Medicare Advantage Update FEBRUARY 2018

BlueCross BlueShield Nebraska

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Medicare Advantage Update contains up-to-date information for providers about Medicare Advantage plans with Blue Cross and Blue Shield of Nebraska (BCBSNE). This newsletter is published by BCBSNE's Health Network Services Department and Marketing Department.

We encourage you to print a copy of this Update and keep it with your BCBSNE Medicare Advantage Core HMO and Choice HMO-POS Provider Manual. To request permission to reprint this material for any other purpose, please send an email to the editor, Sara Cline, at **sara.cline@nebraskablue.com.**

Please refer to your provider manual often. You may view it at **www.nebraskablue.com/maprovidermanual.**

To view past issues of Medicare Advantage Update, visit **www.nebraskablue.com/ma-update.**

Getting ready for your patient's Medicare Advantage preventive care visits

Now that we're embarking on a new year, you'll start seeing new and existing Medicare Advantage (MA) patients for preventive services. This article includes important information about three types of annual preventive care visits:

Visit Type	New/Existing Medicare Advantage members	Frequency	Services
Welcome to Medicare preventive visit	Patient is new to Medicare	1 visit per member per lifetime	Initial preventive history and exam
Annual wellness visit	Existing MA member	12 months after Welcome to Medicare visit	Health risk assessment and update
Routine physical exam	Existing MA member	Annually	Annual preventive history and exam

In this issue → Click on the headline to jump to the article.

The information in this newsletter applies to Blue Cross and Blue Shield of Nebraska's Medicare Advantage Core HMO and Medicare Advantage Choice HMO-POS plans.

The information in these articles is not intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation is done in accordance with applicable state and federal laws and regulations.

Welcome to Medicare visit

The Welcome to Medicare preventive visit, is also referred to as the initial preventive examination. **This is a one-time appointment for new Medicare patients to be scheduled within their first 12 months of enrollment.** Medicare pays for one Welcome to Medicare visit per member, per lifetime.

This initial visit is a great way to get up-to-date information such as health screenings, immunization records and family history.

During the Welcome to Medicare visit, please ensure that the following items are completed:

- A list of your patient's past and current diagnoses
- Family history and social history
- Height, weight, and blood pressure checks
- Body mass index (BMI) calculation
- A simple vision test
- A review of potential risks for depression and falls
- Assessment of functional ability and patient's level of safety
- Discussion about advance directives
- Patient education on preventive services and prescription for any services needed
- An individualized preventive care checklist

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Annual Wellness visit

The Annual Wellness visit is a time for you to update your patient's personalized prevention plan based on the patient's current health situation and risk factors. Health Risk Assessments (HRAs) are also part of the annual Wellness visit.

The health risk assessment is self-reported information that your patient completes before or during the visit. For more information about HRAs, visit Framework for Patient-Centered Health Risk Assessments on the Centers for Disease Control and Prevention website.

Medicare will cover an Annual Wellness visit every 12 months for patients who have been enrolled in Medicare for longer than 12 months.

Patients can schedule their Annual Wellness visit on the same day as their routine physical exam to help you make a complete assessment of their health.

Services at the Annual Wellness visit should include:

- Health risk assessment
- Review of medical, social and family history
- Update of a list of providers and prescriptions
- Height, weight, blood pressure and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- Patient education on preventive services and prescription for any services needed
- Review and update of the individualized preventive care checklist

Routine physical exam

The routine physical exam is covered annually by the Medicare Advantage health plan. These exams are part of the preventive services that are not part of the Welcome to Medicare visit or the Annual Wellness visit.

Routine physical exams are a comprehensive physical exam to assess your patient's health and address any abnormalities or signs of disease. The exam should include:

- Obtaining the patient's medical history and family history
- Inspection
- Palpation
- Auscultation

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Codings Tips:

Each type of preventive care visit has unique coding and billing components. Below are some important elements to consider:

