Medicare Advantage Update
AUGUST 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 **nebraskablue.com/maprovidermanual**.

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

Prior authorizations for Medicare Advantage HMO and HMO-POS plans

Effective Sept. 1, 2018, prior authorization will be required for the following services for Blue Cross and Blue Shield of Nebraska members covered under our Medicare Advantage HMO and HMO-POS plans:

- **High tech radiology and cardiac imaging**
  - Computed tomography (CT), including CTA
  - Magnetic resonance imaging (MRI), including MRA, MRS, MRM, fMRI
  - Nuclear cardiology
  - Positron emission tomography (PET)
  - Stress echocardiology (SE)
  - Resting transthoracic echocardiology (TTE)
  - Transesophageal echocardiology (TEE)
- **Radiation therapy (intensity-modulated radiation therapy/ stereotactic body radiation therapy)**
  - Intensity-modulated radiotherapy (IMRT)
  - Stereotactic radiosurgery (SRS)
  - Stereotactic body radiation therapy (SBRT)
  - Brachytherapy
  - 2D/3D conformal (EBRT)
  - Proton beam therapy
  - Image-guided radiation therapy (IGRT)
  - Fractionation in radiotherapy for whole breast, non-small cell lung cancer, and bone metastases
  - Associated codes including special treatment procedure and physics consult codes

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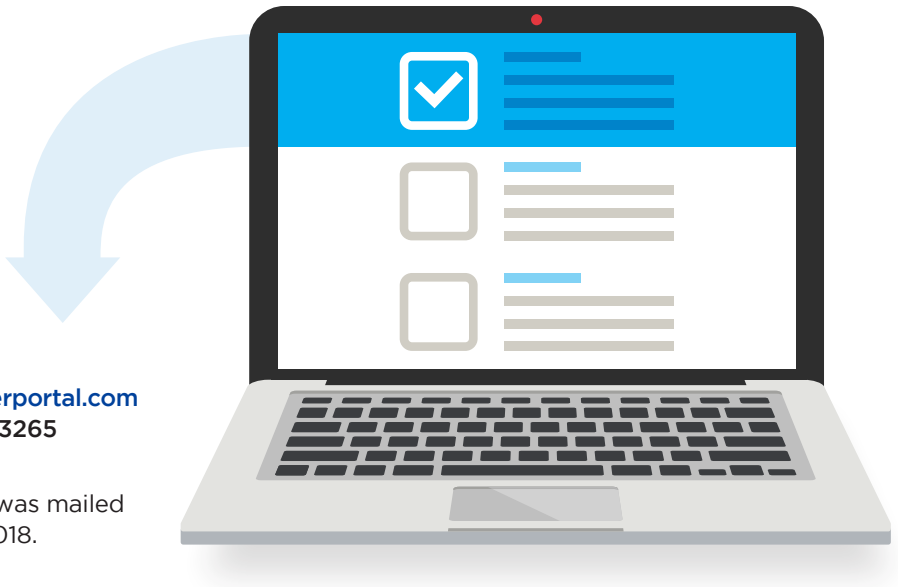
Prior authorizations — *cont.*

- **Spinal fusion**
  - Interventional pain management
  - Epidural injections (interlaminar/caudal and transforaminal)
  - Facet joint injections/medial branch blocks
  - Facet joint radiofrequency nerve ablation
  - Implanted spinal cord stimulators
  - Regional sympathetic blocks
  - Sacroiliac joint injections



Prior authorization requests must be submitted to AIM Specialty Health by logging in to **www.providerportal.com** or by calling the AIM Contact Center at **1-866-745-3265** Monday through Friday, 8 a.m. to 5 p.m. CDT.

This letter outlining the process and requirements was mailed to all Medicare Advantage providers in late June 2018.

If you have questions, please contact Blue Cross and Blue Shield of Nebraska's Medicare Advantage line at **1-888-488-9850**.

