Medicare Advantage Update
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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**.

Blue Cross and Blue Shield of Nebraska is an Independent Licensee of the Blue Cross and Blue Shield Association.

Medicare Advantage 2019 preventive and annual wellness visits

You are probably seeing new or existing patients who are covered under one of the Blue Cross and Blue Shield of Nebraska (BCBSNE) Medicare Advantage insurance plans. Please refer to pages 4-6 of the December 2018 Medicare Advantage Update for information about the Welcome to Medicare preventive visit and the annual wellness visit.

The annual wellness visit plays an important role in helping you develop plans to help your patients improve and maintain their health. To encourage BCBSNE Medicare Advantage members to get an annual wellness visit, we are sending them a brochure that promotes the visits. These visits are available to our members at no extra cost to them. The brochure offers members a $50 gift card for completing an annual wellness visit. Your patients will receive the gift card six to eight weeks after we receive the claim for the visit.

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

New HEDIS® specifications for controlling blood pressure measure reduces need for medical record reviews

The Controlling High Blood pressure (CBP) HEDIS® measure has been updated nationally effective Oct. 1, 2018. This measure assesses patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) as of Dec. 31 of the measurement year.

Blood Pressure CPT® Category II codes can be used to establish compliance with this HEDIS measure. When you add the applicable CPT Category II and ICD-10 codes to your BCBSNE patients' claims, we will not need to review medical records to confirm blood pressure values.

To learn more about blood pressure CPT II coding and other measure changes, view this CBP tip sheet.

Questions about HEDIS compliance? Visit our **HEDIS web page** for answers.

Seven-day limit for opioid drugs

Effective Jan. 1, 2019, new policies for Medicare drug plans aim to identify and manage potential opioid overutilization in the Medicare Part D population. The policies consist of improved safety alerts when opioid prescriptions are dispensed at the pharmacy and drug management programs to better coordinate care when chronic high-risk opioid use is present.

Seven-day supply limit for covered persons taking opioids

The opioid seven-day supply hard safety edit limits the initial dispensing to a supply of seven days or less for opioid naïve covered persons. "Opioid naïve" is defined as a lack of any opioid prescriptions (long-acting or short-acting) within our claims system in the previous 90 days.

Opioid rejects can be overridden for the seven-day supply limit when at least ONE of the following is met:

- There is evidence of a claim that the patient is currently being treated with opioid therapy within the past 90 days OR
- The prescriber states the patient is currently being treated with opioid therapy OR
- The patient is being treated for active cancer-related pain OR
- The patient is being treated for sickle cell disease-related pain OR
- The patient is residing in a long-term care facility OR
- The patient is in hospice care or receiving palliative or end-of-life care OR
- The prescriber has provided documentation in support of use of the requested agent for an extended duration (greater than seven days)

When appropriate, the pharmacy may submit the corresponding codes to override the rejection.

For prescriptions written for more than seven days, the covered person's prescribing provider may submit a prior authorization request to have the clinical circumstances reviewed.

Opioid care coordination alert

The Morphine Milligram Equivalent (MME) cDUR hard edit calculates cumulative daily MME across the submitted claim and selected historical claims. The edit includes thresholds for maximum number of prescribing providers and maximum number of pharmacies, which must be exceeded for potential drug misuse to be reported.

If submitting a prescription for a covered person whose calculated daily MME is 90 mg or more and the covered person has utilization from more than two pharmacies and two prescribing providers, the claim will be rejected.

The dispensing pharmacist may consult with the prescribing provider and, if the prescription is deemed appropriate, may enter an appropriate code to allow for claim payment.

Additional Opioid Safety Edits: Opioid Users Taking Duplicate or Key Potentiator Drugs

Additional soft safety edits will alert pharmacists about covered persons taking duplicative therapy or concurrently using opioids and benzodiazepines.

If you have questions regarding this policy, please call your BCBSNE provider executive.

What are CPT® Category II and Z codes?

- CPT Category II codes describe clinical performance measures such as HbA1c or blood pressure values that are usually included in the patient evaluation and management process. CPT category II codes should be entered in the procedure code field similar to CPT Category I codes.
- Z codes are ICD-10 diagnosis codes that influence a patient's health status and contact with health services. Because Z codes represent reasons for encounters, it may not be necessary to submit a BCBSNE member's medical record to validate a certain diagnosis if the appropriate Z code is submitted with the claim.
- Certain CPT II codes and Z codes facilitate data collection for HEDIS measures. Used together, they can give you credit for quality of care without the need for medical record review and can help close gaps.

  To learn more about CPT II and ICD-10 codes, **view this tip sheet.**

HEDIS medical record reviews begin in February

Each year from February through May, BCBSNE performs medical record reviews to collect HEDIS measurement quality data. BCBSNE uses the vendor CIOX to collect data for Medicare Advantage members.

What are HEDIS reviews?

CIOX looks for clinical details that may not have been captured in claims data such as blood pressure readings, HbA1c lab results, colorectal cancer screenings and body mass index. CIOX may contact your clinic to schedule a HEDIS review or request that you fax the necessary medical records to them. We appreciate your assistance with these important reviews. Your cooperation helps us meet our quality goals as we seek to help improve the overall health of our members – your patients.

CIOX® is an independent company that collects medical records used for HEDIS® measurement quality data for Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross and Blue Shield Association.

New prior authorizations for Medicare Advantage HMO and HMO-POS plans

Effective April 1, 2019, prior authorization will be required for the following services for Blue Cross and Blue Shield of Nebraska (BCBSNE) members covered under our Medicare Advantage HMO and HMO-POS plans:

- Durable Medical Equipment (DME) > $500
- Genetic testing
- Experimental/investigational treatment
- Spinal fusion

Providers should contact BCBSNE Medicare Advantage to obtain an authorization before scheduling or performing any of the above services. Authorization requests can by submitted via fax at 866-422-5120 or by calling 877-399-1671 Monday through Friday 8 a.m. CT to 4:30 p.m. CT.

A letter outlining the process and requirements has been mailed to all Medicare Advantage providers.

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

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.).