potentially avoidable ED visits
- Actionable diagnoses suitable for alternative care settings

Learn more about PRIA on our provider website: Contracting & Credentialing>APM Resources>PRIA.

Administrative Manual updates

The following updates were made to our manual on October 1, 2025:

Facility Guidelines

- Added information about reimbursement updates for Medicare Advantage skilled nursing facilities (SNFs)
- Added a link to SNF claim accuracy tips and best practices, available on our provider website: Claims & Payment>Claims Submission>Other Billing Information
- Streamlined the information about extenuating circumstances

Medical Records Requirements

- Clarified requirements and added tips and examples for retrieving accurate signature information from electronic medical records (EMRs)

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

2026 brings code changes for services and supplies

Please remember to review your 2026 CPT, HCPCS and CDT coding publications for codes that have been added, deleted or changed and to use only valid codes.

- **CDT manual**: Available online through the American Dental Association or by calling 1 (800) 947-4746
- **CPT and HCPCS manuals**: Available through your preferred vendor or online through the American Medical Association (AMA)

Access current reimbursement schedules on Availity Essentials: Claims & Payments> Fee Schedule Listing.

This notice serves as an Amendment to your Participating Agreement. You have the right to terminate your Agreement in accordance with the amendment provisions of the Participating Agreement.

Correct coding updates

Claims received on or after November 7, 2025

Providers are expected to follow correct coding guidelines. We are providing courtesy notice that our pre-pay correct coding editors will apply denials for claims received on or after November 7, 2025, for incorrect reporting in the following circumstances:

- A diagnosis that requires an additional diagnosis is missing from claims data (e.g., a diagnosis of hypertensive retinopathy requires both an ICD-10 code for the eye condition and a separate code for the underlying systemic hypertension)
- Durable medical equipment requiring a rental or purchase modifier is billed without the appropriate modifier
- Modifier 59 is appended to services when no other non-evaluation & management (E&M) services are reported on the same date of service by the same provider
- Modifier XS is reported with an anatomic modifier on the same line
- Repeat genetic testing is billed for disorders that can only be tested once in a patient's lifetime

These reviews are supported by industry standards and our reimbursement policies, including Correct Coding Guidelines (Administrative #129). View our *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

Claims in process on or after February 1, 2026

Claims will be reviewed by a new third-pass pre-payment editor that supports our medical and reimbursement policies. The editor will review provider-submitted commercial and Medicare Advantage claims to reduce post-payment recoveries.

- Types of affected claims include:
- Inpatient and outpatient professional
- Inpatient and outpatient facility
- Inpatient and outpatient hospital

The editor will not affect claims-processing times or the appeals process.

Updates to Part 2 rules for SUD records

In 2024, the U.S. Department of Health and Human Services (HHS) updated the Part 2 rules that protect the confidentiality of substance use disorder (SUD) patient records.

Providers and payers are expected to be in compliance with the updated regulations by February 16, 2026. Asuris is updating its contract language and billing guidelines to conform to the revisions.

Updates include:

- A new sample consent form—titled *Consent for Disclosure of Patient Identifying Information and Substance Use Disorder Patient Records*—has been added to our provider website:
  - Library>Forms
  - Claims & Payment>Claims Submission>Other Billing Information
- Part 2 disclaimer language, which is required on Part 2 claims, has been updated on our provider website: Claims & Payment>Claims Submission>Other Billing Information. The disclaimer language is prescribed by rule.
- Providers will receive updated contract language by November 15, 2025, that clarifies the type of patient consent providers are expected to obtain.

Part 2 rule changes are already in effect, and providers should begin using the newly updated consent guidelines and Part 2 disclaimer as soon as possible, in accordance with their agreement, and by no later than February 16, 2026.

New Professional VBR program reporting metrics flyer available

A new flyer outlining updated reporting metrics for the Professional Value-Based Reimbursement (VBR) program is now available. This resource details the metrics that will be reflected in July 2026 scorecard reports for the October 2026 adjustment. The metrics will first apply to claims with dates of service in 2025.

