Medicare Advantage Update
DECEMBER 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**.

CMS begins annual surveys for Blue Cross and Blue Shield of Nebraska Medicare Advantage members

To determine Star ratings, the Centers for Medicare & Medicaid Services (CMS) use results from the Medicare Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

For the first time ever, CMS sent the HOS this year to randomly selected Blue Cross and Blue Shield of Nebraska Medicare Advantage members. The HOS measures patient-reported health outcomes. Members will receive a follow-up survey in two years to assess any changes in their self-reported health status.

In 2019, our Medicare Advantage members will be eligible to receive the CAHPS survey. It measures the patient experience with health plans, providers and health care facilities, and covers the following areas:

- Health care received in the last six months from the member's personal doctor and specialists
- General rating of the quality of health care received
- Experience with the health insurance plan

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Recommendations for improving CAHPS and HOS measures

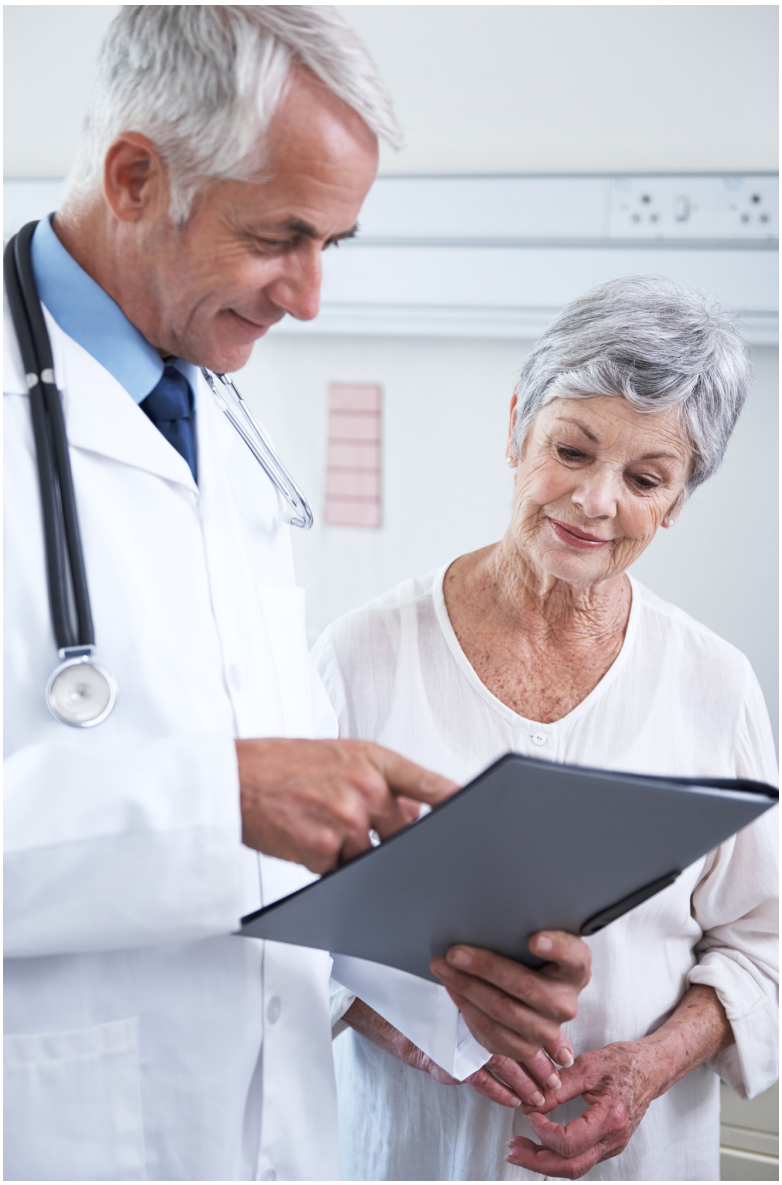
Get ahead of the annual spring surveys with these best practices:

