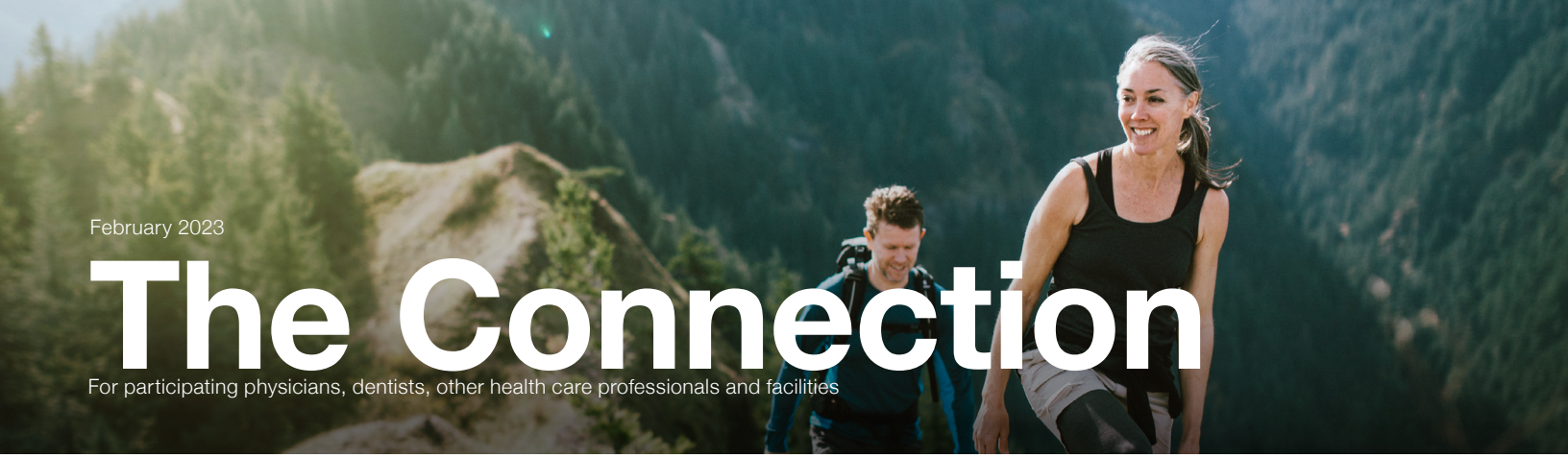

February 2023

The Connection

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

Help reduce hypertension and risk for heart disease

American Heart Month (February) is observed to help raise awareness about cardiovascular health. The principal risk factors for heart disease include high blood pressure, high cholesterol, smoking and obesity. According to the Centers for Disease Control and Prevention (CDC), nearly half of adults in the U.S. have high blood pressure and only about one in four people with high blood pressure have their condition under control.

Rates of high blood pressure control vary

Uncontrolled high blood pressure is common; however, certain groups of people are more likely to have high blood pressure.

- A greater percentage of men (50%) have high blood pressure than women (44%).
- High blood pressure is more common in non-Hispanic black adults (56%) than in non-Hispanic white adults (48%), non-Hispanic Asian adults (46%) or Hispanic adults (39%).
- Among those recommended to take blood pressure medication, blood pressure control is higher among non-Hispanic white adults (32%) than in non-Hispanic black adults (25%), non-Hispanic Asian adults (19%) or Hispanic adults (25%).

We encourage you to educate your patients with hypertension about the importance of tracking their blood pressure, taking prescribed medications, if appropriate, and implementing lifestyle changes to reduce their risk of disease. To identify patients who are due for follow-up appointments, use registries within your electronic medical record to review dates of past prescription refill requests and the last office visit note for follow-up instructions.

For all office visits, we recommend you submit blood pressure results on your claims using CPT level II codes to lessen our requests for medical records and to support our quality reporting for Healthcare Effectiveness Data and Information Set (HEDIS®) and Medicare Star Ratings.

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
▲ Dental must read
‡ DME must read

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

Click on a title to read the article.

About *The Connection*

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

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

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

The Bulletin

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

Share your feedback

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

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Million Hearts

Million Hearts® is a national initiative to prevent one million heart attacks and strokes within five years. It focuses on implementing a small set of evidence-based priorities and targets that can improve anybody's cardiovascular health. Learn more about this initiative and find helpful resources on the Million Hearts website: **millionhearts.hhs.gov**. Check out the Hypertension Control Change Package from Million Hearts, which lists process improvements that outpatient clinical settings can implement as they seek optimal hypertension control: **https://bit.ly/2Net7xY**.

Live to the Beat

Explore and direct your patients to the Live to the Beat campaign, **livetothebeat.org**, which aims to reduce the risk of cardiovascular disease (CVD) among black adults ages 35 to 54. The campaign aims to inspire and build confidence to create behavior change by delivering a steady beat of healthy habits, tips and routines to help reduce the risk of heart attack and stroke.

Hypertension programs available to ASO groups

Livongo for Hypertension and Omada for Hypertension, buy-up options, available to our administrative services only (ASO) groups, provide tools, insights and expert support to help make managing blood pressure simple.

Other resources

To support patient education about hypertension, blood pressure monitoring and the lifestyle changes that can help patients live healthier lives, we recommend resources found in the Conditions section of the American Heart Association website, **heart.org**.

The following HealthWise flyers are available for you to print and share with your patients:

- *High Blood Pressure*
- *High Blood Pressure. ACE Inhibitors and ARBs*
- *High Blood Pressure: Adding DASH to Your Life*

These flyers are available on our provider website: Programs>Cost & Quality>Provider Quality Resource.

