TELE PROVIDER

Saint Mary's Health Plans | ATRIO HEALTH PLANS

IN THIS ISSUE

QUARTER 2 PROVIDER TRAINING UPDATE

Quarter 2 Provider Training had a great turnout with the success of all the attendees that participated. With engaging questions on the topics that were discussed, here is a recap of what you could take away from this training.

Prior Authorizations

ATRIO's medical management team handles the process of identifying if the services are needing a prior authorization. There is a 2023 Medicare PA Grid on our website with a list of codes that are listed. If the service or code is not listed on our PA Grid then, you do not need an authorization. All in-patients need a prior authorization.

PA Submissions: Prior authorizations can be submitted via the provider portal, by faxing in the prior auth to the appropriate county, in person, mail or by phone.

PA Timeframes: Standard timeframes begin when the prior authorization is received by the plan and to the correct servicing county. Standard request is 14days and expedited timeframe is 72hrs of when the PA is received by the correct

department. Part B drugs standard timeframe is 72hrs and expedited is 24hrs. A determination must be made within the applicable timeframes.

PA Amendments: Amendments can be made to an authorization if it doesn't require additional clinical review and is determined by the clinical review team. If the amendment cannot be made, then the provider can submit a prior authorization to be officially reviewed.

PA Grid Changes

Every year medical management and the board go in and decipher whether it is appropriate to need an authorization for specific codes. These codes are updated annually, with the potential of minor changes throughout the year. The following codes have been removed from the 2023 Medicare PA Grid:

Medical Management/Prior-Authorizations Update

- Carpal Tunnel Surgery (64721)
- CT Lung, Cancer Screening (71271)
- Echo (93306)
- Stress Test (SPECT) (78452)
- Brain MRI (70553, 70551)
- Carotid Doppler (93880)
- Cataract Surgery (66984)
- Deb Subq tissue 20 sq cm/< (11042)
- Deb Subq tissue add-on (11045)

If you have any questions, please contact ATRIO customer service.

Mid-Level Billing

Health care providers such as Physician Assistants, APRN, nurse practitioners who are not an MD, are considered mid-level providers. The NPI of the provider that conducted the actual visit is the one that should always be used when billing the health plan. It is important to make note that we bill under the correct NPI of that mid-level provider and not the rendering provider. If there are any questions on how this should be completed, please visit CMS.gov or contact ATRIO provider relations at providerrelations@atriohp.com.

Claim Dispute Process Overview

Payment Dispute

Providers disputing the way a claim was paid.

Timeframe: Payment Disputes can be requested 60 days from the remittance notification date. Payment disputes beyond 60 days from the RA may be dismissed.

Par-Provider Reconsideration

Contracted providers can file a Par-Provider Reconsideration for any claim or claim line that has been denied. This is a service provided by ATRIO, it is not a CMS requirement.

Timeframe: ATRIO must receive the request within 60 calendar days of the denial notification. Untimely filing is 61 or more days. Providers may submit documentation showing proof of timely filing on a case-by-case basis.

COMPLIANCE CORNER

ATRIO has introduced a new process to electronically upload documents from our website. If a provider is asked to provide records the below link can be used to upload documents. This link is available on our website at atriohp.com under the provider resources tab.

Medical Record Audit Response Form

If you have any questions or concerns, please contact provider relations at providerrelations@atriohp.com

PHARMACY

Insulin and Weight Loss

- **Per CMS rule, medications used for weight loss are NOT covered under Part D pharmacy benefits.**

The formulary GLP-1 agonists: Liraglutide (Victoza) and semaglutide (Ozempic) are approved for diabetes by the FDA. These medications do not have an approved indication for weight loss or pre-diabetes. The use of any GLP-1 agonist for weight loss will not be covered by Medicare Part D

- Effective July 1, 2023, insulin covered by Part B (applicable when administered using an insulin pump) will not cost more than $35 for a 30-day supply per CMS IRA (Inflation Reduction Act)

HHS ANNOUNCES RULE TO PROTECT CONSUMERS FROM SURPRISE MEDICAL BILLS/BALANCE BILLING

Impact - Claims Payment Rate

"The Biden-Harris Administration, through the U.S. Departments of Health and Human Services (HHS), Labor, and Treasury, and the Office of Personnel Management, issued "Requirements Related to Surprise Billing; Part I," an interim final rule that will restrict excessive out of pocket costs to consumers from surprise billing and balance billing. Surprise billing happens when people unknowingly get care from providers that are outside of their health plan's network and can happen for both emergency and non-emergency care. Balance billing, when a provider charges a patient the remainder of what their insurance does not pay, is currently prohibited in both Medicare and Medicaid. This rule will extend similar protections to Americans insured through employer-sponsored and commercial health plans.