Survey name and measure	Survey question to patient	Recommendation to provider where applicable
CAHPS: Annual flu vaccine	Have you had a flu shot since July 1, 2018?	Administer flu shot after July 1, 2018 and before Feb. 1, 2019.
CAHPS: Getting appointments and care quickly	In the last six months: • How often did you see the person you came to see within 15 minutes of your appointment time? • 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?	• If you are behind schedule, establish an office protocol to update waiting patients. Often, they are more accepting if they are given a chance to reschedule, see a different provider or know the reason for the delay. • Apologize to patients for delays to acknowledge that you value their time. • Keep a few appointments open each day for urgent visits, including post-inpatient discharge visits. • Offer appointments with a nurse practitioner or physician's assistant to patients who want to be seen on short notice. • Ask patients to make routine checkup and follow-up appointments in advance.
CAHPS: Overall rating of health care quality	Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the past six months?	During the visit, ask your patients how they think you could improve their health care. Asking this question can: • Build trusting relationships between you and your patients. • Give your patients the opportunity to discuss positive interactions that you can relay to your staff. • Provide ideas for opportunities to improve upon, if negative feedback is given.
CAHPS: Care coordination	• When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care? • When your personal doctor ordered a blood test, X-ray or other test for you, did someone from your personal doctor's office follow up to give you those results? • Did your personal doctor talk to you about all the prescription medicines you were taking? • Did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • How often did your personal doctor seem informed and up to date about specialist care?	• Before walking in the exam room, read the current complaints and determine if anything needs a follow-up from previous visits. • When ordering tests, let your patients know when they can expect results. Implement a system to ensure timely notifications of results. • Ask your patients if they saw another provider since you last met with them. If you know patients received specialty care, discuss their visit and if the specialist prescribed any additional medication.

Survey name and measure	Survey question to patient	Recommendation to provider where applicable
HOS: Improving or maintaining physical health	• During the past four weeks, has pain stopped you from doing things you want to do? • Have you had any of the following problems with your work or other regular daily activities because of your physical health? ○ Accomplished less than you would like ○ Didn't do work or other activities as carefully as usual	• Thoroughly evaluate the cause of pain and the current treatment plan. • Identify ways to improve the pain problem. • Determine if your patients could benefit from a consultation with a pain specialist or rheumatologist. • Consider physical therapy, cardiac or pulmonary rehab when appropriate.
HOS: Improving or maintaining physical health	• During the past four weeks, has pain stopped you from doing things you want to do? • Have you had any of the following problems with your work or other regular daily activities because of your physical health? ○ Accomplished less than you would like ○ Didn't do work or other activities as carefully as usual	• Thoroughly evaluate the cause of pain and the current treatment plan. • Identify ways to improve the pain problem. • Determine if your patients could benefit from a consultation with a pain specialist or rheumatologist. • Consider physical therapy, cardiac or pulmonary rehab when appropriate.
HOS: Improving or maintaining mental health	Have you had any of the following problems with your work or other regular daily activities because of emotional problems? • Accomplished less than you would like • Didn't do work or other activities as carefully as usual • Didn't have a lot of energy or felt sad or depressed most days	• During the visit, include emotional wellness in your assessment. • Empathize with patients. • Encourage ideas to improve mental wellness, e.g., exercise, socialization, pet interaction, staying involved with family. • Consider therapy with a mental health professional when appropriate. • Consider a hearing test when appropriate as loss of hearing can be isolating.
HOS: Monitoring physical activity	In the past 12 months, did: • You talk with a doctor or other health care provider about your level of exercise or physical activity? • A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?	• Discuss appropriate physical activity with your patients and offer suggestions based on their ability. • Offer ideas for where patients can go to enjoy a variety of exercise options. These also offer opportunities for social interaction.
HOS: Improving bladder control	• In the past six months, have you accidentally leaked urine? • How much of a problem, if any, was the urine leakage for you? • Have you received other treatments for your current leakage problem?	• Integrate the sensitive conversation about bladder control into your conversations with your patients regularly. • When talking to patients, note that urinary leakage problems can be common as we grow older, but there are treatments that can help. This opens the conversation if they are too embarrassed to bring it up. • Do they have leakage problems? Discuss potential treatment options such as medications, exercises and surgery.
HOS: Reducing the risk of falling	• Did you fall in the last 12 months? • Did you talk to your doctor about falling or problems with balance or walking?	Discuss options for your patients to reduce the risk of falling such as: • Using a cane or walker. • Engaging in an exercise or physical therapy program. • Having a vision or hearing test. • Improving home safety.