Submit provider appeals via Availity Essentials

We provided notification in our December 1, 2022, newsletter that effective March 1, 2023, we will require all post-service provider appeals to be submitted using the Appeals application on Availity Essentials.

The only disputes and appeals that should **not** be submitted via Availity Essentials are:

- Pricing disputes, which are not appeals and are subject to a separate pricing dispute process
- Disputes that meet our extenuating circumstances criteria, which must be submitted via fax
- Appeals that Availity cannot process because of file size limits, which may be submitted via our secure file transfer protocol

Provider must submit all other provider appeals via Availity's Appeals application. Provider appeals sent via an improper method will be returned to the provider with directions to submit using the Appeals application on Availity Essentials.

The Appeals application is a more efficient way of receiving appeals and communicating determinations to providers. The application:

- Streamlines the appeals process by making it easy to submit appeals directly from the Claim Status screen
- Gathers all required information about the claim being disputed
- Prevents duplicate appeals submission

The Appeals dashboard shows the status and history of submitted appeals, eliminating the need for providers to contact us for status information.

Learn more about the Appeals application and view our exception criteria on our provider website: Claims & Payment>Receiving Payment> Pricing Disputes and Appeals.

Accessing the Appeals application

The Appeals application is available on Availity Essentials: Claims & Payments>Appeals. If you do not have access to the Appeals application, please contact your Availity Essentials administrator and request the Claim Status role.

Get help or training

View guides on Availity Essentials: Help & Training>Find Help>Appeals. A recorded demonstration is also available by searching for Appeals: Help & Training>Get Trained.

Responding to documentation requests

When medical records or supporting documentation are needed for claims processing, we request them through Availity's Attachments application, fax, email or USPS. If you receive a request for medical records, 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 about claim attachments and view a *Getting Started Guide* on our provider website: Claims and Payment>Claims Submission> Claims Attachments. Find on-demand and live training options on Availity Essentials: Help & Training>Get Trained, then search for Attachments—New.

Partnering with USAble Life to support our dental networks

This spring, we will partner with USAble Life to support our dental networks with credentialing and contracting, reimbursement and provider data management.

USAble Life, **usablelife.com**, has a successful, multi-decade history providing support to more than 1.5 million dental members in the United States. Our strategic partnership with USAble Life will strengthen our dental networks and support dental providers.

As part of this partnership, we will launch a new dental-specific website, where you can access tools and resources, such as credentialing and contracting information, dental policies, forms, other resources and support staff contact information.

Note: Effective May 1, 2023, our dental correspondence address will change to P.O. Box 45132, Jacksonville, Florida, 32232-9902.

2022 newsletter and bulletin survey results

Thank you for completing our annual newsletter and bulletin survey.

Most respondents agree that our newsletter and bulletin are easy to read and navigate. In addition, most respondents indicate that the articles in our newsletter are useful to their practice.

Key survey findings

- ***The Bulletin* vs. *The Connection***: Respondents indicated that they are unclear about the difference between our publications.
  - ***The Bulletin***: This monthly publication includes updates to our medical and reimbursement policies.
  - ***The Connection***: The newsletter is a comprehensive review of news for providers and is published in February, April, June, August, October and December. It includes updates to our pre-authorization requirements; dental and medication policies; and other important changes that impact providers.
- **Newsletter table of contents**: Respondents use the key in the table of contents to quickly and easily identify articles for their specialty type (e.g., behavioral health, dental and durable medical equipment).
- **Newsletter most-read articles**: The topics identified as the most read include administrative and billing updates; information about Availity Essentials; medical and reimbursement policy updates, pre-authorization changes; and programs that impact providers.

Additional comments

If you have additional comments about our newsletter or bulletin, please email us at **provider_communications@asuris.com**.

Help members get care during COVID, flu and RSV season

COVID-19, flu and RSV are circulating in our communities. Emergency rooms (ERs) have been hit hard, and many are at or over capacity. Please help us alleviate the burden on hospital systems by educating your patients about the care options available to them.

Care options

Asuris members have alternatives to ERs that are often faster, more convenient and less expensive. Remind patients how they can contact you to receive care or advice about their care options, including:

- **Virtual care**: If you offer telehealth services, as many of our medical and behavioral health providers do, remind patients how they can schedule an appointment that will take place without them having to leave their home. Most of our members also have access to medical and behavioral health telehealth vendors that offer convenient appointment times.
- **Advice24 nurse triage**: Most members have access to immediate support through Advice24, for everyday health issues and questions that might otherwise lead to unnecessary urgent care or ER visits. Members can call the Advice24 nurse triage line, or in some cases send a chat message, to connect directly with a registered nurse in seconds. The registered nurse can help navigate the member to the most appropriate care setting, whether it is in-person, virtual or home care. Members may also receive follow-up calls, depending on the clinical need.
- **At-home care**: Asuris members have access to DispatchHealth for care that comes to them.
  - DispatchHealth can treat urinary tract infections; breaks, sprains and bruises; severe cold and flu symptoms; lacerations, abrasions and infections; chronic obstructive pulmonary disease and exacerbations; mild to moderate stomach pains, nausea, vomiting and dehydration; and more.
  - They are available in the greater Spokane area. View the DispatchHealth service area: **dispatchhealth.com/locations**.
  - Download an overview of DispatchHealth's services, learn how to refer patients and view answers to frequently asked questions at **dispatchhealth.com/partners/care-management-provider-group**.
- **Urgent care clinics**: Many urgent care clinics are conveniently located and are more accessible than ERs.

Help your patients know their options before they need care

- Encourage your patients to sign in to **asuris.com** and select Find Care to locate care options near them.