Visit our provider website to access the Professional VBR metrics flyer: Contracting & Credentialing>APM Resources.

Note: These updated metrics do not affect the current VBR program measurement cycle. The reports posted in July 2025 detail the October 2025 adjustments.

Hearing aid professional reimbursement schedule update

Effective January 1, 2026, we are increasing professional reimbursement rates for hearing aids, subject to the member's benefit. This change will apply to all commercial lines of business and plans. **Excluded**: Facilities.

The updated commercial reimbursement schedule will be available on Availity Essentials after January 1, 2026. View our commercial reimbursement schedules by selecting Claims and Payments>Fee Schedule Listing.

If a member chooses to upgrade to a hearing aid product that costs more than the reimbursement or benefit amount, the member should complete a *Non-Covered Services Member Consent Form*. Our *Professional Services Agreements* outline what is required on the waiver form. The *Professional Services Agreement* also indicates that the waiver form must be signed by the member in advance of services being rendered and maintained by the medical group. A sample non-covered services waiver form is available on our provider website: Library>Forms.

Provider write-off for medical necessity denials

As a reminder, in the August 2025 issue of T*he Connection*^{SM}, we announced that providers must write off services we have denied because they do not meet medical necessity, as well as any other services related to the denial, effective November 1, 2025. The provider cannot balance bill the member for services that do not meet medical necessity.

If a member elects to receive services that are not medically necessary, the member may accept financial responsibility by signing a waiver that meets certain requirements. Our *Provider Services Agreements* outline what is required on the waiver form. The *Provider Services Agreement* also indicates that the waiver form must be signed by the member and maintained by the medical group. A sample non-covered services waiver form is available on our provider website: Library>Forms.

Medicare crossover claim reminders

When you submit claims to Medicare for members with Medicare as their primary coverage, wait 30 calendar days from the Medicare remittance date before sending the claim to Asuris.

Why wait 30 days?

In most cases, you won't need to submit the claim to us because Medicare will send it through the crossover process.

Crossed-over claims

If the Medicare remittance advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to us for processing. You do not need to file a claim for the Medicare supplemental benefits.

The Medicare crossover process can take up to 14 business days. This means we are receiving the claim from Medicare at the same time you receive the Medicare remittance advice. As a result, it may take up to 30 additional calendar days for you to receive payment or instructions from us after you receive the Medicare remittance.

We will return or reject any Medicare primary claims that you submit directly to Asuris that crossed over and are received within 30 calendar days of the Medicare remittance date or contain no Medicare remittance date.

Receiving payment

After processing the claim, we will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid directly, and you will need to bill the member.

Claims that don't crossover

If the Medicare remittance advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim and the payment advice to Asuris. We will pay you the Medicare supplemental benefits.

Statutorily excluded services

When you provide services or supplies that Medicare excludes (e.g., home infusion therapy and hearing aids), you can submit the claim directly to Asuris without waiting 30 days after the Medicare remittance date. Submit claims for services that are excluded or not covered by Medicare with modifier GY on each line.

Learn more about Medicare crossover and claims for statutorily excluded services on our provider website:

- Claims & Payment>Claims Submission>Benefit Coordination>Medicare Crossover
- Claims & Payment>Claims Submission>Medicare Statutorily Excluded Services

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective September 1, 2025
eviCore Spine - Interspinous and Interlaminar Stabilization and Distraction Devices (Spacers) (Surgery #155)	- 22867, 22868
Transcatheter Heart Valve Procedures for Mitral or Tricuspid Valve Disorders (Surgery #221)	- 0569T, 0570T, 0646T
Procedure/medical policy	**Added codes effective October 1, 2025**
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- Q4391
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	- 0585U
Radiofrequency and Ultrasound Ablation of the Renal Sympathetic Nerves as a Treatment for Uncontrolled Hypertension (Surgery #235)	- 0338T, 0339T, 0935T, C1735, C1736
Procedure/medical policy	**Changing applied policy beginning January 1, 2026**
Surgical Site of Care – Colonoscopy (Utilization Management #20) **Related**: See *Colonoscopy site-of-care exception changing* on page 9.	- 44388, 44389, 44391, 44392, 44394, 44408, 45378, 45379, 45380-45382, 45384-45386, 45388, 45389, 45390-45393, 45398, G0105, G0121

