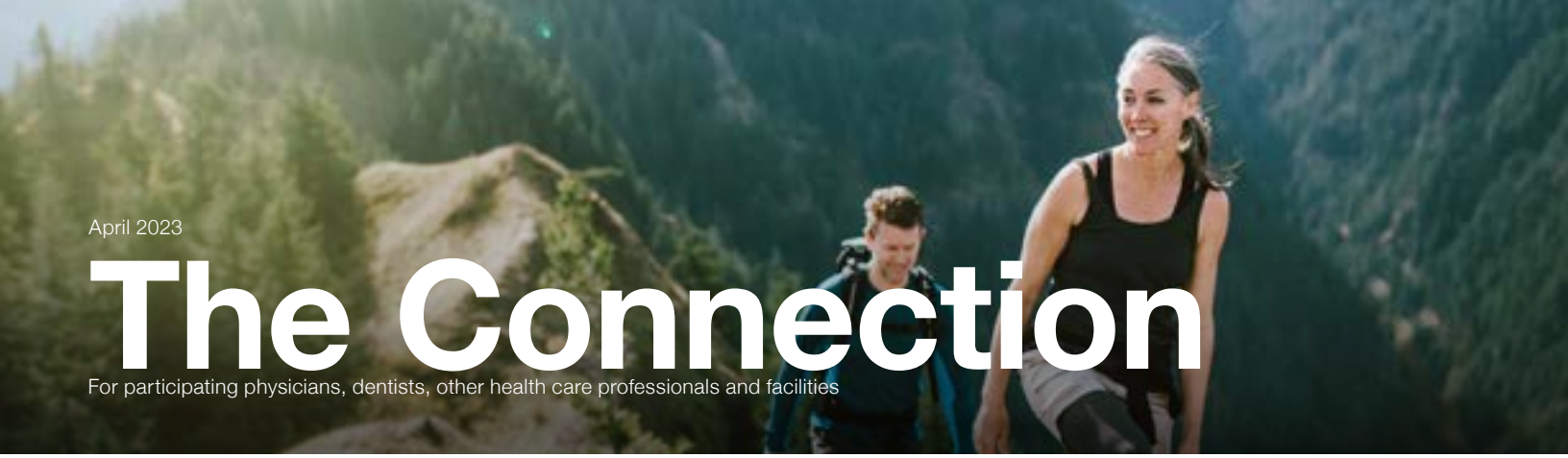

April 2023

The Connection

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

National Healthcare Decisions Day

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

We encourage you to begin or continue advance care planning (ACP) conversations with all your patients as part of the preventive and treatment services you provide.

We reimburse providers who bill for ACP conversations with members, regardless of age or health status.

ACP conversations may include:

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

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

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

Continued on page 3

Easily find information

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

Subscribe today

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

Using our website

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

Stay up to date

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

ASURIS NORTHWEST HEALTH

Asuris Northwest Health

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

Contents

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

Click on a title to read the article.

About *The Connection*

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

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

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

The Bulletin

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

Share your feedback

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

Continued from page 1

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

- Having an ACP conversation with at least 30% of your Asuris Medicare Advantage-attributed patients and submitting a claim with CPT 99497 or CPTII 1123F, 1124F or 1158F. For 2023, we have also added these two new codes to close the ACP gap:
  - **CPT 99483**: Assessment of and care planning for patients with cognitive impairment like dementia, including Alzheimer's disease, at any stage of impairment.
  - **HCPCS S0257**: Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
  - **Note**: To support gap closure for this measure, we will continue to allow you to report CPT II codes with visits where your patient's wishes may only require a review and not a full conversation that justifies reporting CPT 99497.
- Referring Medicare Advantage patients to specialty palliative care providers, who then submit a claim for a palliative care consult/encounter (ICD Z51.5)

Serious Illness Messaging Toolkit

Terms like hospice, palliative care and advance care planning can be confusing to patients. The Serious Illness Messaging Toolkit includes tips for how to talk about serious illness using evidence-based research. The toolkit is available at **seriousillnessmessaging.org/using-the-toolkit**.

Other resources

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

Administrative Manual updates

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

Alternative Care

- Updated treatment plans section

Medical Management

- Updated company name for Carelon Medical Benefits Management (Carelon, formerly AIM Specialty Health)
- Added site of service requirements for joint surgeries
  - **Related**: See *Joint surgery pre-authorization changes delayed one month* on page 11.

Therapy Guidelines

- Updated treatment plans section

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

Check your email for agreement documents

To ensure that agreement documents comply with current regulatory requirements, we are replacing Individual provider agreements and *Medical Group Agreements* (MGAs) with a new, standardized *Professional Services Agreement* (PSA).

Notes:

- Network participation remains the same.
- All providers must be credentialed before they can join our network(s).
- All eligible providers under the PSA must participate in the same networks.

View frequently asked questions about our recontracting efforts on our provider website: Contacting & Credentialing>Contracting.

What you need to know about the end of the public health emergency

Editor's note (updated April 20, 2023): Clarification on Paxlovid coverage tiers added.