Remind your patients about the best ways to avoid getting sick

Encourage your patients to:

- Get vaccinated—COVID, flu and pneumonia vaccines are safe and effective
- Wash hands often
- Stay home if they're sick
- Avoid touching their face
- Wear a mask in public places
- Frequently disinfect touched objects and surfaces

We're here to help

Members can call the Customer Service number on the back of their member ID card for help understanding their care options.

COVID-19 updates

We will continue to update the COVID-19 section of our website to make sure you have the latest COVID-19-related information and helpful resources. In addition, we will include updates in future issues of this newsletter.

Note: When we learn that the Public Health Emergency is ending, we will provide as much notice as possible about any changes to members' benefits or provider reimbursement.

Annual HEDIS medical record collection

Our HEDIS medical record reviews for measurement year 2022 will begin this month, continuing through May. We have contracted with Inovalon to contact providers and collect data using a HIPAA-compliant process. We appreciate your help during this process and will work with your office to collect medical records by fax, mail or onsite visit (for larger clinics).

As a reminder, it is your responsibility as a participating Asuris provider to respond to these requests in a timely manner. Unless your provider agreement specifically states otherwise, you are required to provide us or Inovalon access to member records for these purposes free of charge. A signed release from your patient—our member—is not required for us to obtain these records. If you contract with a copy service, please remember that you are responsible for guaranteeing they deliver the charts on time, without cost to us or Inovalon.

You can learn more about this year's review on our provider website: Programs>Cost & Quality> Quality Program>HEDIS Reporting.

New enhanced cost estimator tool

We are committed to supporting price transparency and affordability in health care, as demonstrated through the many cost-savings programs available to members through our health plan. Some aspects of affordability and price transparency are mandated through federal legislation. We strive to provide members the best possible experience when navigating health care costs.

Beginning January 1, 2023, the Consolidated Appropriations Act of 2021 (CAA) and Transparency in Coverage Rule (TIC), **asuris.com/employer/resources/caa-tic-rule**, require health insurers (including self-funded plans) to offer a tool that enables members to obtain good-faith estimates of their out-of-pocket costs for 496 common shoppable items and services. The purpose is to allow members to shop and compare negotiated and historical claims-based treatment costs from multiple providers in their network, helping them make more informed decisions when accessing treatment.

We're updating our cost estimator tool on asuris.com to include the following required information with every estimate delivered:

- **Estimated cost-sharing liability**: The estimated amount for the covered item/service the member will be responsible for based on their plan coverage
- **Accumulator amounts**: The member's financial responsibility at the time of the request considering their deductible and out-of-pocket limit
- **Negotiated rates**: The cost for the covered item/service from any in-network provider
- **Out-of-network amounts**: The maximum amount paid for the item/service at an out-of-network provider
- **Bundled payments**: All bundled payment arrangements with included services and associated costs disclosed
- **Pre-authorization requirements**: Notification of whether the item/service is subject to pre-authorization for coverage
- **Disclosure notices**: Notification to member of any specific disclosures (e.g., actual charges may vary; estimate is not a guarantee of coverage)

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.**

Administrative Manual updates

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

Facility Guidelines

- Updated links
- Clarified site of service information
- Updated the hospice and home health revenue and procedure code lists

Introduction

- Updated Responsibilities of Participation section

Medical Management

- Removed home sleep testing from services covered under our Sleep Medicine program

Provider and Facility Resources

- Added information about fragmented/split professional billing

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

DME code to be added to NRS list

Effective May 1, 2023, we will add HCPCS E0936 to our non-reimbursable services (NRS) list for commercial claims. This durable medical equipment (DME) code will be added to the *Clinical Edits by Code List* on the Coding Toolkit section of our provider website.

This change is supported by our *Non-Reimbursable Services* (Administrative #107) reimbursement policy.

Understanding the Coding Advisor program

Our Coding Advisor program with Change Healthcare identifies billing outliers by comparing claims activity among provider specialties.

Providers billing high-level codes significantly more often than peers may receive a report from Change Healthcare outlining the typical distribution of these claims and how their pattern differs. These reports are educational and are not a substitute for the independent medical judgment of health care providers. They are an opportunity for providers to ensure patients' medical records support the services provided and that their staff understands and follows the applicable documentation and reporting guidelines.

Asuris and Change Healthcare acknowledge that providers' treatment decisions are based on clinical judgment and the patients' needs.

Change Healthcare will continue to engage with identified providers by sending updated reports. If subsequent analysis reveals the proportion of reported high-level codes continues to exceed the typical distribution, they may contact providers to request further validation and to offer education from their mastery-level professional coders.

Pre-authorization updates

Commercial

Procedure/medical policy	Added codes effective January 1, 2023
Administrative Guidelines to Determine Dental vs Medical Services (Allied Health #35)	21245, 21246, 21248, 21249
Digital Therapeutic Products for Attention Deficit Hyperactivity Disorder (Medicine #175.01)	98978
Evaluating the Utility of Genetic Panels (Genetic Testing #64)	81441, 81451, 81456
Expanded Molecular Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	81449, 81456
Extracranial Carotid Angioplasty and Stenting (Surgery #93)	C7532
Genetic and Molecular Diagnostics–Single Gene or Variant Testing (Genetic Testing #20)	81441
Genetic Testing for Myeloid Neoplasms and Leukemia (Genetic Testing #59)	81451, 81456
Sacroiliac Joint Fusion	0775T
Transcutaneous Bone-Conduction and Bone-Anchored Hearing Aids (Surgery #121)	69729, 69730
Ventral (Including Incisional) Hernia Repair (Surgery #12.03)	49591, 49593, 49595, 49613, 49615, 49617, 49621
Procedure/medical policy	**Added codes effective February 1, 2023**
Circulating Tumor DNA and Circulating Tumor Cells for Management (Liquid Biopsy) of Solid Tumor Cancers (Laboratory #46)	0239U, 0326U
Procedure/medical policy	**Added codes effective April 1, 2023**
Biofeedback (Allied Health #32)	90875, 90876, 90901, 90912, 90913
Neurofeedback (Medicine #65)	90875, 90876, 90901