Comprehensive diabetes care

Diabetes requires consistent medical care and monitoring to reduce the risk of complications and improve outcomes.

These Healthcare Effectiveness Data and Information Set (HEDIS®) measures examine the percentage of adults ages 18 to 75 with Type 1 and Type 2 diabetes who had each of the following:

- Hemoglobin A1C (HbA1C) in control
- Monitoring for nephropathy
- Blood pressure in control
- Eye exam (retinal) performed

The HbA1C test reflects blood sugar control. It is typically checked two to four times per year.

<7.0% is optimal for most people

<8.0% is acceptable in select populations

>9.0% denotes poor control

Interventions to improve outcomes for diabetics go beyond glycemic control. Early detection of retinal eye disease allows for prompt treatment to help minimize vision complications. Urine microalbumin screens for patients with diabetes and hypertension can identify renal disease several years before it becomes significant enough to cause symptoms. In diabetics, microalbumin urine testing can detect nephropathy five years earlier than urine protein tests.

The National Kidney Foundation recommends annual microalbumin screenings for diabetic patients. Diabetic patients with elevated urine microalbumin levels have a five- to ten-fold increase in cardiovascular mortality, retinopathy and end stage renal disease. The recommended target blood pressure for diabetics is less than 140/90 mmHg.

Comprehensive diabetes care measures are collected for HEDIS purposes from two key sources:

- Administrative data (This includes claims data)
- Data from chart reviews (This is a random sample of medical records selected for review. Proper documentation of tests performed, with dates and results, and any exclusions are essential for accurate chart reviews)

Important note about continuous enrollment and exclusionary criteria	
Continuous enrollment	Must be continuously enrolled with the same Medicare Advantage plan for the current calendar year.
Exclusionary criteria	• Diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the calendar year or the prior year. • Patients in hospice.

Diabetes care: HbA1C in control	
Description*	The percentage of members with diabetes and a documented HbA1c ≤ 9.0% using the latest lab conducted in the calendar year.
Compliant population (numerator)	• The number of members with diabetes with an HbA1c ≤9.0%. • This measure considers the last lab conducted during the calendar year. The member is not compliant if the most recent result is >9.0%, missing a result from the most recent test or the test was not done during the calendar year.
Eligible population (denominator)	All members with Type 1 or Type 2 diabetes as defined above.
Level of measure	Provider level.
Procedure code to support gap closure (if service is performed in-office)	• 3044F – Most recent hemoglobin A1c (HbA1c) level less than 7.0% (compliant). • 3045F – Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (compliant). • 3046F – Most recent hemoglobin A1c (HbA1c) level greater than 9.0% (while non-compliant, this will reduce need to locate lab result).
Medical record documentation to support gap closure	• Documentation in the medical record should include a copy of the lab report. • In the absence of the lab report, the HbA1c collected date and result must be documented in the medical record. The following notation in the chart counts towards compliance: A1c, HbA1c, HgBA1c, hemoglobin A1c or glycohemoglobin A1c. • Most recent hemoglobin A1c level value must be less than or equal to 9.0%.

Diabetes care: Monitoring for nephropathy	
Description*	The percentage of members with diabetes who have had one of the following: • At least one screen for micro/macroalbumin in the calendar year. • Received medical treatment for nephropathy in the calendar year. • Had a visit with a nephrologist in the calendar year. • At least one dispensing event of ACEI/ARB medication in the current year. • Evidence of stage 4 or 5 chronic kidney disease, end state renal disease or kidney transplant.

*Please refer to HEDIS specifications for more detailed information.

continued...