On January 30, 2023, the Biden administration announced the intent to end the federal public health emergency (PHE) at 11:59 p.m. on May 11, 2023. Included below are the member benefit and provider reimbursement changes that will occur for dates of service on and after May 12, 2023, for commercial and Medicare Advantage members.

Benefits that will roll back to non-PHE status

- COVID-19 testing performed in the provider's office and treatment will be covered at regular plan cost shares for in- and out-of-network services.
- Out-of-network COVID-19 testing claims will be priced at allowed amounts rather than a negotiated or cash price. For commercial members, balance billing may apply depending on the service.
- We will return to our standard credentialing process for locum tenens and expedited credentialing.
- We will no longer cover costs for personal protective equipment.
- We will no longer cover over-the-counter (OTC) tests. Medicare Advantage members on certain plans have OTC benefits that allow for purchasing test kits.
- Vaccine counseling will be subject to regular plan benefits.

Medicare Advantage member benefits

During the PHE, we temporarily expanded benefit coverage to make it easier for members to access the care they needed during the pandemic. Many other Medicare Advantage plans ended some of these provisions several months ago, but we've kept them in place as long as the federal government allowed.

For Medicare Advantage members, out-of-network services, including medical and dental, will be covered as out-of-network. If a member has out-of-network dental services, they will be subject to balance billing by the provider for any amount that we don't cover.

Benefits that will be updated based on federal guidance

- COVID-19 vaccines will be covered as preventive care and may apply cost share based on plan benefits.
  - **Note**: Providers must submit claims for the vaccine using the appropriate codes.
- For commercial members, Paxlovid will be covered on the non-preferred brand tier. For Medicare Advantage members, Paxlovid will be covered as a Tier 3 preferred drug.
- Telehealth:
  - We will continue to cover expanded telehealth services through December 31, 2024.
  - Some of the temporary telehealth services allowed during the PHE have been added to our *Virtual Care* (Administrative #132) commercial and Medicare Advantage reimbursement policies to permanently expand telehealth coverage to include such services as home visits, behavioral health counseling and therapy, nutritional counseling and more.
  - View our *Virtual Care* (Administrative #132) reimbursement policies: Library>Policies & Guidelines>Reimbursement Policy Manual.

Self-funded customizations

Administrative services only (ASO) groups may have an option to adjust their benefits in light of these changes.

Other PHE updates

We are still evaluating how the end of the federal PHE will impact other benefits and provisions, such as expanded timeframes for claim submission, appeals, special enrollment and premium grace periods.

Important updates for dental providers

Strengthening our dental networks

Over the past few months, we have shared news about our dental partnership with USAble Life. We're excited to announce the transition will begin in June.

This partnership brings a wealth of resources to dental providers, including:

- Dental-focused claims and customer service
- Dedicated provider management teams for credentialing and contracting
- Dental-specific resources, including an *Administrative Manual*

A new website for dental providers

The dental resources hosted on our provider website will be available on our new dental website, asurisdental.com. On this website, you'll be able to access credentialing and contracting information, dental policies, forms, reimbursement schedules and other resources. When the new site is launched, we will remove existing dental content from **asuris.com** and redirect users to those pages.

Note: Providers should continue to use Availity Essentials to access member eligibility, benefits, reimbursement schedules and claims-related information.

Change of address for dental correspondence

Our dental correspondence change of address will now be effective June 16, 2023. Dental correspondence will be sent from P.O. Box 45132, Jacksonville, Florida, 32232-9902.

Credentialing vendor update

We've contracted with VPoint to verify credentials and provide ongoing monitoring services for our dental provider networks starting in June. VPoint is a nationally recognized health care practitioner Credentials Verification Organization (CVO).

Our goal in retaining the services of VPoint is to decrease the number of forms and hard copies you need to submit for each individual health care plan in your office. Because VPoint is a centralized CVO for many other dental plans, this will minimize duplication of your efforts.

All dental providers will receive a letter in June, which will include additional information about VPoint.

New enrollment process for electronic funds transfer (EFT)

Once asurisdental.com launches in June, dental providers will also need to register for EFT payments using a new enrollment process outlined in the *My Patients Benefit Guide* on the new website. Providers will need to maintain EFT setup through Availity Essentials.

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**.

Audit vendors

CERIS will conduct second-pass diagnosis-related group (DRG) claims for services delivered on or after July 1, 2023, on our behalf.

Additionally, Performant is conducting skilled nursing facility (SNF), emergency department evaluation and management (ED E&M) and initial DRG reviews on our behalf.

These vendors will contact your office if your claim is selected for this review:

- To validate the services billed on the claim
- To verify the pricing method applied is correct
- To verify the payment rendered is appropriate to the member's benefits

If you disagree with the vendor's findings, you can appeal to the appropriate vendor. Their contact information is provided on the determination letter. If recoupment is necessary, we will adjust a future claim payment.

These reviews are being conducted for our commercial and Medicare Advantage plans.

Billing drug administration without a drug code

Reminder: Drug administration codes billed without an accompanying HCPCS drug code will be denied. When a provider bills the administration code and another provider is to be reimbursed for the drug code, the administering provider must include a charge on their claim with a phantom drug code for a penny ($.01) or less, depending on system limitations.