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Commercial (continued)

Procedure/medical policy	Added codes effective May 1, 2023
Joint management site-of-service	20520, 20525, 20670, 20680, 20693, 20694, 23000, 23020, 23120, 23130, 23410, 23412, 23415, 23420, 23430, 23440, 23450, 23455, 23460, 23462, 23465, 23466, 23515, 23550, 23615, 23630, 23655, 23665, 24105, 24305, 24340-24343, 24345, 24346, 24357-24359, 24505, 24516, 24530, 24538, 24545, 24546, 24575, 24579, 24586, 24605, 24620, 24635, 24655, 24665, 24666, 24685, 25000, 25107, 25111, 25112, 25118, 25210, 25215, 25240, 25260, 25270, 25280, 25290, 25295, 25310, 25320, 25360, 25390, 25447, 25505, 25515, 25545, 25565, 25574, 25575, 25600, 25605-25609, 25628, 25645, 25652, 25825, 26011, 26020, 26055, 26080, 26121, 26123, 26145, 26160, 26236, 26320, 26340, 26350, 26356, 26370, 26410, 26418, 26426, 26440, 26445, 26480, 26516, 26520, 26525, 26540, 26541, 26608, 26615, 26650, 26665, 26676, 26725, 26727, 26735, 26746, 26756, 26765, 26785, 26850, 26860, 26951, 26952, 27130, 27332-27335, 27403, 27412, 27415, 27416, 27418, 27420, 27422, 27424, 27425, 27427-27430, 27438, 27440-27443, 27446, 27447, 27605, 27606, 27612, 27620, 27625, 27626, 27650, 27652, 27654, 27659, 27675, 27676, 27680, 27685, 27687, 27690, 27691, 27695, 27696, 27698, 27705, 27752, 27762, 27766, 27769, 27781, 27784, 27786, 27788, 27792, 27810, 27814, 27818, 27822, 27823, 27840, 28002, 28005, 28008, 28010, 28022, 28035, 28060, 28062, 28080, 28086, 28090, 28092, 28110, 28112, 28113, 28116, 28118, 28119, 28120, 28122, 28124, 28160, 28190, 28192, 28200, 28208, 28230, 28232, 28234, 28238, 28250, 28270, 28272, 28285, 28288, 28289, 28291, 28292, 28295-28300, 28304, 28306, 28308, 28310, 28313, 28315, 28322, 28415, 28445, 28465, 28475, 28476, 28485, 28505, 28515, 28525, 28555, 28585, 28615, 28645, 28715, 28725, 28740, 28750, 28755, 28810, 28820, 28825, 29805-29807, 29819-29828, 29834, 29837, 29838, 29844, 29846, 29848, 29860-29863, 29866, 29867, 29870, 29871, 29873-29877, 29879-29889, 29891-29895, 29897, 29898, 29914-29916

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Medicare Advantage

Procedure/medical policy	Added codes effective January 1, 2023
Dental Services (Allied Health #35)	21245, 21246, 21248, 21249
Genetic and Molecular Diagnostics–Next Generation Sequencing and Genetic Panel Testing (Genetic Testing #64)	0356U, 0362U, 81418, 81441, 81449, 81451, 81456
Genetic and Molecular Diagnostics–Single Gene or Variant Testing (Genetic Testing #20)	0355U
Sacroiliac Joint Fusion (Surgery #193)	0775T
Procedure/medical policy	**Added codes effective May 1, 2023**
Joint management site-of-service	20520, 20525, 20670, 20680, 20693, 20694, 23000, 23020, 23120, 23130, 23410, 23412, 23415, 23420, 23430, 23440, 23450, 23455, 23460, 23462, 23465, 23466, 23515, 23550, 23615, 23630, 23655, 23665, 24105, 24305, 24340-24343, 24345-24357, 24358, 24359, 24505, 24516, 24530, 24538, 24545, 24546, 24575, 24579, 24586, 24605, 24620, 24635, 24655, 24665, 24666, 24685, 25000, 25107, 25111, 25112, 25118, 25210, 25215, 25240, 25260, 25270, 25280, 25290, 25295, 25310, 25320, 25360, 25390, 25447, 25505, 25515, 25545, 25565, 25574, 25575, 25600, 25605-25609, 25628, 25645, 25652, 25825, 26011, 26020, 26055, 26080, 26121, 26123, 26145, 26160, 26236, 26320, 26340, 26350, 26356, 26370, 26410, 26418, 26426, 26440, 26445, 26480, 26516, 26520, 26525, 26540, 26541, 26608, 26615, 26650, 26665, 26676, 26725, 26727, 26735, 26746, 26756, 26765, 26785, 26850, 26860, 26951, 26952, 27130, 27332-27335, 27403, 27412, 27415, 27416, 27418, 27420, 27422, 27424, 27425, 27427-27430, 27438, 27440-27443, 27446, 27447, 27605, 27606, 27612, 27620, 27625, 27626, 27650, 27652, 27654, 27659, 27675, 27676, 27680, 27685, 27687, 27690, 27691, 27695, 27696, 27698, 27705, 27752, 27762, 27766, 27769, 27781, 27784, 27786, 27788, 27792, 27810, 27814, 27818, 27822, 27823, 27840, 28002, 28005, 28008, 28010, 28022, 28035, 28060, 28062, 28080, 28086, 28090, 28092, 28110, 28112, 28113, 28116, 28118-28120, 28122, 28124, 28160, 28190, 28192, 28200, 28208, 28230, 28232, 28234, 28238, 28250, 28270, 28272, 28285, 28288, 28289, 28291, 28292, 28295-28300, 28304, 28306, 28308, 28310, 28313, 28315, 28322, 28415, 28445, 28465, 28475, 28476, 28485, 28505, 28515, 28525, 28555, 28585, 28615, 28645, 28715, 28725, 28740, 28750, 28755, 28810, 28820, 28825, 29805, 29806, 29807, 29819-29828, 29834, 29837, 29838, 29844, 29846, 29848, 29860-29863, 29866, 29867, 29870, 29871, 29873-29877, 29879-29889, 29891-29895, 29897, 29898, 29914-29916

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.