Welcome to Medicare Visit or Initial Preventive Physical Examination (IPPE) Billing Code	**Annual Wellness Visit (AWV)** includes a personalized prevention plan of service Billing Codes (PPPS)	**Routine Physical Exam** Billing Codes
• G0402	• G0438 – First visit AWV, can only be billed one time, *12 months after a G0402 (IPPE)* • G0439 – Annual Wellness Visit (subsequent)	• **New Patient** 99386 *(40-64 years old)* 99387 *(65 years and older)* • **Established Patient** 99396 *(40-64 years old)* 99397 *(65 years and older)*
• **Note:** When you furnish a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service along with the IPPE, Medicare may pay for the additional service. • Report the additional Current Procedural Terminology (CPT) code (99201–99215) with modifier -25. • That portion of the visit must be medically necessary to treat the patient's illness or injury, or to improve the functioning of a malformed body member. • While the preventive visit is no cost to the patient, a copay and/ or deductible may apply on the additional service rendered.	• **Note:** G0438 or G0439 must not be billed within 12 months or previous billing of a G0402 (IPPE). Per CMS, when you furnish a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service along with the AWV, Medicare may pay for the additional service. • Report the additional CPT code with modifier -25. • That portion of the visit must be medically necessary to treat the patient's illness or injury, or to improve the functioning of a malformed body member. • While the preventive visit is no cost to the patient, a copay and/ or deductible may apply on the additional service rendered.	• **Note:** Service can be billed along with the Welcome to Medicare visit or annual Wellness visit via Modifier 25. • There is no patient copay for the Welcome to Medicare Visit and annual Wellness visit. • Nebraska Medicare Advantage plans cover the cost of routine physical exams with no copay to the member. • If additional services are performed, a patient copay may apply.

You can find more information about these preventive care visits by going to:

The ABCs of the Initial Preventive Exam and The ABCs of the Annual Wellness Visit on the Centers for Medicare & Medicaid Services website at www.cms.gov

For more information on risk assessment and HEDIS best practices, please refer to Blue Cross and Blue Shield of Nebraska's provider manual at www.nebraskablue.com/ maprovidermanual.

Important update for Medicare Advantage providers regarding prior authorization requirements

The effective date for prior authorization of the services listed below has changed from April 1, 2018 to May 1, 2018. Please note this is a 30-day postponement of the date stated in the January General Update.

Starting May 1, 2018, prior authorizations for Medicare Advantage members will be required for the following services:

- Durable medical equipment greater than $500
- Genetic testing
- Services deemed investigational
- Spinal fusion and pain management injections
- High-tech radiology (MRI, CT, PET, etc.)
- Intensity-modulated radiation therapy and stereotactic body radiation therapy

This is in addition to the prior authorization requirements that are already in place for acute hospital admissions, 14–day bundling for readmissions, post–acute admissions and Part B medication.

Note: This is for Medicare Advantage only. Medical policy details will be provided at a later date.

For additional benefit information, please contact Blue Cross and Blue Shield of Nebraska's Medicare Advantage Provider Service Center **1-888-505-2022**. For prior authorizations, please contact **1-877-399-1671**.

Urinary incontinence

According to the National Association for Continence, 1 in 5 individuals older than 40 suffers from urinary incontinence (UI). In older patients, UI can significantly impact a patient's quality of life. This can result in:

- Avoidance of activities
- Limited social interaction
- Depression
- Insomnia
- Risk for falls

Forms of UI

- Urge incontinence: An urgent need to urinate resulting in the loss of urine before one makes it to the toilet.
- Stress incontinence: Movement such as coughing, sneezing, running or heavy lifting puts pressure (stress) on the bladder and causes urine leakage.
- Mixed incontinence: A combination of stress and urge incontinence.
- Overflow incontinence: The bladder doesn't completely empty, causing leakage when the bladder becomes overly full.
- Functional incontinence: One or more physical or mental reasons prevents the patient from getting to the bathroom in time.

According to the Agency for Healthcare Research and Quality, more than 50 percent of women never get treatment for their incontinence. Some of the reasons for this is that patients:

- Find it embarrassing to discuss this matter with their healthcare providers
- Assume that UI is natural to the aging process
- Do not realize that this is a treatable condition

Starting the discussion about UI with patients may be what helps them understand they no longer have to live with it. With your help, UI doesn't have to take over the lives of your patients. Discussing the variety of treatments available can help them enjoy life without the worry of incontinence.

Coding Tips

The comorbidities seen in older persons with UI are generally chronic diseases such as diabetes mellitus or benign prostatic hyperplasia. Patients with UI may have neurological comorbidities such as multiple sclerosis, spinal cord lesions or injuries, or genitourinary comorbidities such as recurrent, symptomatic urinary tract infections.

It is important to capture all pertinent diagnoses and comorbidities when coding UI. The table below offers some examples for coding UI and associated comorbidities.