Are you ready for your Medicare Advantage patients?

With the new year fast approaching, there's a good chance you'll see some new patients or existing patients who are covered under one of the BCBSNE Medicare Advantage insurance plans. To better prepare your office for these patients, we want to share this important information regarding the Welcome to Medicare Preventive Visit and Annual Wellness Visit. If your first patient meeting is not for the Welcome to Medicare Preventive Visit or the Annual Wellness Visit, be sure to schedule one of these appointments.



How many months is a patient who is new to Medicare eligible for the Welcome to Medicare Visit?

The Welcome to Medicare Visit covers a one-time exam within the first 12 months the patient is enrolled in Part B.

What is the CPT code for each visit?

The CPT code for the Welcome to Medicare Visit is G0402. The code for the initial Annual Wellness Visit is G0438 and the code for subsequent visits is G0439.

Can I bill a "Welcome to Medicare" and an "Annual Wellness Visit" in the same calendar year?

No, providers cannot bill both visits in the same calendar year. Only one visit can be billed per calendar year.

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Welcome to Medicare Preventive Visit

This one-time appointment for new Medicare Part B patients is a great way to get up-to-date information on health screenings, immunization records, family and medical history and other preventive care services for your patients.

During this visit you should:

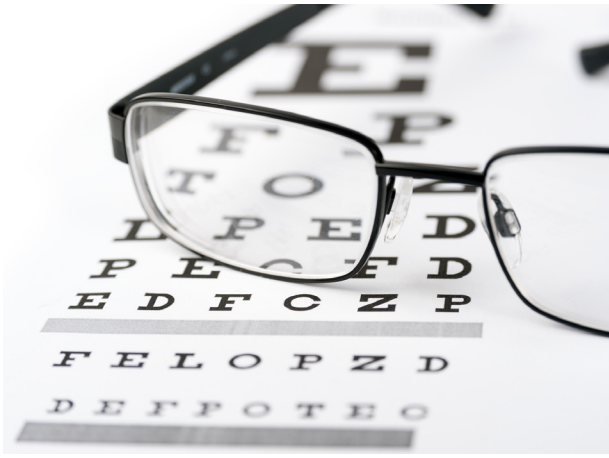
- Record your patient's medical and social history (like alcohol or tobacco use, diet and activity level)
- Check height, weight and blood pressure
- Calculate body mass index (BMI)
- Perform a simple vision test
- Evaluate patient's safety and potential risk for depression
- Offer a discussion on advance directives
- Provide education on preventive services needed and prescribe the necessary services
- Create a a health screening checklist for upcoming preventive services for your patient

Annual Wellness Visit

For Medicare Part B patients who have been covered under their plans for more than 12 months, the Annual Wellness Visit is a chance for you to develop or update their personalized prevention plan based on their current health situation and risk factors.

Services at the Annual Wellness Visit include:

- Health risk assessment
- Review of medical and family history
- Updating a list of current providers and medications
- Height, weight, blood pressure and BMI measurement
- Detection of any cognitive impairment
- Personalized health advice based on risk factors with treatment options
- Education on preventive services needed and prescribing the necessary services
- Updating the health screening checklist for upcoming preventive services



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Both of these visits are excellent opportunities for you to plan the health care your patient needs for the year. Following the health screening checklist developed during these visits will also result in meeting the requirements for HEDIS® (Star clinical quality).