Medical record requirements

We would like to remind you of the following requirements and guidelines for medical record documentation and requests for review.

Record requests
We request medical records to support a variety of requirements and compliance activities, including claim review, risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®), government required activities, audits and more. We often contract with vendors to obtain medical records for these purposes. It is your responsibility as a participating Asuris provider to respond to these requests in a timely manner.

Note: Records submitted for review that are not properly authenticated or signed may be subject to claim recoupment. A provider may amend the record with a valid signature within 180 days of date of service.

Requirements
Each entry or page in the patient's medical record must include:

- The patient's name, date of birth and date of service to verify who the patient is and what date services were provided.
- The rendering provider's signature at the completion of the chart note, medical records, operative report or any other medical document in a patient's file. If an entry spans multiple pages, the signature is required at the end of the entry, but the patient identifiers must be on each page.
- **Note**: CMS has specific requirements for providers to include their electronic signature on electronic medical records. Each signature must include the provider credentials, provider name, date and time stamp.

In addition, the following should be included:

- Information on advance directives
- Specific and clear treatment plans
- Complete, accurate and legible documentation
- Complete history, examination and medical decisions
- Identification of all providers participating in the patient's care
- Diagnostic testing, laboratory tests, radiology reports and results
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Complete descriptions of the patient's concerns and reason for seeking medical care
- A problem list, including significant illnesses and medical and psychological conditions
- Evaluation and assessment of the provider's findings and a complete list of all diagnoses
- Information on allergies and adverse reactions or a notation that the patient has no allergies or history of adverse reactions

All medical records must be maintained for at least 10 years after the date of medical services. For more information about medical recordkeeping, please see the site review standards on our website: Programs>Cost and Quality>Quality Program>Site Review Standards.

Social determinants of health resources

We are working tirelessly to close health equity gaps to ensure simpler, better, more affordable health care for those we serve—from all backgrounds and walks of life. This includes collecting and tracking social determinants of health (SDOH) information about our members to understand barriers and support equitable access to quality health care and health education.

SDOH have a major impact on people's health, well-being and quality of life. Examples of SDOH include:

- Polluted air and water
- Language and literacy skills
- Racism, discrimination and violence
- Education, job opportunities and income
- Safe housing, transportation and neighborhoods
- Access to nutritious foods and physical activity opportunities

The SDOH ICD-10-CM Z codes make it possible to measure social risk factors and social needs. They add greater specificity to capture a more holistic view of a patient's health.

Resources

- Our updated SDOH flyer, available on our provider website: Forms & Documents> Social Determinants of Health
- CMS, 2023 ICD-10-CM updates: **cms.gov/ medicare/icd-10/2023-icd-10-cm**
- CMS ICD-10-CM Official Guidelines for Coding and Reporting: **cms.gov/files/document/ fy-2023-icd-10-cm-coding-guidelinesupdated-01/11/2023.pdf**
- Everything Payers Need to Know About the SDoH ICD-10 Code Expansion: **https://f. hubspotusercontent40.net/hubfs/500440/ SDoH_ Code_Expansion_White_Paper.pdf**
- ICD10data.com: **icd10data.com/ICD10CM/ Codes/Z00-Z99**

Responding to documentation requests

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

To avoid claim-processing delays, please set up access to the Availity Attachments application today. This will ensure you receive notification and can submit documentation when requested.

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

Availity tips: EFT enrollment and tracking

We require participating providers to receive claims payment via electronic funds transfer (EFT). To enroll for EFT, use the Transaction Enrollment application on Availity Essentials: My Providers>Enrollments Center>Transaction Enrollment.

- To enroll, change a current enrollment or cancel a previous enrollment, click the blue **Enroll** button and choose **Enroll a provider** to begin the registration.
- After you submit the enrollment, we will receive the registration and begin validation.

For security purposes, our EFT enrollment team will contact you to confirm the information you provide. **You must confirm your enrollment details with us to complete the EFT enrollment process.**

Note: If your enrollment cannot be validated after multiple validation attempts, it may be rejected.

To see the progress of your EFT registration, view process notes or action items, be sure to check the Transaction Enrollment application until your enrollment is complete:

- Open the Transaction Enrollment application
- Apply filters as needed from the column on the left
- Click anywhere on your enrollment request
- Review process notes displayed under your request
- Make note of any actions you need to take

Learn more about EFT and view a step-by-step guide to enrolling on our provider website: Claims & Payment>Electronic Transactions.