Medicare Advantage

Procedure/medical policy	Added codes effective September 1, 2025
eviCore Spine	- 22867, 22868
Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	- 0108U
Procedure/medical policy	**Added codes effective October 1, 2025**
Biochemical and Cellular Markers of Alzheimer's Disease (Laboratory #22)	- 0596U
Bioengineered Skin and Soft Tissue Substitutes and Amniotic Products (Medicine #170)	- A2036-A2039, Q4383-Q4397
Biomarkers for Cardiovascular Disease (Laboratory #78)	- 81439
Laboratory Tests for Organ Transplant Rejection (Laboratory #51)	- 0118U, 0319U, 0320U, 0493U, 0508U, 0509U, 0540U, 0544U, 0575U, 0581U
Molecular Panel Testing for Identification of Microorganisms (Genetic Testing #85)	- 0429U, 0590U, 0595U
Multimarker and Proteomics-based Serum Testing Related to Ovarian Cancer (Laboratory #60)	- 0577U
Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	- 0335U, 0579U, 0584U, 0588U, 0589U, 0594U, 0598U

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Medicare Advantage

Procedure/medical policy	Added codes effective October 1, 2025
Pharmacogenomic (PGx) Testing (Genetic Testing #10)	- 0029U-0034U, 0070U-0076U, 0169U, 0173U, 0175U, 0347U-0350U, 0411U, 0419U, 0423U, 0434U, 0460U, 0461U, 0476U, 0477U, 0516U, 0533U, 81225-81227, 81230, 81231, 81247, 81283, 81306, 81328, 81335, 81350, 81355, 81374, 81377, 81381, 81383, 81400-81408, 81418, G9143
Pneumatic Compression Devices (Durable Medical Equipment #78)	- E0658, E0659
Testing for Cancer Diagnosis, Prognosis, and Treatment Selection (Genetic Testing #83)	- 0464U, 0578U, 0586U, 0591U, 0592U, 0597U, 0599U

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 and behavioral health pre-authorizations through the Availity Essentials Electronic Authorization application.

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 August 2025 issue of *The Bulletin* about changes to the *Extravascular (Substernal) Implantable Cardioverter-Defibrillator* (Surgery #17) commercial medical policy, which are effective November 1, 2025

No medical policies in the September 2025 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>Medical Policy.

Reimbursement policy updates

No reimbursement policies in the August and September 2025 issues of *The Bulletin* required 90-day notice.

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

Updates to timely records policy

When we request records to support claims/ reimbursement, providers have 90 calendar days to submit them. Effective January 1, 2026: We will no longer accept requested records after the 90-day deadline. Providing records after this deadline will not change adjudication of the claim.

This requirement applies to clinical records, as well as financial records (i.e., itemizations and invoices) that aren't available by EMR.

Impact to providers

- To have records reviewed after the 90-day deadline, providers will need to follow the dispute process as stated in section 1.4 of the Appeals for Providers section of our *Administrative Manual*, available on the homepage of our provider website.
- Failure to submit timely records may result in claims denied as provider liability. Providers cannot balance bill members for provider liability denials.

More information

- Review the *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines>Reimbursement Policy.
- We announced updates to our *Timely Receipt of Medical Records* (Administrative #145) reimbursement policy, which applies to commercial and Medicare Advantage, in the October 2025 issue of *The Bulletin*, available on our provider website: Library>Bulletins.

