December Informed Newsletter

December 19, 2023

Wishing You a Happy and Healthy Holidays

It's hard to believe it's already the holiday season, with another new year right around the corner. We're grateful for *all* you've done for our members – and for us – throughout 2023, and we can never thank you enough for your partnership. We hope you, your staff and all your loved ones have a beautiful, cheerful and blessed holidays. As together we embark upon 2024, we're forever thankful that you're our partner.

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Help patients find you.

Our LexisNexis Risk Solutions Partnership

As you know, it's vital that your patients – and potential patients – have access to accurate, up-to-date information about your practice in our provider directory. To ensure this accuracy, the No Surprises Act, the Illinois Department of Human Services, the Illinois Department of Insurance, and the Centers for Medicare & Medicaid Services **all require** that providers review and update their information quarterly or whenever there is a significant change.

Patients must be able to call the phone number listed in our provider directory and make an appointment with that specific provider at that location.

We know paperwork is often time-consuming, so to help you meet this requirement, we've partnered with LexisNexis® Risk Solutions. **They'll be reaching out to you on a quarterly basis via phone or email to help you verify that your provider information is accurate and up to date.**

If you have any questions or have concerns with your updates, please contact your provider relations specialist or call our Provider Services team at (800) 851-3379, option 3.

If you need to send updated provider demographic information to us, please send that information to Provider.Updates@HealthAlliance.org.

Thank you for your cooperation in this important initiative.

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Help us move the needle.

Together we can help people live their healthiest lives. Find reminders, tips and more in this section, to guide improvements in patient outcomes. Help us move the needle.

Are you "antibiotics aware"?
Help protect your patients and fight the spread of superbugs.

It's an alarming but true fact: antibiotics are responsible for almost 20% of emergency department visits for adverse drug events. And they're the most common cause of these visits for children under 18.

Prescribing antibiotics isn't always the best choice – and sometimes it can even be harmful. The CDC is urging doctors and other healthcare professionals to only prescribe antibiotics when necessary. This'll help combat antibiotic resistance and the spread of superbugs, as well as protect your patients from antibiotic-related adverse drug events.

The CDC encourages you to follow these steps – and to share this important information with your fellow providers:

- Only prescribe antibiotics when they're clinically indicated and when they're needed. You can do harm by prescribing unneeded antibiotics.
- Follow clinical guidelines on how to best evaluate and treat infections.
- Make sure you always prescribe the **right antibiotic**, at the **right dose**, for the **right duration**, and at the **right time**.
- Educate your patients about why they don't need antibiotics for viral respiratory infections – and tell them what they *should* be doing to feel better instead, and how best to seek care in these situations.
- Talk to your patients and their families about possible harms from antibiotics – like allergic reactions, *Clostridioides difficile* and antibiotic-resistant infections.
- Help educate your patients and their loved ones to recognize the signs and symptoms of worsening infection and sepsis – and to know when they should seek medical care.

Visit this CDC webpage for more information and helpful resources. And thank you for being "antibiotics aware."

Testing is key for CKD.

Make sure your patients get regular tests for chronic kidney disease (CKD) if they have risk factors for the disease. Why is this so important? Consider this key information from the National Kidney Foundation®:

- CKD raises the risk for cardiovascular events and the progression to kidney failure and death.
- About **30 million** Americans have CKD – but **over 80%** of these people are completely unaware they have it.
- Approximately **9 in 10** adults with both CKD and type 2 diabetes are *not* aware they have CKD.
- About **half of all patients with advanced CKD (Stage G4)** remain undiagnosed.

What to Know About Testing

Two tests are used together to assess for CKD (and to monitor the disease once treatment begins): **estimated glomerular filtration rate (eGFR)** and **urine albumin-creatinine ratio (ACR)**. According to the National Kidney Foundation:

> In clinical practice, the most common tests for chronic kidney disease include glomerular filtration rate estimated from the serum creatinine concentration (eGFR) using the CKD-EPI (CKD Epidemiology Collaboration) equation and albuminuria from the urinary albumin-creatinine ratio (ACR).

CKD is defined as **estimated glomerular filtration rate (eGFR) < 60 ml/min/1.73m²** and/or **markers of kidney damage for at least three months**.

Current guidelines for testing recommend that adults with diabetes and/or hypertension should be evaluated **at least once every year**.

For more information (for both you and your patients) about testing, see here and here.

Dual Diagnosis – What You Need to Know

"Dual diagnosis" is when someone has both a mental health disorder and an alcohol or drug problem. Here's the key information to know, from the National Library of Medicine.

- Mental health disorders and substance use/abuse issues frequently occur alongside one another.
- Approximately half of all people with a mental health disorder will also have a substance use disorder at some point in their lives, and vice versa.
- When someone has both, the interactions of the two conditions can make each condition worse.