Joint surgeries to be reviewed for site of surgery

For joint surgeries performed in the outpatient hospital setting on or after May 1, 2023, eviCore healthcare (eviCore) will review for the site of service. Joint surgeries should be performed in ambulatory surgical centers (ASCs) unless an outpatient hospital setting is medically necessary.

eviCore may review the site of service for surgeries on both small and large joints.

These site of service reviews are an extension of our Physical Medicine program and include new codes that do not require pre-authorization for the service. Use Availity's Electronic Authorization application to check whether a member's services are subject to the Physical Medicine program's pre-authorization requirements.

Our complete pre-authorization lists are available in the Pre-authorization section of our provider website. View program information on our provider website: Programs>Medical Management>Physical Medicine.

Related: See *Pre-authorization updates* on pages 10 and 11.

Home health requirement liberalized

In December 2022, we extended the period in which home health does not require pre-authorization for Medicare Advantage members. Pre-authorization is now required on day 61. Providers should submit pre-authorization requests on day 55 to 58 to ensure uninterrupted services.

Change for some radiology requests delayed

In the December 2022 issue of this newsletter, we announced that AIM Specialty Health (AIM) would begin requesting additional clinical information for select radiology pre-authorization requests for commercial members. This change has been delayed. Look for additional information in upcoming issues of this newsletter.

AIM changing its name to Carelon

AIM is changing its name to Carelon Specialty Health (Carelon) effective March 1, 2023. AIM joined the Carelon family of companies in 2022.

Clinical Practice Guideline update

We revised the Preventive Services Guideline for Children and Adolescents Clinical Practice Guideline, effective December 1, 2022, to update the immunization recommendations to 2022.

Clinical Practice Guidelines are systematically developed statements on medical and behavioral health practices that help physicians and other health care professionals make decisions about appropriate health care for specific conditions. View the guidelines on our provider website:Library>Policies & Guidelines> Clinical Practice Guidelines.

The Bulletin recap

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

Medical policy updates

We provided 90-day notice in the December 2022 issue of *The Bulletin* about changes to the *Electrical Bone Growth Stimulators (Osteogenic Stimulation)* (Durable Medical Equipment #83.11) medical policy, which are effective March 1, 2023.

We provided 90-day notice in the January 2023 issue of The Bulletin about the following medical policies, which are effective April 1, 2023:

- *Biofeedback* (Allied Health #32)
- *Neurofeedback* (Medicine #65)

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 December 2022 issue of *The Bulletin* about changes to the *Inpatient Medications Reimbursed Under Medical Coverage* (Facility #116) reimbursement policy, which are effective March 1, 2023.

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.

Virtual care policy changes

In the January 1, 2023, issue of *The Bulletin*, we announced updates to our commercial *Virtual Care* (Administrative #132) reimbursement policy and a new Medicare Advantage *Virtual Care* (Administrative #132) reimbursement policy. The policies include the following information:

Modifiers GT and 93 reflect the technology used

- **Modifier GT**: Telehealth performed using audio and video technology
- **Modifier 93**: Telehealth performed using audio technology only

Additional changes to commercial policy

- **Permanent expansion of services**: Added 60 services, including home visits, behavioral health counseling and therapy, nutritional counseling and more
- **Remote monitoring**: Added as non-reimbursable, including remote physiology and remote therapeutic monitoring
- **Established patient guidelines**: Updated established patient guidelines to require that in-person or real-time interactive visits use both audio and video with the performing provider, a provider employed at the same medical group as the performing provider or with the referring provider within the past three years for behavioral health or past two years for all other services

Additional details about Medicare Advantage policy

Medicare Advantage previously followed our commercial *Virtual Care* reimbursement policy. This new policy lists reimbursable and non-reimbursable services, as well as guidelines for established patients. The Medicare Advantage policy allows shorter timeframes in which a provider last saw a patient in real time (in person or in an interactive telehealth visit using audio and video).

The Bulletin is available on our provider website: Library>Bulletins.

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 January 15, 2023	Description
New medication policies	
Hemgenix, etranacogene dezaparvovec, dru735	- The use of Hemgenix in the treatment of hemophilia B is considered not medically necessary and, therefore, not covered because of low certainty that it improves clinically relevant outcomes compared to alternate treatments for hemophilia B, including prophylactic exogenous FIX
Medications for Amyotrophic Lateral Sclerosis (ALS), dru734	- New combination policy replaced individual policy for Radicava (dru510) and added new FDA-approved self-administered medication Relyvrio (sodium phenylbutyrate and taurursodiol)
Medications for transthyretin-mediated amyloidosis, dru733	- New combination policy replaced individual policies for Onpattro (patisiran) (dru577), Tegsedi (inotersen) (dru579) and Vyndamax/Vyndaqel (tafamidis) (dru595) and added new FDA-approved provider-administered medication Amvuttra (vutrisiran) - Removed requirement for "no prior liver transplant" for Onpattro (patisiran) and Amvuttra (vutrisiran) based on expert feedback and phase 3b trial results
Revised medication policies	
Adcetris, brentuximab vedotin, dru264	- Updated classical Hodgkin lymphoma (cHL) criteria to allow coverage in first-line setting when used with chemotherapy for stage 3 and stage 4 disease
Blincyto, blinatumomab, dru388	- Updated criteria for acute lymphoblastic leukemia (ALL) to reflect revised FDA-approved indication; covered only for CD19-positive ALL - Removed requirement that Blincyto (blinatumomab) be used as monotherapy