Comprehensive diabetes care — *cont.*

Diabetes care: Monitoring for nephropathy — continued	
Compliant population (numerator)	Members with diabetes who have had one of the following: • At least one screen for micro/macroalbumin in the calendar year. • Received medical treatment for nephropathy in the calendar year. • Had a visit with a nephrologist in the calendar year. • At least one dispensing event of ACEI/ARB medication in the calendar year.
Eligible population (denominator)	All members with diabetes as defined above.
Level of measure	Provider level.
Procedure code to support gap closure	• 3060F – For documentation of positive microalbuminuria test reviewed • 3061F – For documentation of negative microalbuminuria test reviewed • 3062F – For documentation of positive macroalbuminuria test reviewed • 3066F – For documentation of treatment for nephropathy • 4010F – For evidence of ACE/ARB therapy prescribed or taken
Medical record documentation to support gap closure	Documentation in the medical record in support of screening or treatment should include: • Screening for nephropathy via a urine test for albumin or protein. • At minimum, documentation must include a note indicating the date when a urine test was performed and the result or finding. Any of the following meet criteria: 24-hour urine for albumin or protein, timed urine for albumin or protein, spot urine for albumin or protein, urine for albumin / creatinine ratio, 24-hour urine for total protein or random urine for protein/creatinine ratio. • Evidence of medical attention for nephropathy that includes at least one of the following: - Documentation of a visit to a nephrologist. - Documentation of a renal transplant. - Documentation of medical attention for any of the following: Diabetic nephropathy, end stage renal disease, chronic renal failure, chronic kidney disease, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis or hemodialysis or peritoneal dialysis. - Evidence of angiotensin-converting enzyme inhibitor or angiotensin II receptor blocker therapy. • The patient must have received, at minimum, an ambulatory prescription for ACE inhibitors or ARBs in the calendar year.

Diabetes care: Blood Pressure Control	
Description*	The percentage of members with diabetes whose most recent blood pressure during the calendar year is less than 140/90.
Compliant population (numerator)	Members with diabetes with a blood pressure of less than 140/90, using the most recent blood pressure documented during the calendar year.
Eligible population (denominator)	All patients with diabetes as defined above.
Level of measure	Provider level.
Procedure code to support gap closure	Compliant readings: • 3074F – Most recent systolic blood pressure <130 mm Hg • 3075F – Most recent systolic blood pressure 130-139 mm Hg • 3078F – Most recent diastolic blood pressure <80 mm Hg • 3079F – Most recent diastolic blood pressure 80-89 mm Hg Non-compliant readings: (While non-compliant, this will reduce the need to locate readings.) • 3077F – Most recent systolic blood pressure greater than or equal to 140 mm Hg. • 3080F – Most recent diastolic blood pressure greater than or equal to 90 mm Hg.
Medical record documentation to support gap closure	Documentation in the medical record must include the date and result using the distinct blood pressure value. To be compliant, the last documented blood pressure during the calendar year must be less than 140/90.

*Please refer to HEDIS specifications for more detailed information.

Diabetes care: Retinal eye exam	
Description*	The percentage of patients with diabetes who have had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the calendar year. The name of the eye care professional must be on the results or documented in the record. • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the current calendar year.
Compliant population (numerator)	Patients with diabetes who have had one of the following: • At least one retinal eye exam by an eye care professional (optometrist or ophthalmologist) in the calendar year. • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the current calendar year.
Eligible population (denominator)	All patients with diabetes as defined above.
Level of measure	Provider level.
Procedure code to support gap closure	• 2022F – Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed. - May be billed by any provider when they receive the eye exam report from the eye care professional. This can be billed alone. An office visit is not necessary. • 2024F – Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed. • 2026F – Eye imaging validated to match diagnosis from seven standard field stereoscopic photo results documented and reviewed. • 3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year).
Medical record documentation to support gap closure	Documentation in the medical record must include one of the following: • A letter or copy of the eye exam report prepared by an ophthalmologist or optometrist indicating that an ophthalmoscopic exam was completed, the date when the exam was performed and the results. (The letter can also be written by a PCP indicating that a retinal exam was performed, and showing the date of service and results.) • A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (ophthalmologist or optometrist) reviewed the results. • Results in the chart can also be from a qualified reading center that operates under the direction of a retinal specialist.