Pre-authorization updates

Commercial Pre-authorization List updates

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)	0242U
Procedure/medical policy	**Added codes effective March 1, 2023**
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	15771, 15773
Procedure/medical policy	**Added codes effective April 1, 2023**
ClonoSEQ® Testing for the Assessment of Measurable Residual Disease (MRD) (Genetic Testing #88)	0364U
Expanded Molecular Testing of Cancers to Select Targeted Therapies (Genetic Testing #83)	0379U
Procedure/medical policy	**Adding codes effective July 1, 2023**
Surgical site of service – outpatient hospital	11755, 14040, 14060, 15850, 17311, 17313, 30130, 30140, 30520, 30802, 31200, 31205, 31525, 31574, 31591, 32408, 32555, 32557, 38221, 38222, 42821, 42826, 42831, 43260, 43261, 46505, 46607, 49082, 49422, 50430, 51715, 52001, 52235, 52287, 52450, 53445, 54150, 54161-54164, 54300, 54450, 54840, 55040, 55041, 55700, 56810, 57283, 58263, 62270, 63661, 63663, 64418, 64425, 64530, 64610, 64642, 64644, 64646, 64702, 64718, 64719, 64721, 64774, 64795, 64831, 65756, 65779, 65780, 65855, 66183, 66761, 66840, 66850, 67028, 67218, 68320
Ventral (Including Incisional) Hernia Repair (Surgery #12.03)	Code 15734 will require pre-authorization for diagnosis codes K42.0, K42.1, K42.9 K45.0, K45.1, K45.8, K46.0, K46.1, K46.9 and M62.0

Medicare Advantage Pre-Authorization List updates

Procedure/medical policy	Added codes effective March 1, 2023
Gender Affirming Interventions for Gender Dysphoria (Medicine #153)	15771, 15773
Procedure/medical policy	**Added codes effective April 1, 2023**
Genetic and Molecular Diagnostics – Next Generation Sequencing, Genetic Panels, and Biomarker Testing (Genetic Testing #64)	0364U, 0371U, 0372U, 0375U-0380U, 0386U

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Medicare Advantage Pre-Authorization List updates (continued)

Procedure/medical policy	Adding codes effective July 1, 2023
Surgical site of service – outpatient hospital	11755, 14040, 14060, 15850, 17311, 17313, 30130, 30140, 30520, 30802, 31200, 31205, 31525, 31574, 31591, 32408, 32555, 32557, 38221, 38222, 42821, 42826, 42831, 43260, 43261, 46505, 46607, 49082, 49422, 50430, 51715, 52001, 52235, 52287, 52450, 53445, 54150, 54161-54164, 54300, 54450, 54840, 55040, 55041, 55700, 56810, 57283, 58263, 62270, 63661, 64418, 64425, 64530, 64610, 64642, 64644, 64646, 64702, 64718, 64719, 64721, 64774, 64795, 64831, 65756, 65779, 65780, 65855, 66183, 66761, 66840, 66850, 67028, 67218, 68320

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

Procedures at hospitals to require pre-authorization

In 2022, we began reviewing colonoscopy and endoscopy services when performed in an outpatient hospital setting. We are expanding these site-of-service pre-authorization requirements to include additional services where a lower level of care may be appropriate.

Effective July 1, 2023, select procedures affecting many specialties will require pre-authorization for the site of service when performed at an outpatient hospital surgical site:

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

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

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

Save time and effort with Availity

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

Submit the *Surgical Site of Service Additional Information Form* with faxed pre-authorization requests to provide attestation-based supporting documentation. Failure to submit a completed and signed form will delay review.

Additional information

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

- Pre-authorization>Commercial
- Pre-authorization>Medicare Advantage

View the *Surgical Site of Service – Hospital Outpatient* commercial and Medicare Advantage medical policies on our provider website: Library>Policies & Guidelines>Medical Policy.

Radiology requests may require additional documentation

Beginning July 1, 2023, Carelon may request additional clinical information for radiology pre-authorization requests for commercial and Medicare Advantage members. If requested, providers will need to submit documentation from the patient's medical record to demonstrate that services are clinically appropriate. Carelon will request this documentation only for select procedures when certain clinical indications are present. Examples include:

- CT of the sinuses for sinusitis
- CT of the chest for pulmonary nodules or as follow-up to previous imaging that indicated abnormality
- MRI of the brain for headaches
- MRI of a lower extremity for a tendon injury
- MRI of the lumbar spine as follow-up to previous imaging that indicated abnormality

This additional information will be requested during the provider's regular submission process. A request cannot be submitted unless the requested information is included, but you can save your entry to finish the request later.

Clarification regarding radiology eligibility message

Compared to 2022, fewer radiology requests require an order number from Carelon, formerly AIM. If a provider requests an order number and receives the following message in Carelon's ProviderPortal, the member's plan doesn't participate in our radiology program:

"Based on the Date of Service entered, the selected member is currently not eligible for an Order ID. Please contact the health plan."

This message means the service does not require an order number or pre-authorization through Carelon. Providers do not need to call Asuris.

The Bulletin recap

We publish updates to medical 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 information

No policy updates in the February or March 2023 issues 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

We provided 90-day notice in the March 2023 issue of *The Bulletin* about the new *Physician Concierge Services* (Administrative #130) commercial reimbursement policy, which is effective June 1, 2023.

We review reimbursement policies on an annual basis. View our *Reimbursement Policy Manual* on our provider website: Library>Policies & Guidelines> Reimbursement Policy.

Joint surgery pre-authorization changes delayed one month

eviCore healthcare (eviCore) will begin reviewing the site of service for outpatient hospital joint surgeries performed on or after June 1, 2023; this date is one month later than previously announced.

Joint surgeries should be performed in ambulatory surgical centers (ASCs) unless an outpatient hospital setting is medically necessary.