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Effective January 15, 2023	Description
Revised medication policies (continued)	
Botulinum toxin type A injection, dru006	- Based on pre-authorization feedback, added coverage criteria for refractory post-herpetic neuralgia requiring step therapy through other treatment options: pregabalin/gabapentin and a tricyclic antidepressant (TCA) or a serotonin and norepinephrine reuptake inhibitor (SNRI) - For urinary incontinence caused by detrusor overactivity (such as overactive bladder [OAB]), added Myrbetriq to list of acceptable step therapies - For Hirschsprung disease, clarified criteria to cover Botox for severe refractory constipation caused by increased anal sphincter tone or withholding; the step therapy requirement with a bowel regimen for constipation remains
Enhertu, fam-trastuzumab deruxtecan, dru623	- Added coverage criteria for patients with advanced HER2-low breast cancer in the second- or subsequent-line treatment setting, a new FDA-approved indication - Added coverage criteria for patients with advanced non-small cell lung cancer (NSCLC) with an activating HER2 (ERBB2) mutation as defined at **oncokb.org**, a new FDA-approved indication. Use in HER2 mutations not considered "oncogenic or likely oncogenic" as defined at **oncokb.org** will be considered investigational
Enzyme Replacement Therapies, dru426	- Added new FDA-approved Xenpozyme (olipudase alfa) to policy, limiting coverage to patients diagnosed with acid sphingomyelinase deficiency (ASMD), confirmed by positive SMPD1 gene mutation or deficiency in the ASM enzyme, when prescribed by or in consultation with a specialist for patients who have documented evidence of non-central nervous system manifestations of ASMD
Evrysdi, Risdiplam, dru647	- Removed limitation on use in individuals younger than two months because the FDA has approved use in this population
Imfinzi, durvalumab, dru500	- Added coverage criteria for new FDA-approved indication, limiting coverage to the first-line setting for locally advanced or metastatic biliary tract cancer (BTC) when given in combination with gemcitabine plus cisplatin and when the patient has not had prior PD-1/PD-L1-blocking antibody therapy
Myobloc, rimabotulinumtoxinB, dru048	- For urinary incontinence caused by detrusor overactivity (such as OAB), added Myrbetriq (mirabegron) as an acceptable step
Opdivo, nivolumab, dru390	- Added coverage criteria in the neoadjuvant NSCLC setting, a new FDA-approved indication - Limited coverage to patients: • Whose tumor is greater than four cm • When node positive • When there has been no prior systemic anti-cancer therapy • And when Opdivo (nivolumab) is administered in combination with platinum doublet chemotherapy - **Note:** The requirement for no prior therapy is more restrictive than the label but is supported as part of trial design

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Effective January 15, 2023	Description
Revised medication policies (continued)	
Padcev, enfortumab vedotin, dru622	- Updated criteria to allow coverage for second-line use (after PD-1/PD-L1 inh) in cases where the patient is not eligible for platinum-based chemotherapy based on updated FDA-approved indication
Products with Therapeutically Equivalent Biosimilars/Reference Products, dru620	- Added new FDA-approved Vegzelma (bevacizumab-adcd) to policy as non-preferred - Added new FDA-approved Rolvedon (eflapegrastim-xnst) to policy as non-preferred - Moved pegfilgrastim products from dru563 to this policy - Updated step therapy requirements for Neulasta OnPro to bypass preferred product requirements if medical need requirements are met
Site of Care Review, dru408	- Removed the following medications from the policy because of lack of availability with home infusion provider: Crysvita (burosumab-twza), Elelyso (taliglucerase alfa), Naglazyme (galsulfase), Onpattro (patisiran), Revcovi (elapegademase-lvlr) and Vimizim (elosulfase alfa)
Spravato, esketamine, dru605	- Updated continuation of therapy criteria to include psychiatric mental health (PMH) provider requirement - Expanded prescriber requirement criterion to include PMH nurse practitioner (NP) - Reworded PMH provider assessment (attestation)
Tecentriq, atezolizumab, dru463	- Clarified wording for operational consistency (PD-L1 expression; provider attestation for Child-Pugh score, quantity limit table) - Clarified adjuvant non-small cell lung cancer (NSCLC) criteria to be clear that Tecentriq (atezolizumab) is not covered after neoadjuvant PD1/PDL1 given the recent approval of Opdivo (nivolumab) for neoadjuvant NSCLC use
Effective January 19, 2023	**Description**
Revised medication policies	
Drugs for chronic inflammatory diseases, dru444	- Added Sotyktu (deucravacitinib) to policy for plaque psoriasis (PsO) as a level 3 self-administered option - Added Spevigo (spesolimab) to policy for generalized pustular psoriasis (GPP) as a provider-administered option - Added Rinvoq (upadacitinib) as a level 2 self-administered treatment option for non-radiographic axial spondyloarthritis, a new FDA-approved indication - Updated quantity limit to include new 180 mg maintenance dose for Crohn's disease