*Please refer to HEDIS specifications for more detailed information.

Statin use for people with diabetes

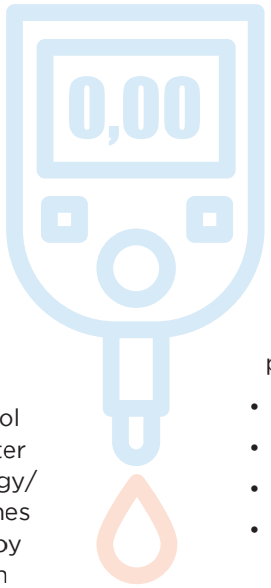
In 2017, the American Diabetes Association recommended that all people with diabetes mellitus take statins. Encouraging patients to take control of risk factors that lower their overall risk for developing heart disease is key. These risk factors include:

- High cholesterol
- High blood pressure
- Being overweight or obese
- Smoking
- A low level of physical activity

Statins are effective and well-tolerated cholesterol lowering medicines that have been linked to better overall health. The American College of Cardiology/ American Heart Association (ACC/AHA) guidelines suggest moderate- to high-intensity statin therapy for primary prevention for people age 40-75 with diabetes (class I recommendation)[1].

Historically, as providers created a treatment plan for their patients with diabetes, they based their decision to prescribe a statin primarily on the patient's LDL value. Now, other risk factors are also considered in this decision. Statins are often recommended for people who have:

- A diagnosis of heart disease
- An LDL cholesterol level of 190 mg/dL or higher
- Diabetes and an LDL of 71 mg/dL or higher
- A 10-year heart attack risk of 7.5 percent or higher and an LDL of at least 100 mg/dL



Star Quality measure

Statin Use for Persons with Diabetes (SUPD) is the newest Centers for Medicare & Medicaid Services (CMS) Part D measure. SUPD is a quality measure that relates to cardiovascular disease and was endorsed by the Pharmacy Quality Alliance (PQA) in 2014. CMS has adopted this measure as a Star Quality measure starting with the 2017 plan year.

When a statin is prescribed, please talk to your patient about:

- Why a statin is so important to reduce risk factors
- Their target levels of LDL cholesterol
- The possible side effects of statins
- How to manage the side effects of statins

[1] 2013 ACC/AHA Prevention Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, a report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines. Circulation 2014;129:S1-S45 https://www.ahajournals.org/doi/abs/10.1161/01.cir.0000437738.63853.7a Accessed 7/24/18.

Introducing the Remote CDI program from Tessellate

We've partnered with Tessellate to administer the Remote Clinical Documentation Improvement (CDI) program, scheduled to kick off in September 2018. Tessellate is a leading provider of risk adjustment and quality solutions for Medicare Advantage Plans.

Remote CDI is an incentive program for providers treating our Medicare Advantage members. The program helps improve risk scores, reduce risk adjustment data validation (RADV), audit risk and increase Star Quality ratings. The Centers for Medicare & Medicaid Services (CMS) requires that chronic medical conditions be documented in the medical record every calendar year.

The CDI Alert form is used by Tessellate to assist providers with appropriate documentation of the patient's medical conditions, according to CMS guidelines. This form includes a list of chronic medical conditions that appears to be present but not addressed in the current calendar year.

In the next few weeks, Tessellate will begin mailing our Medicare Advantage providers an informational packet about the Remote CDI program. The packet will include:

- An introductory letter
- The Remote CDI program overview, further describing the program and information on how to participate
- A sample CDI Alert form
- A provider participation fax form, to be filled out and faxed to Tessellate confirming your participation in the Remote CDI program

Participating providers will receive a **$75 incentive** for each member when:

- A face-to-face office visit is conducted,
- The CDI Alert form is completed, and
- Supporting medical documentation is attached to the CDI Alert form and these documents are returned to Tessellate

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** (M-F, 8 a.m. - 4:30 p.m.)