Despite the fact that these disorders often occur together, this doesn't necessarily mean that one caused the other (even when one condition appeared first). So why do they occur together so frequently? Doctors and scientists point to a few possibilities:

- Mental health and substance use disorders **share common risk factors**, including stress, trauma and genetics.
- Mental health conditions can be one factor that contributes to substance use (and eventual abuse) – for example, people might use alcohol or drugs to temporarily feel better (what's known as **"self-medication"**).
- Some mental health disorders may **change the brain** to make substance addiction more likely.
- Alcohol and drug use, and addiction, can **also change the brain**, making mental health disorders more likely.

To effectively treat someone with a dual diagnosis, you must treat both conditions. Treatments can include behavioral therapies, support groups and medications, as appropriate. Very crucially, the person needs to stop using alcohol and drugs.

Thank you for helping this important group of patients.

HEDIS Quality Measures – Statin Therapy

By working together, we can help patients with high cholesterol stay healthy. The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standards that helps us together assess the care and treatments patients receive. **This article gives you information on the HEDIS quality measures for statin therapy for high cholesterol, and tips on how to meet these measures and provide the best care.**

Why are these measures important?

According to the CDC, almost 2 in 5 U.S. adults have high cholesterol (defined as total blood cholesterol ≥ 200 mg/dL). Too much cholesterol puts patients at risk for heart disease and stroke, two leading causes of death. Please help us together improve our performance on the following HEDIS quality measures, by encouraging your patients to focus on prevention and wellness by starting and continuing statin therapy.

What are the HEDIS measures?

There are two HEDIS quality measures involving statin therapy:

1. **Statin Use in Persons with Diabetes (SUPD)** looks at the percentage of patients age 40 to 75, with diabetes but who **do not** have clinical atherosclerotic cardiovascular disease (ASCVD), who:
    a. Were **dispensed at least one statin medication** (of any intensity) during the measurement year.
    b. **Adhered to/remained on their statin medication** (of any intensity) for at least 80% of the treatment period.
2. **Statin Therapy for Patients with Cardiovascular Disease (SPC)** looks at the percentage of male (age 21 to 75) and female (age 40 to 75) patients with **clinical atherosclerotic cardiovascular disease (ASCVD)** who:
    a. Were **dispensed at least one high-intensity or moderate-intensity statin medication** during the measurement year.
    b. **Adhered to/remained on their high-intensity or moderate-intensity statin medication** for at least 80% of the treatment period.

Please note: Patients in hospice or with a diagnosis of end-stage renal disease (ESRD) are excluded from these measures.

Information in this article is based on National Committee for Quality Assurance (NCQA) HEDIS® technical specifications. For details, visit ncqa.org.

Thank you for all you do to help keep our members healthy.

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New Standard Prior Authorization List for 2024

Click here to view our new Standard Prior Authorization list for 2024, effective January 1, 2024. Please login to Provider.HealthAlliance.org to perform a member-plan specific search to determine whether the requested CPT and HCPCS codes require prior authorization and contact our Customer Solutions team with any questions.

Coding Counts:
Documentation Matters – History of, Active or In Remission

Supporting documentation and accurate coding are key to making sure your patients receive the care they need. Here are this issue's coding tips for you and your staff.

History vs. Active Voice

Often, documentation beginning with "history of" is meant to tell the story of the patient's health and may be used for persisting conditions. The problem is that coding is literal and therefore the accuracy of your documentation is critical. Documentation and coding must align:

- If your intention is to address a condition that has **resolved**, then using "history of" is appropriate. In this case, your diagnosis should be a "history of" code as well.
- If your intention is to address a **persisting condition (one that's still present)**, then "history of" is **not appropriate** and it will create conflict with your active diagnosis code.

Here are some better ways to show that a condition is persisting:

- "The patient has…"
- "The patient is being treated for/seen for…"
- "The patient has a long-standing history of persisting…" (The word "persisting" is critical.)

History vs. In Remission

"History of" should also be differentiated from "in remission." "History of" implies that **the condition is resolved**. "In remission," on the other hand, has multiple variations – but the base meaning is that the condition **isn't fully resolved, but rather it's currently without signs or symptoms**. Below are examples.

Remission Documentation for Cancer	Corresponds to:

Cancer in Remission (Undefined)	Active/Persisting Cancer
Cancer in Partial Remission	Active/Persisting Cancer
Cancer in Complete Remission	History of Cancer (Resolved/Cured)
History of Cancer in Remission	History of Cancer (Resolved/Cured)

Examples of the Impact of Documentation

Documentation	**Supported Code**
The patient *has* leukemia.	C95.90 Leukemia
The patient has a *history of* leukemia.	Z85.6 History of Leukemia
The patient has leukemia *in remission*.	C95.91 Leukemia in Remission
The patient has a *history of* leukemia *in remission*.	Z85.6 History of Leukemia

Categories of Codes with "In Remission"

- Mental and behavioral health disorders: Alcohol and drug abuse, and major depression disorder.
- Cancers: leukemia, multiple myeloma and malignant plasma cell neoplasms.
- *As a general rule, "in remission" will be considered historical/resolved for all other conditions, with the exception of lymphoma and the specified conditions listed above.*

Final Key Thought

Remember: documentation for coding is literal. What's important is not what you meant, but rather what you chronicled and reported. Your diagnosis and documentation must align.