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Effective March 1, 2023	Description
New medication policies	
Gonadotropin-releasing hormone (GnRH) receptor antagonist-containing products, dru729	- New combination policy replaces individual policies for Oriahnn/Myfembree (dru655) and Orilissa (dru580) - Adding coverage criteria for Myfembree (relugolix/estradiol/norethindrone acetate) for new FDA-approved indication for moderate to severe pain associated with endometriosis
High-Cost Topical Medications, dru723	- New policy for new FDA-approved Vtama (tapinarof) and Zoryve (roflumilast) limits coverage to patients with plaque psoriasis when lower-cost standard of care topicals are not a treatment option
Revised medication policies	
Alpha-1 proteinase inhibitors, dru382	- Clarifying diagnostic criteria to exclude coverage for patients with MZ genotype in line with guidelines
Dupixent, dupilumab, dru493	- Adding coverage criteria for prurigo nodularis, a new FDA-approved indication • Limiting coverage to patients with moderate to severe prurigo nodularis when standard of care treatments such as topical steroids, phototherapy and systemic oral medications are not a treatment option • The step therapy requirement is more restrictive than the label but is supported by guidelines
Fibroblast growth factor receptor (FGFR) inhibitors, dru695	• Adding coverage for myeloid/lymphoid neoplasms (MLNs) for Pemazyre (pemigatinib) based on new indication. Truseltiq (infigratinib) was not approved/studied in this condition, so its coverage will not be expanded to this use • Limiting coverage to patients with an MLN with FGFR1 rearrangement that relapsed or was refractory to prior therapy and there was no prior tyrosine kinase inhibitor (TKI) therapy directed against FGFR1 (including pemigatinib); the requirement for no prior TKI is more restrictive than the label but in line with trial design
High-Cost Antidepressant Medications, dru352	- Adding new FDA-approved Auvelity (dextromethorphan HBr and bupropion HCl)
High-cost ophthalmic prostaglandin analogues and prostaglandin agonists, dru476	- Adding new FDA-approved Omlonti (omidenepag isopropyl)
Libtayo, cemiplimab-rwlc, dru565	- Adding recurrent cervical cancer to policy as not medically necessary because the manufacturer has withdrawn the Biologic License Application (BLA) for this indication
Monoclonal antibodies for asthma and other immune conditions, dru538	- Updating chronic idiopathic/spontaneous urticaria (CIU/CSU) reauthorization and quantity limit for patients with a partial response to Xolair (omalizumab) but persistent symptoms - Adding chronic eosinophilic pneumonia (CEP) and hypereosinophilic syndrome (HES) to the list of investigational uses - Clarifying uses that are not medically necessary to include allergic rhinitis for all monoclonal antibody therapies in this policy

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Effective March 1, 2023	Description
Revised medication policies (continued)	
Non-preferred multiple sclerosis treatments, dru511	- Adding new FDA-approved fingolimod ODT (Tascenso) to policy as non-preferred - Updating coverage criteria for brand Gilenya to require trial of generic fingolimod
Ofev, nintedanib, dru369	- Adding requirement for step therapy through generic pirfenidone prior to coverage of brand Esbriet (pirfenidone) or Ofev (nintedanib)
Pirfenidone (generic, Esbriet), dru368	- Adding requirement for step therapy through generic pirfenidone prior to coverage of brand Esbriet (pirfenidone) or Ofev (nintedanib)
Rearranged during transection (RET) Inhibitors, dru726	- The use of Retevmo in RET fusion-positive solid tumors other than metastatic non-small cell lung cancer (NSCLC), medullary thyroid cancer (MTC) and thyroid cancer will be considered investigational and therefore not covered • Data in this setting is limited to case series with representation of only one to two patients for most tumor types • Additionally, objective response rate (ORR), the surrogate endpoint evaluated in the trial, has not been validated to correlate with any clinically relevant endpoint
Xifaxan, rifaximin, dru410	- Removing irritable bowel syndrome with diarrhea (IBS-D) and small intestinal bacterial overgrowth (SIBO) from continuation of therapy eligibility because indications are acute; full policy criteria must be met for coverage
Archived policies	
Lyrica CR, pregabalin extended-release, dru532	- Lyrica CR will no longer require pre-authorization
Marqibo, vincristine sulfate liposome injection, dru278	- Marqibo will no longer require pre-authorization
Nuplazid, pimavanserin, dru459	- Nuplazid will no longer require 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.

Articles in this issue with behavioral health content	Page
2022 newsletter and bulletin survey results	4
Understanding the Coding Advisor Program	8
Virtual care policy changes	13
Incident-to billing allowed for behavioral health services	20

Additionally, the follwing 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

Behavioral health corner

Incident-to billing allowed for behavioral health services

We published new *Incident to Services* (Administrative #148) commercial and Medicare Advantage reimbursement policies on January 1, 2023, that allow access to additional behavioral health providers. The new provider types allowed to render incident-to services provide additional capacity to meet our members' needs. Incident-to services must fall within the scope of practice as authorized under state law.

Because of the line of business differences, the commercial and Medicare Advantage policies differ in important ways. For example, commercial will now allow "associate providers" to render services via incident-to billing criteria. In contrast, Medicare Advantage will permit licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs) to render services via incident-to billing.

Requirements for our commercial policy

Supervising providers

- Services are part of the member's normal course of treatment.
- The supervising physician or other eligible health care practitioner must:
  - Monitor the course of treatment and be available by telephone or telehealth for consultation as needed
  - Be in the same provider group as the associate provider
  - Review documentation of the patient's overall treatment
  - Document meetings with the associate provider to supervise or monitor care

Associate providers

- Must be licensed master's social workers (LMSWs) or
- Must be registered with their appropriate state licensure board and on a formal track/program for licensure:
  - Master's-prepared behavioral health clinicians
  - Doctorate-prepared behavioral health clinicians
- Cannot supervise another associate or perform services independently in their own practice

An associate's qualifications should align with the provider under which the service will be submitted. For example, an LMSW cannot bill under a doctorate level-credentialed provider, but a doctorate prepared associate may bill under a doctorate-level credentialed provider.