"No patient should forgo care for fear of surprise billing," said HHS Secretary Becerra. "Health insurance should offer patients peace of mind that they won't be saddled with unexpected costs. The Biden-Harris Administration remains committed to ensuring transparency and affordable care, and with this rule, Americans will get the assurance of no surprises."

Among other provisions, today's interim final rule:

Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.

Bans high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.

Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.

Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

These provisions will provide patients with financial peace of mind while seeking emergency care as well as safeguard them from unknowingly accepting out-of-network care and subsequently incurring surprise billing expenses.

Tackling surprise billing is critically important, as it often has devastating financial consequences for individuals and their families. Two-thirds of all bankruptcies filed in the United States are tied

to medical expenses. Researchers estimate that 1 of every 6 emergency room visits and inpatient hospital stays involve care from at least one out-of-network provider, resulting in surprise medical bills. And a 2019 study by the Government Accountability Office (GAO) found that the median price charged by air ambulance providers ranged from $36,400 to more than $40,000, and over 70% of these transports were furnished out-of-network, meaning most or all costs fell to the insured individual alone. Thanks to the Biden-Harris Administration and bipartisan congressional support, HHS, Labor, Treasury, and OPM are promulgating rules that will protect consumers from financial ruin simply because they could not ask for an in-network provider during their treatment.

"No one should ever be threatened with financial ruin simply for seeking needed medical care," said U.S. Secretary of Labor Marty Walsh. "Today's Interim Final Rule is a major step in implementing the bipartisan No Surprises Act that will protect Americans from exorbitant health costs for unknowingly receiving care from out-of-network providers."

"Facing a difficult medical situation is challenging enough – no one should then face a surprise medical bill when they get home," said OPM Director Kiran Ahuja. "This interim rule helps to protect Americans from financial ruin and honors federal employees, retirees, their covered family members and other enrollees who receive healthcare through the FEHB Program, the largest employer-sponsored plan, by giving them new protections from unexpected medical bills."

Today's interim final rule with request for comments implements the first of several requirements passed with bipartisan support in title I (the "No Surprises Act") of division BB of the Consolidated Appropriations Act, 2021. The regulations issued today will take effect for health care providers and facilities January 1, 2022. For group health plans, health insurance issuers, and FEHB Program carriers, the provisions will take effect for plan, policy, or contract years beginning on or after January 1, 2022.

Fact sheets on this interim final rule can be found *here* and *here*.

The interim final rule with comment period can be accessed *here*.

If you have any further questions regarding balance billing please visit the links above or reach out to ATRIO provider relations at *providerrelations@atriohp.com*.

STARS

Provider Tips for Improving Health Outcomes Measured through the CMS Health Outcomes Survey (HOS)

What is the Health Outcomes Survey (HOS)?

The HOS is a Medicare Survey that asks beneficiaries to detail their interactions with their physicians. It also asks Medicare beneficiaries if their providers addressed their health concerns. The results of the HOS help evaluate how beneficiaries view their current health status.

The HOS is administered annually by CMS to a random sample of Medicare beneficiaries drawn from each participating MA plan (i.e., a baseline survey is administered to a new group each year) during July to November. Two years later, these same respondents are surveyed again (i.e., follow up measurement) on maintaining or improving physical and mental health.

How Can You Help Improve Health Outcomes?

You can help improve your patient's health and HOS measures by using the patient's annual wellness visit to discuss these measures. Please consider incorporating HOS-like questions, like those in the table below, in your initial and ongoing health assessments to help promote and enhance patient-provider interactions that can result in improved communication and quality of life. ATRIO thanks you for your daily dedication to keeping patients healthier and more engaged with improving their health outcomes.

HOS: Survey domains	HOS: Survey Questions
Improving or Maintaining Physical Health	• Have you had any of the following problems with your work or other regular daily activities because of your physical health? • During the past four weeks, has pain stopped you from doing things you want to do?
Improving or Maintaining Mental Health	• Have you had any of the following problems with your work or other regular daily activities because of emotional health? • Have you had a lack of energy or felt sad or depressed most days?
Monitoring Physical Activity	• In the past 12 months, did a doctor or other healthcare provider advise you to start, increase or maintain your level of exercise or physical activity
Improving Bladder Control	• Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine? • Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? (bladder training, exercises, medication, surgery)
Reducing the Risk of Falling	• Did you fall in the past 12 months? • In the past 12 months, did a doctor or other healthcare provider talk with you about falling or problems with balance or walking?