We thank you for your attention to detail and professionalism, and we're always here to help. To find more risk adjustment coding resources, visit our Coding Counts page. Thank you for your continued care and dedication to our members' health.

Questions?

Please contact us at CodingCounts@HealthAlliance.org.

RSV Vaccine: Updated Coverage Guidance for ABRYSVO for Pregnant Women

Note: This article only applies to members on our Commercial plans. It does not apply to members on our Medicare plans, and it does not apply to members on any of our Reid Health Alliance Medicare plans.

Here is an important update on guidance for the RSV vaccine for pregnant women.

The CDC's Advisory Committee on Immunization Practices (ACIP) recently published **recommendations for respiratory syncytial virus (RSV)-associated lower respiratory tract disease prevention in pregnant women who are 32 through 36 weeks' gestation**. **ABRYSVO™ (CPT: 90678) is now indicated for this patient population and will be available at the preventive benefit for qualifying members.** ABRYSVO was previously approved for select patients age 60 years or older, identified through shared decision-making with their physician. **Below is updated coverage information based on where the vaccine will be administered.**

Pharmacy Coverage (NDC 0069-0207-01, 0069-0250-01, 0069-0344-):** ABRYSVO is currently available at the nonpreferred brand tier and limited to patients age 60 years or older. Point-of-sale messaging will be implemented to direct pharmacies to confirm that the patient is within the eligible maternal population. Once confirmed, pharmacies are able to enter an override code for the vaccine to pay at $0 copay. Limited to one dose per year, since revaccination is not recommended at this time.

Medical Coverage (CPT Code 90678): ABRYSVO is currently available at the comparable general medical tier and limited to patients age 60 years or older. Medical coding will be updated to allow for pregnant individuals younger than 60 to obtain the vaccine at $0 copay if submitted with a qualifying maternity-care code to support that the patient is within the approved gestational period of 32-36 weeks. Limited to one dose per year, since revaccination is not recommended at this time.

If you have any questions, feel free to reach out.

Midwest – Pharmacy Updates

All Plans

Rare Diseases

Formulary Additions

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        - Medicare—Non-Formulary
- Elfabrio (pegunigalsidase alfa)—Enzyme replacement therapy for adults with confirmed Fabry disease (Anderson-Fabry disease)
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Ophthalmology

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Miscellaneous Criteria Changes—Commercial and Medicare (Impacted members have been notified.)

- Continuous Glucose Monitors
    - Coverage discontinuing effective 1/1/24 for members who are not on insulin
    - CGMs can be applied in-office and billed to medical benefit for reimbursement

Commercial

Rare Diseases

Criteria Changes

- Carbaglu (carglumic acid)
    - Added step through generic product

- Keveyis (dichlorphenamide)
    - Added step through generic product

Formulary Changes—Commercial

Positive Changes

- Tezspire Products
    - Move from non-preferred specialty to preferred specialty tier
- Qulipta
    - Move from non-preferred brand to preferred brand tier
- Vyvanse Chewable Tablets
    - Remove prior authorization
    - Age edit will remain in place (covered ages 6-12 per package label)
- Symfi and Symfi Lo
    - Move from non-preferred specialty to non-preferred generic tiers

Negative Changes (effective 1/1/2024) **(Impacted members have been notified.)**

Product	Change	Reasoning	Member Impact
Wound Care Dressings	Move to non-formulary	Products range from $220-18,000 per package size	No utilization
Mircera	Move from non-preferred brand to non-preferred specialty	Align with other anemia in CKD products	None
Dexycu	Move from non-preferred brand to non-preferred specialty	Align with other ophthalmic dexamethasone products	No utilization
TiceBCG	Move from general medical to non-preferred specialty	Align with other bladder cancer treatments	None
Daunorubicin		Align with other leukemia treatments	None
Hepatits B immune globulins		Average cost: $3,268/claim	None

Medicare

Formulary Changes—Medicare

Positive Changes

Medication	New MDL	Reasoning
Arixtra (fondaparinux)	None	Deemed to have low risk of misuse within this therapeutic category
Fragmin (dalteparin)	None	
Lovnox (enoxaparin)	None	

Please Note: The P&T Committee meets bimonthly, and formulary changes and criteria changes can occur during the meetings. Negative formulary changes are made effective on 1/1 and 7/1, while positive formulary changes are effective immediately to better serve our members and providers. Drug coverage and policies in the following categories will be reviewed during the remainder of 2023 and changes may be made:

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Northwest – Pharmacy Updates

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Privacy Practices

Code of Conduct

Non-Discrimination Notice

Policies & Procedures

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