Colonoscopy site-of-care exception changing

Effective January 1, 2026, providers will no longer be able to cite a lack of ambulatory surgical center (ASC) privileges when requesting to perform a screening or surveillance colonoscopy in an outpatient hospital setting.

Colonoscopies performed in an outpatient hospital setting already require pre-authorization for commercial members. We announced in the October 2025 issue of *The Bulletin* that we will begin reviewing these procedures under a new medical policy: *Surgical Site of Care – Colonoscopy* (Utilization Management #20). **Related**: See *Pre-authorization updates* on pages 6-7.

Under this policy, providers may continue to perform diagnostic colonoscopies in an outpatient hospital setting if:

- Clinical criteria are met, and
- The provider lacks ASC privileges, or an in-network ASC is not available locally

Site-of-care reviews

We assess the site of care for select services to determine whether the requested location is appropriate. This ensures care is delivered in the most appropriate and cost-effective setting. Our reviews consider an individual's health status, facility and geographic availability, specialty requirements and other relevant factors.

Notes:

- We currently review colonoscopies under our *Surgical Site of Care – Hospital Outpatient* (Utilization Management #19) medical policy.
- A site-of-care pre-authorization denial is not a denial of services; it is only a denial of the requested outpatient hospital setting.
- Blank forms will not be accepted and will be voided.

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 care, so you don't need to complete and submit attestation-based supporting documentation.

For colonoscopies performed on or after January 1, 2026, faxed pre-authorization requests must include the new *Surgical Site of Care (Colonoscopy) Additional Information Form*, which will be available on our provider website in December. **Failure to submit a completed and signed form will delay review**.

More information

Review these resources on our provider website:

- The new policy in our *Medical Policy Manual*: Library>Policies & Guidelines>Medical Policy
- The policy announcement in the October 1, 2025, issue of *The Bulletin*: Library>Bulletins
- **Coming soon**: Additional information in the December 2025 issue of this newsletter

Medication policy updates

Effective January 1, 2026, we will make changes to the following medication policies:

- *Drugs for Chronic Inflammatory Diseases (Standard Plus Formulary)*, dru444
- *Enzyme Replacement Therapy,* dru426
- *Medicare Part B Step Therapy*, dru-m001
- *Medications for Hereditary Angioedema*, dru535
- *Medications for Epidermolysis Bullosa*, dru759
- *Non-Preferred Blood Glucose Test Strips and Blood Glucose Meters*, dru505
- *Non-Preferred Drugs*, dru760
- *Products with Therapeutically Equivalent Biosimilars/ Reference Products*, dru620
- *Site of care review,* dru408
- *Synagis, palivizumab, Respiratory syncytial virus (RSV) immune prophylaxis*, dru029
- *Yondelis, trabectedin*, dru440

View medication policy additions and changes on our website: Policies & Guidelines>Medication Policy Updates. This content is updated with new required notifications and information about the changes on the first of the following months: February, April, June, August, October, December. Providers are responsible for obtaining pre-authorization as required in our medication policies.

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.

2026 commercial products and networks

Each year, we conduct a comprehensive review of our provider networks and product offerings to ensure we serve our members' diverse health care needs and deliver high-quality, cost-effective health care solutions. As part of this process, we also implement changes to comply with Affordable Care Act (ACA) requirements and state and federal mandates.

Below is an overview of the changes to our product portfolio for 2026.

Group network and product updates

We are increasing vision allowances for small employer (1 to 50) group metallic products and fully insured groups (51+).

More information

Information about our 2026 small and large group products will available on our provider website in January, 1, 2026: Products>Commercial.

Individual network and product updates

Our product portfolio will include:

- Exclusive provider organization (EPO) products; EPO members only have in-network benefits, and members will be responsible for 100% of out-of-network costs except:
  - Out-of-network emergency room, ambulance and urgent care services will be covered at the in-network benefit level. Urgent care services are subject to balance billing.
  - When traveling out of our service area, urgent care, emergency room and ambulance services are covered with no balance billing if the member sees a participating MultiPlan provider.
- High-deductible health plans (HDHP) that can be paired with a health savings account (HSA)

The **new** Individual Connect network will support our products.