Provider website resources

- View our complete Pre-authorization lists
- Physical Medicine program information: Programs>Medical Management>Physical Medicine.

New diagnoses to require pre-authorization for hernia repair code

For hernia repair surgeries performed on or after July 1, 2023, CPT 15734 will require pre-authorization for the following additional ICD-10-CM codes:

- M62.0 for diastasis
- K42.0, K42.1, K42.9 for umbilical hernias
- K45.0, K45.1, K45.8, K46.0, K46.1, K46.9 for other abdominal wall hernias

This change is supported by our *Ventral (Including Incisional) Hernia Repair* (Surgery #12.03) medical policy.

New specialty medication provider network coming

As stewards of our member's health care expenses, we are committed to delivering sustainable high-quality care to meet member needs. The price trend of many specialty medications has been growing at double the rate of inflation for years. This trend is even greater for provider-administered specialty medications in certain settings.

We've received increased requests for white-bagging solutions from employer groups. However, we feel providers should be part of the dispensing process, so we've designed a holistic solution, called Asuris EquaPathRx™, that keeps the provider-patient relationship intact. We're one of the first health plans in our region to adopt this type of strategy. This approach has been successful in other parts of the country.

To move toward equitable and sustainable costs for provider-administered specialty medications in all settings, our pharmacy benefit manager, Prime Therapeutics, will launch IntegratedRx™-Medical, a specialty medication provider network for Asuris members, effective January 1, 2024. We'll also implement a new benefit for members on commercial products as coverage renews in 2024 to support this, and it will also be available to administrative services only (ASO) groups.

Join the Prime Therapeutics IntegratedRx-Medical Network

Beginning January 1, 2024, we'll require certain specialty medications for members included in Asuris EquaPathRx to be fulfilled using the IntegratedRx-Medical Network.
Starting in April 2023, Prime will contact providers to begin the credentialing and contracting process for this new network.

- Each provider group or facility that offers administration of specialty medications will need to be credentialed and contracted as a dispensing provider with Prime Therapeutics.
- If your organization operates a specialty pharmacy that you want included in this network, they'll need to complete the credentialing and contracting process to be included, even if they have an existing pharmacy contract with Prime Therapeutics.
- Your contract with Prime will have a reimbursement schedule that includes the medications in the Asuris EquaPathRx program.

How the new network will work for your patients

Effective January 1, 2024, for members included in the Asuris EquaPathRx, we'll no longer provide coverage for select provider-administered medications except when obtained through the new IntegratedRx-Medical Network.

If you join the IntegratedRx-Medical Network, you'll be able to submit medication claims directly to Prime Therapeutics without patient interruption or a requirement to change administration sites.

Prime will reimburse you for the medication at the rates on your Prime reimbursement schedule, and the medical claim for any administration-related services will still be submitted to Asuris, as it is today. Participation in the network also:

- Ensures the claim meets payment criteria before you administer the medication
- Allows flexibility for provider procurement of medication; you can procure through existing methods, including 340B or specialty pharmacy as desired

If you don't join the IntegratedRx-Medical Network, you'll need to use a participating IntegratedRx-Medical Network specialty pharmacy to fill medications for members with the Asuris EquaPathRx benefit in 2024.

The list of medications (with HCPCS and NDC codes) that will be included in this program effective January 1, 2024, is on our provider website: Programs>Medical Management>Pharmacy.

Impacts to reimbursement for medications

We understand this change will impact reimbursement and operational processes for some medications, but it's necessary to ensure costs remain predictable and affordable for our groups and members—your patients.

For members included in the Asuris EquaPathRx program, any provisions in existing provider agreements between Asuris and the provider group or facility that address provider-administered medications and reimbursement schedules do not apply for the select list of provider-administered specialty medications in Asuris EquaPathRx.

For members not included in the Asuris LevelRx program, reimbursement for provider administered medications will continue under your existing Asuris provider agreement terms.

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We believe the Prime Therapeutics reimbursement schedule for the IntegratedRx-Medical Network is fair and reasonable to accomplish that goal with the least interference to your current processes for prescribing and administering these specialty medications. **Participation in the IntegratedRx-Medical Network won't affect your ability to use the 340B pathway to acquire medications.**

What's next

We'll share more information about the Asuris EquaPathRx throughout 2023. Look for these communications:

- The October 2023 issue of *The Connection*℠ will include more information about Asuris EquaPathRx, including medication policy changes and product updates for 2024.
- The October 2023 issue of *The Bulletin* will include any related updates to reimbursement or medical policies.

In addition, later this year, we'll work with Prime to provide instructions to verify member benefits and detailed claim submission instructions, including training opportunities for you and your staff.

We value the care and consideration you give to our members, especially as we work together to ensure economically sustainable, high-quality care is available with providers our members know and trust. We look forward to your inclusion in the IntegratedRx-Medical Network.

Medication policy reminders

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 website: Programs> Medical Management>Pharmacy.

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 Centers for Medicare & Medicaid Services (CMS) has designated as PNA before they become ineligible for reimbursement. See our *Non-Reimbursable Services* (Administrative #107) reimbursement policy on our provider website: Policies & Guidelines>Reimbursement Policy.