Some examples of preventive services include:

- **Colon cancer screening**
  - o FOBT yearly
  - o Sigmoidoscopy every five years
  - o Colonoscopy every ten years
  - o Cologuard every three years
- **Breast cancer screening**
  - o Mammography every two years
- **Osteoporosis testing in older women**
  - o Bone mineral density testing in women ages 65-85 every two years
- **Comprehensive diabetes care:**
  - o Urine microalbumin screening - yearly
  - o Retinal eye exam – every other year if negative or every year if positive

These visits are also great opportunities to review or create a risk assessment for your patients. This risk assessment includes a complete list of the patient's chronic medical conditions. Your patients can then take advantage of specific disease and care management programs.

This benefits both you and your patient by:

- Uncovering care management opportunities
- Better managing patient medication use
- Reducing avoidable hospital admissions

For more information on risk adjustment and HEDIS best practices, please visit the provider toolkit on nebraskablue.com/providers/medicare-advantage and keep an eye out for coding and documentation tips in this newsletter throughout the year.

Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance.

Reimbursement available for Star measure: conducting medication reconciliation post-discharge (MRP)

The medication reconciliation post-discharge Star measure:

This CMS Star measure assesses patients age 18 and older who were discharged from an acute or nonacute inpatient stay between Jan. 1 and Dec. 1 of the measurement year. It looks at patients whose medications were reconciled from the date of discharge through 30 days after discharge (31 days total).

Medication reconciliation post-discharge reimbursement:

BCBSNE will reimburse providers who conduct medication reconciliation in the outpatient setting **within 30 days** of an inpatient discharge for Medicare Advantage Core and Medicare Advantage Choice members.

When members are discharged from an inpatient stay, schedule a post-discharge office visit as soon as possible and perform medication reconciliation during the visit:

- The outpatient medical record must state that the "current and discharge medications were reconciled"
- Submit a $10 claim for 1111F with the post-discharge office visit claim within 30 days of the discharge
- Medication reconciliation should be performed after every inpatient discharge

1111F is a reporting CPT II code which states, "Discharge medications reconciled with the current medication list in outpatient medical record." In addition to the reimbursement for the office visit, BCBSNE will reimburse providers an additional $10 for billing 1111F within 30 days of the patient's discharge. Conducting medication reconciliation after every discharge is an important step to ensure that medication errors are addressed and patients understand their new medications as well as medications that should no longer be taken.

Medicare Advantage claim filing reminders

In order to ensure that Medicare Advantage claims are processed in a timely manner and in compliance with CMS requirements, please take note of the following guidelines:

- All Medicare Advantage BCBSNE subscriber IDs start with an "N" followed by eight numbers (example: N12345678). The Medicare Advantage Prefix is "YMA".
- Patient Relationship should always be marked as "self."
- If you are submitting a claim for a service such as a lab, ambulance, DME supplier, ambulatory surgical center (ASC), independent diagnostic testing facility (IDTF), etc., or if you are a solo practitioner not associated with a group, you should not include a rendering National Provider Identifier (NPI) on the claim.
- If the rendering provider is part of a group practice organization, enter the group practice organization NPI as the billing provider NPI.
- Billing provider address must be a street address; P.O. Box addresses are not acceptable.
- Medicare Advantage plans are Medicare replacements; therefore, it is not necessary to submit Medicare Advantage claims to Medicare. If you submit claims to Medicare in error, please do not include Medicare remittance advice when subsequently submitting to BCBSNE, as doing so will delay the processing of the claim.

Remittance advices and payments for Medicare Advantage claims are issued separately from other BCBSNE business. Therefore, you will need to work with the dedicated Customer Service team for this product for any questions or issues. They can be reached at 888-505-2022. There are **three ways** to identify a Medicare Advantage payment:

1. It will state "SAPPHIRE EDGE, INC. SUB BCBSNE."
2. The member's policy number begins with the prefix "YMA."
3. If it is an EFT payment, the related check number will begin with a "5." Please note that paper checks will begin with a "4."