- Supports off-exchange products
- **Network service area**: Adams, Asotin, Benton, Clallam, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whitman and Yakima counties
- **Sales area**: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla and Whitman counties

The open enrollment period for individuals in Washington seeking coverage beginning on January 1, 2026, is from November 1, 2025, through January 15, 2026. Individuals may qualify for special enrollment periods outside of this period if they experience certain life events. Members whose plans are being discontinued have received notice from us about options available to them in 2026.

More information

Information about our 2026 Individual products is available on our provider website: Products>Commercial.

Benefit highlights for all our commercial products

- In addition to having access to telehealth services from in-network providers, members will have access to telehealth services for urgent care and behavioral health through the national telehealth provider Doctor on Demand. Some groups will have access to medical and behavioral health providers through MDLIVE.
- Most members will have access to either telephone or chat nurse triage lines (depending on their plan), available 24/7.
- Hinge Health, a personalized virtual exercise program, is available to help eligible members manage mobility and pain in joints, spine and muscles.
- Bump2Baby℠ maternity management program is available to support parents-to-be.

Verify network participation

Participating providers: For a list of the networks that you participate in, refer to your *Professional Network Addendum*. You can also verify your network participation and find other in-network providers using our provider search tool on our website.

Verify eligibility and benefits

You can verify your patients' eligibility and benefits on Availity Essentials.

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Verify your network participation for 2026 to help ensure members can continue in-network care

We are introducing a new Individual Connect network for our Individual and family plans in 2026. To ensure your patients continue to receive in-network services, please verify your participation in the new Individual Connect provider network and refer patients to in-network providers. You can find 2026 in-network Individual Connect providers using our provider search tool, available on our website. We are sending letters to members with their 2026 network and plan options.

If you need help finding an in-network provider for your patient, please contact the Provider Contact Center.

2026 updates to Washington state Essential Health Benefits

Washington state has announced significant updates to its Essential Health Benefits (EHB) that will take effect on January 1, 2026, as plans renew. These changes will impact coverage for your patients on commercial plans, depending on your patients' coverage. The 2026 updates include modifications to the following benefit areas.

Individual and small group

- **Acupuncture**—Visit limits removed
- **Artificial insemination**—New coverage for qualifying plans limited to simple preparation (sperm washing and isolation) and placement of sperm into cervix or uterus to achieve pregnancy.
- **Neurodevelopmental/habilitative/rehabilitative support**—Enhanced flexibility **Note**: When someone with a neurodevelopmental diagnosis uses all their neurodevelopmental therapy benefits, they will be able to start charging that same therapy against their rehabilitative benefits and then their habilitative benefits. If you have questions about your patients' benefits after checking Availity Essentials, contact the Provider Contact Center.
- **Hearing instruments and services**—Expanded coverage
- **Inpatient donor breast milk**—Added to maternity benefits
- **Foot care and pediatric dental**—Language clarifications

Large group

- **Neurodevelopmental/rehabilitative**—Enhanced flexibility **Note**: When someone with a neurodevelopmental diagnosis uses all their neurodevelopmental therapy benefits, they will be able to start charging that same therapy against their rehabilitative benefits. (Large group products do not have habilitative benefits.) If you have questions about your patients' benefits after checking Availity Essentials, call the Provider Contact Center. benefits.) If you have questions about your patients' benefits after checking Availity Essentials, contact the Provider Contact Center
- **Hearing instruments and services**—Expanded coverage
- **Foot care**—Language clarifications

Effective January 1, 2026, you can verify your patients' updated benefits using Availity Essentials.

FreeStyle Libre discontinuations

Abbott is discontinuing FreeStyle Libre 2 and FreeStyle Libre 3 continuous glucose monitor sensors by September 30, 2025, replacing them with the Freestyle Libre 2 Plus and FreeStyle Libre 3 Plus sensors.