Billing requirements

- Bill incident-to services with the modifier SA.
- Submit claims under the physician's or other eligible health care provider's name and identification.

Requirements for our Medicare Advantage policy

Our Medicare Advantage reimbursement policy follows CMS guidelines for incident-to billing, which have been updated to allow for LPCs and LMFTs to render services when policy criteria are met. The general supervision requirements state that the services are part of the member's normal course of treatment.

Billing requirements

- Bill incident-to services with the modifier SA.
- Submit claims under the physician's or other eligible health care provider's name and identification.

Read the policies

The *Incident to Services* (Administrative #148) reimbursement policies were announced in the January 1, 2023, issue of *The Bulletin*, available on our provider website: What's New & Publications> Bulletins. View the policies in our *Reimbursement Policy Manual* on our provider website: Policies & Guidelines>Reimbursement Policy.

Resources available for treatment of low back pain

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

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

The measure looks at the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. Asuris scored in the 75th percentile for this measure when compared to similar plans nationally.

Care support flyers

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

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

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

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

Quality toolkit available to help improve member experience

Improving the member experience scores in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)/Health Outcomes Survey (HOS) surveys is challenging.

CAHPS/HOS scores account for more than a quarter of a health plan's overall CMS Medicare Advantage Star Ratings. When these ratings improve, it's an indicator that Asuris members are having meaningful conversations with their providers and receiving helpful information during their provider visits to lead healthier lives.

We've created a new Quality Improvement Toolkit with information about member benefits, resources and best practices for having conversations with your patients about these topics:

- Cancer screening
- Care coordination
- Chlamydia screening
- Fall risk coaching
- Getting care quickly
- Hypertension
- Incontinence management
- Influenza immunization
- Medications, including information about reviewing a patient's medications
- Monitoring physical activity
- Overall health rating
- Pneumonia immunization
- Tobacco cessation
- Well-child visits

View the toolkit on our provider website: Programs>Cost & Quality>Provider Quality Resources.

Monitoring physical activity and improving quality

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

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 reducing fall risk.
- 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.
- Social support from family and friends has been consistently and positively related to sustaining regular physical activity. Consider ways to encourage social support.
- 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.

Flyers are available to help you facilitate conversations that address topics such as fitness and physical activity. They're 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. The following flyers are available in our new Quality Improvement Toolkit in both English and Spanish:

- *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*

Access the toolkit on our provider website: Programs>Cost & Quality>Provider Quality Resources.

You can also view member tools and resources on the Healthwise Knowledgebase for this and other health topics on our provider website: Programs> Member Programs and Tools.

Medicare Advantage QIP reminders

2022 Medicare Advantage Quality Incentive Program (MA QIP)

December 31, 2022, was the last day to provide services or screenings to close gaps for the 2022 program. You may continue to submit gap closure information for the 2022 MA QIP according to the following deadlines:

- February 28, 2023—Last day to submit supplemental data
- February 28, 2023—Last day to work in the Care Gap Management Application (CGMA)
- March 31, 2023—Last day to submit medical or pharmacy claims

The CGMA will display 2022 data through February 2023 to allow you to submit your final 2022 documentation.

2023 MA QIP

Jumpstart your 2023 MA QIP performance. Start scheduling members for their preventive care visits (PCV) or annual wellness visits (AWV) today.

We recommend that you **see every member every year** for their PCV/AWV and use this visit as an opportunity to assess your patient's chronic conditions and address all of their preventive care needs. Please email **QIPQuestions@asuris.com** if you'd like to talk about work-flow suggestions for how to use a nurse-led model to schedule and complete Medicare AWVs for all your patients.

PCV/AWV tips

- AWVs are reimbursable on the same day as acute care visits (except for visits at rural health centers and federally qualified health centers). Ensure that your documentation represents that both visits took place.
- AWV and PCV will be reimbursed separately when billed on the same date of service. Ensure that your documentation represents that both visits took place.
- We will reimburse for AWVs and PCVs billed once per calendar year. There is no requirement to wait 11 months between visits.

Flu vaccines

Encouraging patients to get their annual flu vaccination is a year-round project.

- **If you are seeing a patient before March 31, 2023**:
  - Record that your patient had a flu shot in 2022 and still receive credit for 2022 gap closure in the MA QIP.
  - It is also acceptable to bill HCPCS G8482 by itself on a $0.00 claim after receiving verbal confirmation that a member received their flu vaccine from another provider and documenting this in the medical record.
- **No matter when you see your patients throughout the year**:
  - Talk to your patient about the importance of having a flu shot this year.
  - Remind your patient that you want to know if they got their shot from another provider.
  - Ask your patient to call the office and report when and where they receive their immunizations.
  - If you give vaccinations in your office, schedule your member to come back in the fall to receive their vaccination.

MOON required for Medicare members

All hospitals and critical access hospitals (CAHs) are required to provide written notification and an oral explanation to Medicare beneficiaries receiving outpatient observation services for more than 24 hours using the *Medicare Outpatient Observation Notice (MOON)*, form CMS-10611.

You can find the notice and accompanying instructions at: **cms.gov/Medicare/Medicare-General-Information/BNI/MOON**. A link to this form is also available on our provider website: Library>Forms.

The MOON is designed to inform Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility (SNF) services. Hospitals and CAHs must deliver the notice to the health plan within 36 hours of the start of observation services or sooner if the individual is transferred, discharged or admitted.

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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