Improving members' experience with medications

There are many factors that influence members' experience with obtaining medications and adhering to their treatment plan. We are working to increase the support and assistance we offer for members to improve their health outcomes and experience.

Reasons your patient may not be taking medications you prescribed

Sometimes members are prescribed medications they cannot obtain for various reasons (e.g., cost, nonformulary, pre-authorization or step therapy requirements or medications excluded from coverage.) These barriers can lead to untreated or poorly controlled conditions and impact the quality of care the patient feels they received.

Look for the **Medications and member experience with medications** category in the Quality Improvement Toolkit, available in the Toolkits section on our provider website. The toolkit includes best practices and action items, along with a variety of flyers you can share with your patients.

Helping your Medicare Advantage patients

To help your patients get their needed prescription medications, consider the following:

- Look up your patient's formulary to determine coverage and cost information: **asuris.com/medicare/pharmacy**
  - Selecting a drug in Tier 1 or a generic drug will decrease costs for your patient.
  - If pre-authorization or formulary exception is required, submit a request before prescribing the treatment.
  - Take quantity limits into consideration.
- Prescribe a 100-day supply for chronic medications (e.g., oral diabetes medications, antihypertensives, statins). Even if your patient already receives a 90-day supply, switching them to a 100-day supply gives them 10 more days of medication at no additional cost.
- If you prescribe an over-the-counter (OTC) medication, remind your patients that they may have OTC benefits. They can call the number on the back of their insurance card to find out.
- Avoid prescribing CMS-excluded drugs. These include but are not limited to:
  - Fertility drugs
  - Nonprescription drugs
  - Drugs used for anorexia, weight loss or gain
  - Drugs for symptomatic relief of cough and colds
  - Drugs used for cosmetic purposes or hair growth
  - Drugs for the treatment of sexual or erectile dysfunction
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride
- If the patient has difficulty with transportation, consider sending the prescription to a home delivery pharmacy or a pharmacy that delivers like PillPack by Amazon Pharmacy.
  - Express Scripts Home Delivery
    express-scripts.com
    Phone: 1 (833) 599-0451
    Fax: 1 (800) 837-0959
  - AllianceRx Walgreens Pharmacy
    alliancerxwp.com/home-delivery
    Phone: 1 (888) 832-5462
    Fax: 1 (800) 332-9581
  - Postal Prescription Services
    ppsrx.com
    Phone: 1 (800) 552-6694
    Fax: 1 (800) 723-9023
  - PillPack by Amazon Pharmacy
    pillpack.com
    Phone: 1 (855) 745-5725 ext 3
  - Costco Mail Order Pharmacy
    Phone: 1 (800) 607-6861
    Fax: 1 (800) 633-0334
  - Amazon Pharmacy Home Delivery
    pharmacy.amazon.com/prescribers
    Phone: 1 (855) 206-3605
    Fax: 1 (512) 884-5981

Statin use for cardiovascular disease or diabetes

As a reminder, please update patient records to include statin use for your Medicare Advantage patients who have diabetes or clinical atherosclerotic cardiovascular disease (ASCVD).

We know you are familiar with the adherence and compliance measures, but we wanted to reiterate the importance of updating patient records each year with the appropriate ICD-10 code for patients who have demonstrated an intolerance to statins in the past. Each patient who has a reported intolerance must have it documented each year at a provider visit. The codes that are acceptable to indicate statin intolerance are listed below.

Providing these codes helps us minimize education to those patients who have demonstrated an intolerance and identify patients who could benefit from the addition of a statin. This will also limit the amount of information sent to you regarding your patients who are listed under this measure because their records do not indicate an exclusion.

Asuris-accepted ICD-10 codes for statin intolerance or contraindication

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

Notes:

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

Learn more about the Medicare Advantage Quality Incentive Program (MA QIP) on our provider website: Programs>Medicare QIP.

Behavioral health corner

About behavioral health corner

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

Additionally, the 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

Understanding incident-to services rules for behavioral health services

Incident-to services help us meet member's care needs by expanding the provider types that can provide services. In incident-to scenarios, the supervising provider bills for services, and claims process according to the supervising provider's agreement.

Supervision requirements

Providers rendering services via incident-to billing criteria must be supervised by a credentialed provider with equal or higher-level education.

Provider searches

If your patient asks whether they can receive in-network services from a provider not contracted with us, let them know the associate provider is considered in-network when rendering services under a supervision arrangement with an eligible in-network behavioral health provider.

Providers rendering incident-to services aren't eligible to submit their own claims, and therefore, won't appear in a provider search. However, the contracted provider under which the associate provider performs incident-to services will appear in a provider search.

Medicare Advantage provider types

Licensed marriage and family therapists (LMFTs) and licensed professional counselors (LPCs) are not eligible to directly bill Medicare plans, but CMS now allows LMFTs and LPCs to render services under the general supervision of an eligible behavioral health provider.