The Plus sensors:

- Are still compatible with the existing smartphone apps and readers
- Have extended wear time, up to 15 days
- Are compatible with selected insulin pumps
- Are suitable for ages 2 and up

You will need to submit new prescriptions for your patients to transition to the Plus sensors. Learn more about the FreeStyle Libre transition for prescribers.

Preferred diabetes supply manufacturer change

Starting January 1, 2026, we are changing our preferred manufacturer of diabetes supplies and will stop covering LifeScan products in retail and home delivery pharmacies. We will cover Ascensia or Abbott products on all lines of business.

How this affects your patients

Members will need to switch to products from Ascensia or Abbott when they need a new glucometer or test strips on or after January 1, 2026. We are notifying members of the steps they should take for this transition, including any coupon codes that they can use to reduce costs.

What you should do

- Start prescribing Ascensia or Abbott glucometers and test strips now for patients who are new to treatment.
- Be prepared to issue new prescriptions on or after January 1, 2026, for patients who use a LifeScan product so they can easily switch to the new products.

Condition Manager will include chronic low back pain

Our Condition Manager buy-up program will include chronic low back pain at no additional cost to administrative services only (ASO) groups, effective January 1, 2026. This enhancement builds upon our existing comprehensive care for members with the following chronic conditions:

- Asthma
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disorder (COPD)
- Diabetes (Type 1 and 2)
- Congestive heart failure (CHF)
- **Effective January 1, 2026**: Chronic low back pain

The program connects members with dedicated Care Advocates who provide:

- Personalized resources for navigating appropriate care
- Educational support for effective condition management
- Ongoing guidance throughout their health care journey

Learn more about the Condition Manager program on our provider website: Programs>Medical Management>Care Management.

New Quality Measures Guide available

Our updated *Quality Measures Guide* is now available on our provider website: Library>Printed Materials. The guide includes information about a variety of quality and member experience measures that are reported or monitored most frequently for the following programs and initiatives:

- Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews
- Medicare Advantage incentive programs
- Value-based agreements (VBAs)

We've also introduced critical and new measures this year. These measures may not be part of our current incentive programs but are important for patient safety and quality outcomes.

Note: The guide does not include information about all HEDIS- or Star-related measures.

2026 APM quality program updates

We're excited to share important updates to our quality program for commercial alternative payment models (APMs), effective January 1, 2026. These enhancements reflect our continued commitment to supporting comprehensive, high-quality care for our members and apply to providers participating in Commercial Total Care Program and Accountable Health Network (AHN) agreements.

Key program enhancements

New behavioral health focus

We recognize the critical importance of behavioral health in overall patient wellness. To better support these outcomes, we've added three new reporting-only behavioral health measures:

- Follow-Up After Emergency Department Visit for Substance Use (FUA)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Note: These measures are for informational purposes only and will help you track behavioral health care outcomes for your Commercial Total Care or AHN patients.

Revised measures

We made the following changes:

- Eye Exam for Patients with Diabetes (EED) replaced Plan All-Cause Readmissions (PCR) as a quality measure, with PCR becoming an alternate measure
- Statin Therapy for Patients with Cardiovascular Disease (SPC) replaced Statin Therapy for Patients with Diabetes (SPD) as an alternate measure
- Chlamydia Screening (CHL) replaced Weight Assessment and Counseling (WCC) as a quality measure in our Pediatric quality program

All measures continue to focus on evidence-based practices that drive meaningful health outcomes.

New 2026 APM quality program guide available

We've updated our APM quality program guide to reflect the 2026 program enhancements. You can access the new guide on our provider website: Contracting & Credentialing>APM Resources.

Quality in Action articles

The Quality in Action section on our provider website is an extension of this publication.