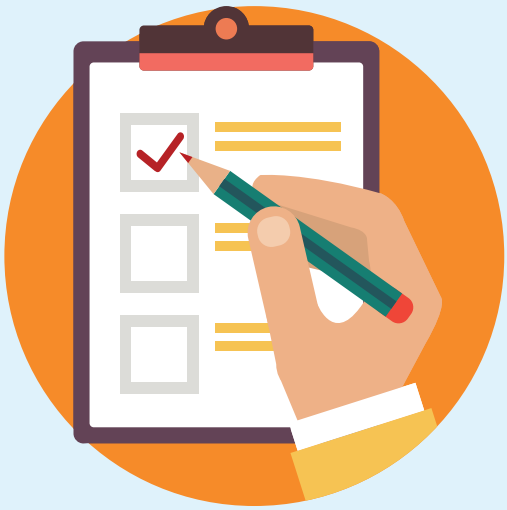
Diagnosis	Comorbidity	ICD-10CM code
Stress incontinence	Diabetes mellitus Type1 without complications	N39.3, E10.9
Overflow incontinence	Spinal cord disease, un-specified	N39.490, G95.9

Source: http://www.pericoach.com/2016/03/02/understanding-y-incontinence

CAHPS® and HOS survey information

In the December 2017 Medicare Advantage Update, we provided you with a summary of what the "Consumer Assessment of Healthcare Providers and Systems" (CAHPS) survey and "Health Outcomes survey" (HOS) is, and explained why these patient surveys are so important to your practice. To view the newsletter, go to www.nebraskablue.com/ma-update.

This article gives you additional insight into the questions these two surveys address with patients, and provides you with recommendations to achieve positive survey results.



Survey Name and Measure	Sample Survey Question to the Patient	Recommendations and Rationale for Providers, when applicable
CAHPS: Getting appointments and care quickly	• When you needed care right away, how often did you get care as soon as you thought you needed it? • Not counting the times when you needed care right away, how often did you get care as soon as you thought you needed it?	• Keep a few appointments open each day for urgent or "sick" visits. • Offer patients appointments with an available provider for those who want to be seen on short notice. • Ask patients to make routine check-up and follow-up appointments in advance.

HOS: Monitoring physical activity	• In the past 12 months, did:
	  • You talk with your doctor about your level of exercise and physical activity?
	  • A doctor advise you to start, increase or maintain your level of physical activity?
		• Discuss appropriate physical activity with your patient.
		• Offer suggestions for where patients can engage in activities that offer a variety of exercise opportunities.

→ Watch for additional survey questions in upcoming issues of the Medicare Advantage newsletter at www.nebraskablue.com/ma-update.

Controlling high blood pressure

High blood pressure increases the risk for heart disease and stroke which are the leading causes of death in the United States. This article is intended as a tool that will help providers maximize patient health outcomes in accordance with the National Committee for Quality Assurance (NCQA) HEDIS measurement for high quality of care.

HEDIS® Measure

This measure assesses patients between the ages of 18-85 years old who have a diagnosis of hypertension and whose blood pressure is adequately controlled during the measurement year. Adequate blood pressure control is defined as patients who are:

- 18-59 years old whose blood pressure is <140/90
- 60-85 years old without diabetes whose blood pressure is <150/90
- 60-85 years old with diabetes whose blood pressure is <140/90

Measure exclusions

Patients who have any of the following conditions are excluded from this measure:

- End-stage renal disease or kidney transplant on or prior to Dec. 31 of the measurement year
  - » Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis
- Had a diagnosis of pregnancy during the measurement year
- Had a non-acute inpatient admission during the measurement year (e.g., skilled nursing facility, long-term care facility)

Medical record documentation

- The most recent BP reading in the measurement year is used to establish whether the patient's blood pressure is adequately controlled. If there is more than one reading at a visit, the lowest BP values are used.
- Remember to always record the date on which the BP value was obtained.
- The diagnosis of high blood pressure must be documented in the medical record prior to June 30 of the current measurement year.
- Acceptable documentation to confirm diagnosis of high blood pressure includes:

Improving quality performance

• HTN • High BP • Elevated BP • Hypertension	• Borderline hypertension • Intermittent HTN • History of HTN • Hypertensive vascular disease • Hyperpiesia/Hyperpiesis

- It is not advisable to round the value of the blood pressure reading because rounding off the BP value could mean the difference between a controlled and uncontrolled BP value.
- Repeat blood pressure later in the visit if the initial value is elevated. It often drops once the patient has relaxed.
- Educate the patient to monitor blood pressure at home and when to seek medical attention. Document this in the medical record.
- If your patient has additional needs, e.g., a specific cardiac diet or cardiology consult, be sure to document these management steps in your medical record.
- Encourage patient compliance by reinforcing the importance of regular monitoring, taking medications as prescribed and asking

If you have questions or would like more information about the articles in this newsletter, please contact:

Your Provider Relationship Manager at 1-877-435-7258
Monday-Friday, 8 a.m. - 4:30 p.m.