More information

- The CMS Physician Fee Schedule: **cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched**
- On our provider website
  - View the *Incident to Services* (Administrative #148) commercial and Medicare Advantage reimbursement policies in our *Reimbursement Policy Manual*: Policies & Guidelines>Reimbursement Policy
  - Review the provider types with which we contract: Contracting & Credentialing>Provider Types

Behavioral health corner

Peer support program available now

Our new peer support program is open to Medicare Advantage members younger than 65. We have chosen this underserved population as our initial focus while we work to expand the program.

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

We encourage providers to refer eligible Medicare Advantage patients who could benefit from this supportive program. Hospitals, freestanding facilities and other providers can refer a member to the peer support program by calling our Provider Contact Center.

Help our members find you

Because behavioral health care providers have different educational backgrounds, areas of experience and clinical focus, finding the right behavioral health provider can be a confusing and daunting process for our members.

We want to empower our members to make well-informed decisions about their mental health care. We've deployed a new *Behavioral Health Practitioner Areas of Interest* form on our provider website that includes 10 new modalities and revised areas of clinical focus. Information you submit using these forms enhances our online provider directory search, the Find a Doctor tool, to help our members find behavioral health providers who specialize by treatment type, age group, primary and secondary areas of clinical focus, and treatment modality.

To ensure the right patients find your practice, we recommend you complete an updated *Behavioral Health Practitioner Areas of Interest* form, available on our provider website: Contact Us> Update Your Information.

Behavioral health toolkit for the primary care setting

Proper mental health and substance use treatment are integral to a person's overall health. We recognize that PCPs serve a vital role in discussing, diagnosing and treating behavioral health conditions.

Our behavioral health toolkit includes condition-specific screening tools and trusted resources for 12 diagnoses or challenges, as well as information about:

- In-network virtual care providers
- Our care management services, including case management
- Determining the best path forward in the early stages of a patient's evaluation and treatment
- Ongoing condition management

The toolkit is available on our provider website, Behavioral Health>Behavioral Health Toolkit.

Behavioral health corner

Telehealth can support PCP and facility care

Timely access to behavioral health care is critical to patients' overall well-being. Telehealth appointments can help meet that need.

PCPs: If your patient needs a referral for behavioral health evaluation or treatment, you can recommend they check whether the following providers are in their network.

For facilities: To improve our members' outcomes and to reduce or avoid readmissions, it is important that patients are seen by a behavioral health provider within seven days of discharge from an inpatient or residential facility. We encourage you to share the following telehealth options with your patients to help them receive needed post-discharge care. **Note**: Discharge appointments do not count as follow-up appointments.

No referral needed

Members can use the Find a Doctor tool on our member website, **asuris.com**, and search Places by Name for the telehealth providers listed below. They can also call or chat online with Customer Service for assistance. Members can then contact these providers to begin treatment.

Not all telehealth options are available to all members. Members can call the Customer Service number on the back of their card to verify a provider group is in-network.

In-network providers

- **AbleTo**: The Therapy+ program is a structured, eight-week series of one-on-one cognitive behavioral therapy (CBT) by phone or video with a licensed therapist, with medication management and digital tools for support available between sessions
  - **ableto.com**
- **Boulder Care**: Addiction treatment—including medication-assisted treatment (MAT) for opioid use disorders (OUD), which can begin in the ED—that offers support through peer coaching, care coordination and other recovery tools
  - **boulder.care**
- **Charlie Health**: Mental health intensive outpatient treatment for teens and young adults, as well as their families
  - **charliehealth.com**
- **Eleanor Health**: Addiction and substance use disorder treatment provider with integrated evidence-based outpatient care and recovery for opioid and other substance use disorders
  - **eleanorhealth.com/locations/washington**
- **Equip**: Family-based treatment of eating disorders for individuals ages 6 to 24 that includes a care team consisting of a therapist, a physician, a family mentor, a peer mentor and a dietician
  - **equip.health**
- **NoCD**: Specialized care for obsessive compulsive disorder (OCD) using exposure and response prevention (ERP) treatment
  - **treatmyocd.com**
- **Talkspace**: Mental health counseling available 24/7/365 via text, audio or video messaging
  - **talkspace.com/partnerinsurance**

Resources

- The providers listed in this article are available on our provider website: Behavioral Health>Behavioral Health Toolkit
- Learn more about telehealth, including national vendors not mentioned here, on our provider website: Care Options>Telehealth
- Providers can check members' standard telehealth benefits by performing an eligibility and benefits inquiry in Availity Essentials: Eligibility and Benefits>Benefit Type>Professional (Physician) Visit—Home
- Read about the Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure, which helps ensure members transition safely from an acute hospital setting back to their home environments: Behavioral Health>Facilities>HEDIS Post-Discharge Follow-Up

Help your patients know where to go for care

We encourage you to help educate your patients about the care options that can be used when your office is closed or as an alternative to an emergency room (ER) visit for non-acute or non-life-threatening conditions.

Care options

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. Most of our members also have access to telehealth vendors that offer convenient appointment times.

Related: For more information about virtual behavioral health options, see *Telehealth can support PCP and facility care* on page 18.

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 their clinical need.

Urgent care

Many urgent care clinics are conveniently located and more accessible than ERs. Remind your patients when to visit an urgent care clinic versus an ER.