MEMBER UPDATES

ATRIO sends out a member newsletter to keep our members apprised of any important information. If you would like to see what our members are up to please visit the below link:

ATRIO Member Newsletter

IMPORTANT LINKS

Provider Manual 2023:

https://www.atriohp.com/documents/providers/Medicare-2023-Oregon-Provider-Manual_Final.pdf

Centers for Medicare & Medicaid Services HIPAA Eligibility Transaction System (HETS):

https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Index.html

To check which drugs are on the ATRIO Formulary, go to "Find a Drug"

www.atriohp.com/oregon/find-a-drug/

Provider Claim Dispute Form (Reconsiderations and Payment Disputes)

https://www.atriohp.com/oregon/providers/provider-resources/provider-claim-dispute-form/

***Full information is available on our website at:**
https://www.atriohp.com/oregon/providers/provider-resources/

CONTACT | COMMUNICATION | TRAINING

CONTACT INFO

Saint Mary's ATRIO Health Plans
Sarah Hernandez
Provider Relations Rep

520 W. 6th Street
Reno, NV 89503

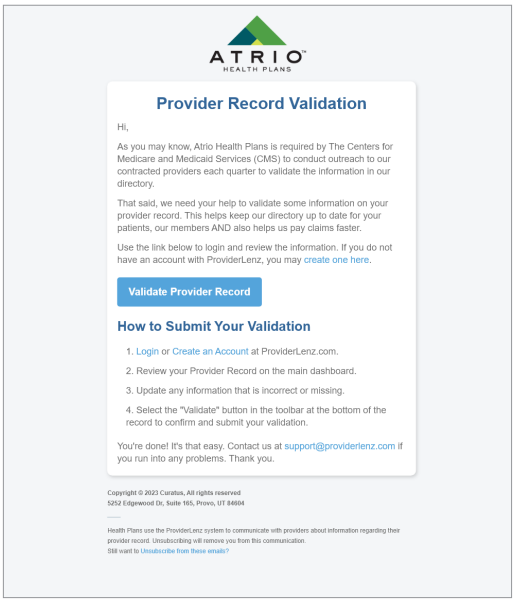
O: 775-418-4913

E: providerrelations@atriohp.com

In Person Training:
Be on the lookout for upcoming dates and trainings

PROVIDER RECORD

Be on the lookout for an email from ProviderLenz Directory where important communications will be sent from on behalf of ATRIO. It is not spam or phishing attempts.



ATRIO HEALTH PLANS

Provider Record Validation

Hi,

As you may know, Atrio Health Plans is required by The Centers for Medicare and Medicaid Services (CMS) to conduct outreach to our contracted providers each quarter to validate the information in our directory.

That said, we need your help to validate some information on your provider record. This helps keep our directory up to date for your patients, our members AND also helps us pay claims faster.

Use the link below to login and review the information. If you do not have an account with ProviderLenz, you may create one here.

Validate Provider Record

How to Submit Your Validation

1. Login or Create an Account at ProviderLenz.com.
2. Review your Provider Record on the main dashboard.
3. Update any information that is incorrect or missing.
4. Select the "Validate" button in the toolbar at the bottom of the record to confirm and submit your validation.

You're done! It's that easy. Contact us at support@providerlenz.com if you run into any problems. Thank you.

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5252 Edgewood Dr, Suite 165, Provo, UT 84604

Health Plans use the ProviderLenz system to communicate with providers about information regarding their provider record. Unsubscribing will remove you from this communication.
Still want to Unsubscribe from these emails?

TRAINING / MEETINGS

Training Meeting Dates
Every Quarter Check your Email and Fax for upcoming Events

Tuesday Meetings Link: *https://us06web.zoom.us/meeting/register/tZIld--hqTgoGtN3_QrFceLJzwC-l1uRj03b*

Meeting ID: 868 0697 3207

Virtual Office Hours
Every Tuesday 1:00 pm — 3:00 pm
Every Thursday 1:00 pm — 3:00 pm

Meetings Link: *https://us06web.zoom.us/meeting/register/tZIld--hqTgoGtN3_QrFceLJzwC-l1uRj03b*

Meeting ID: 868 0697 3207