Read the following recently published articles to improve your patients' experience and health outcomes:

- *Help your patients save money and improve medication adherence*
- *Closing the gap in early breast cancer detection*
- *Screening for behavioral health conditions in primary care*
- *The importance of medication reviews*

2026 Medicare Advantage product discontinuation

After careful evaluation of our products and networks in a changing health care environment, we have made the decision to discontinue our Medicare Advantage PPO offerings in Spokane County, effective January 1, 2026. We will notify members in October 2025.

We are committed to serving our members through the end of this year, and processing claims for services provided through December 31, 2025.

We will continue to offer Medicare supplement plans for Medicare beneficiaries in our service area.

Maximize your performance on our Medicare Advantage incentive programs

The fourth quarter presents a unique opportunity to make significant strides in closing gaps that will improve quality scores and performance in our incentive programs. We appreciate your dedication and action to support our Medicare Advantage members this year.

Final attribution update

To provide your group with roster stability in the last three months of the program year, member attribution is locked after our last attribution file is loaded to the Care Gap Management Application (CGMA) in early October. You may see a reduction in your roster if patients lose eligibility after the final attribution file is loaded.

Even though new patients will not be added to your CGMA roster, you may continue to see new chronic condition assessment and quality gaps for existing patients in the CGMA.

Chronic condition assessment gaps

New gaps added after October 1, 2025, will only be added to your performance denominator if the gap is closed. If you close a chronic condition assessment gap after October 1, 2025, the closed gap will be added to both your numerator and denominator.

Medicare Star Rating and quality gaps

You may see new gaps but only for existing patients on your roster. Gaps that open after October 1, 2025, will be added to your denominator in accordance with the specifications for each measure.

Prioritize patients with highest number of open gaps

If your patients still have gaps that require an office visit or screening to be completed this year, we encourage you to contact them to schedule now. You can review your patients and sort them by largest number of open gaps on the CGMA.

To ensure that we have the necessary information to close your gaps for the 2025 program, we will accept claims or compliant documentation until the dates listed below for each method of gap closure submission:

- **December 31, 2025**—Last day to perform services
- **January 31, 2026**
  - Last day to submit evidence through the CGMA to close gaps
  - Last day to submit structured supplemental data files
- **March 31, 2026**—Last day to submit medical or pharmacy claims

CGMA user audit coming soon

Twice per year, we complete a user audit to verify that the appropriate users have access. Note: CGMA accounts that are inactive for 120 calendar days are locked and will need to be reactivated if the user still needs access. QIP Primary Contacts must respond to the audit to maintain access for themselves and others associated with their TIN. Thank you in advance for complying with this audit to ensure that protected health information remains safe.

Resources

Learn about the incentive programs, attribution adjustment options by member type and read details about the measures in the *Quality Measures Guide* on our provider website: Programs>Medicare Advantage Incentive Programs.

Email our QIPQuestions team if you have additional questions about the programs.

DirectDerm: Virtual dermatology care for Medicare Advantage members

DirectDerm offers a seamless, efficient and effective solution for diagnosing and managing skin conditions remotely. This teledermatology service connects patients with board-certified dermatologists through a secure online platform, enabling expert dermatological care without the need for an in-person visit. DirectDerm ensures that patients have access to timely and accurate diagnoses, treatment plans and follow-up care.

As a health care provider, DirectDerm can help you and your Asuris Medicare Advantage patients:

- When a condition or lesion needs to be evaluated sooner rather than later.
- If your patient needs a dermatology consult before an in-person visit is available.
- If location or circumstances (e.g., young children in the home, remote location or weather conditions) make it difficult for a patient to travel to a dermatologist.
- If you would like a dermatologist's opinion on a diagnosis or treatment choice for a patient's skin condition. DirectDerm can help with individual cases and provide educational support.

Learn more DirectDerm, including the conditions they treat and how to submit a patient referral, in the Telehealth Vendors section of the Care Options Toolkit on our provider website.

Resources for you

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

Publications team

Written, designed and edited by the Provider Communications team.