Remind patients to consider urgent care clinics for illnesses and injuries beyond the scope of virtual care, such as migraine; abdominal pain; sprains, strains and cuts; and severe cold and flu symptoms.

On-call medical care at home with DispatchHealth

With DispatchHealth, **dispatchhealth.com**, members in the greater Spokane area can receive care in the comfort of their home and avoid a trip to urgent care or the ER.

Related: See *On-call medical care at home* on page 20.

Emergency room

Remind patients to go to the ER if they are experiencing acute or life-threatening symptoms, such as chest pain, shortness of breath, signs of a possible stroke, uncontrollable bleeding, severe burns, head injuries (especially loss of consciousness) or seizures.

Connect your patients to care

- Remind your patients to sign in to **asuris.com** and select **Find Care** to view their in-person, virtual, urgent and at-home care options.
- Our Customer Service team is also able to help members identify their care options. Customer Service numbers are listed on the back of member ID cards.

Our care managers proactively reach out to members who have had several ER visits. In addition, we educate our members about their care options through emails, our member websites, social media and blogs.

On-call medical care at home with DispatchHealth

With DispatchHealth, **dispatchhealth.com**, members can receive care in the comfort of their home and avoid a trip to urgent care or the ER.

- DispatchHealth providers serve patients in the greater Spokane area.
- They are available after-hours (operating 7 days a week, including holidays, from 8 a.m.-10 p.m.) and when offices or clinics are experiencing capacity constraints at a cost similar to an urgent care visit.

DispatchHealth treats these conditions and more:

- Urinary tract infections
- Breaks, sprains and bruises
- Severe cold and flu symptoms
- Lacerations, abrasions and infections
- Chronic obstructive pulmonary disease (COPD) and exacerbations
- Mild to moderate stomach pains, nausea, vomiting and dehydration

Their medical team can provide many of the same services as an urgent care facility, including:

- Onsite labs
- Sutures and lancing
- IV placement with fluids
- Urinary catheter insertion
- Medication and antibiotics
- Ordering additional services (e.g., EKG)

Easily connect your patients to DispatchHealth:

- Download this overview to share with providers in your office: **dispatchhealth.sharepoint.com/:b:/s/DHMarketing/Ed2idcct0z5HpJcJ1RCusEMBCJI-6PhTJ4c6T4z2J7IcgA?e=Qn0tUb**.
- Share this flyer with your patients to help educate them about this option: **beonbrand.getbynder.com/m/6abd52697008eba6/original/Member-One-Pager-DispatchHealth.pdf**
- When care is needed, you or your patient can call 1 (833) 652-0539 or use the online portal to request a visit at **dispatchhealth.com/locations**.
- After you or the member requests care, a team of trained emergency medical professionals, a physician assistant or nurse practitioner, and a medical technician will arrive at the member's location.
- The on-site medical team will coordinate care at the bedside, as appropriate, and direct the member to you for follow up.
- You will receive the patient's clinical encounter notes from DispatchHealth summarizing the visit.

Watch these short videos to learn about DispatchHealth's:

- In-home treatment capabilities: **vimeo.com/779300678**
- Medical kits and how DispatchHealth can care for patients at home: **vimeo.com/560986386**
- Ability to care for high-risk patients with urgent needs or transportation issues: **vimeo.com/779298483**

Members can find the DispatchHealth contact information by signing in to their **asuris.com** account and selecting **Find Care**. Members can also contact Customer Service.

Encouraging preventive cancer screenings

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

We cover a variety of preventive services at no cost (no copay and no deductible) to our members. Preventive services can help detect the following cancers before symptoms appear and when treatment is more likely to be successful.

Screening coverage for commercial members

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

Member reminders for colon cancer, breast cancer and cervical cancer

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

Preventive vs. diagnostic care

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

View our preventive care lists

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

Best practices and member flyers

Our Quality Improvement Toolkit includes best practices and resources you can share with your patients that address the importance of breast, cervical and colon cancer screenings: Programs> Cost & Quality>Quality Improvement Toolkit.

MA QIP reminders

Please note the following reminders and updates for our MA QIP.

2022 program year

User audit and payment address verification
During the month of April, we will perform two important program activities:

- All users will be asked to validate the list of Care Gap Management Application (CGMA) users for their organization.
- Organizations will be asked to confirm their payment address for the 2022 QIP payout.

Thank you for verifying this information to ensure uninterrupted service and proper QIP payout.

Payout for the 2022 program year will be mailed by June 30, 2023.

2023 program year

2023 program data in the CGMA
The 2023 QIP program year gaps are now visible in the CGMA.

New features in the CGMA
We are continually working with Novillus to improve your user experience in the CGMA. The following CGMA reporting is improved for 2023:

- New pharmacy engagement program reporting available in the Reports menu
- Enhanced reporting includes gap status and submission data

Other new features include:

- Mouse-over detail added to navigation buttons
- Date of birth (DOB) member search option
- Medication adherence gaps include an action label
- Event date column on the member-level gap screen
- Closed gaps label changed to green to make this status stand out
- Submit button options updated to Agree/Disagree
- Enhanced Detail View screen now shows number of gaps to close to achieve the next Star level

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

Resources for you

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

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