Medicare Advantage Update
DECEMBER 2019

BlueCross BlueShield Nebraska

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA NebraskaBlue.com

Medicare Advantage Update contains up-to-date information for providers about Medicare Advantage plans with Blue Cross and Blue Shield of Nebraska (BCBSNE).

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, Cassie Wade, at Cassandra.Wade@NebraskaBlue.com.

Please refer to your provider manual often. You may view it at NebraskaBlue.com/MA-Manual.

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.

2020 annual wellness visit

The new year will bring new and existing BCBSNE Medicare Advantage members to your medical practice for their annual wellness visits. These visits play an important role in helping your patients maintain or improve their health. The visits are available at no extra cost to BCBSNE members – and members will receive a $50 gift card for completing a visit.

New in 2020, Medicare Advantage providers will also receive $50 for closing the visit care gap. The types of visits that will close this gap include:

- Physical exam codes
  - 99381 to 99387 and 99391 to 99397
- Wellness exam codes
  - G0438, G0439
- Welcome to Medicare exam code
  - G0402

The Centers for Medicare and Medicaid Services (CMS) requires one year and one day between annual wellness visits. Please schedule your Medicare Advantage patients' annual wellness visits accordingly.

In this issue

2020 annual wellness visit	1
The importance of measuring body mass index	2
Medicare Advantage prior authorization requests	2
Annual surveys for Medicare Advantage members	3
Management of rheumatoid arthritis and osteoporosis to limit disability	3

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 (NCQA).

The importance of measuring body mass index

An easy first step to help determine if a patient is overweight is to measure the patient's body mass index (BMI), or percentage of body fat.

Measuring BMI is important to identify increased risk of morbidity and mortality. Weight loss can help with reduction in obesity-related morbidity. Without screening, many high-risk patients may not receive counseling about health risks, lifestyle changes, obesity treatment options and risk factor reduction, such as weight loss.

The HEDIS Adult BMI Assessment (ABA) assesses adults ages 18 to 74 who have had their BMI documented during an outpatient visit in the past two years. BMI documentation is commonly missed, which results in not meeting this quality measure.

BMI classifications are based on risk of cardiovascular disease. Please refer to the ABA tip sheet for patient education talking points and ICD-10 codes to include on claims.

Medicare Advantage prior authorization requests

Contact BCBSNE Medicare Advantage to obtain authorization before scheduling or performing services that require prior authorization.

Prior authorization requests for all Medicare Advantage plans may be submitted by fax at **866-422-5120** or by calling **877-399-1671** Monday through Friday 8 a.m. to 4:30 p.m. CT. The services listed below require prior authorizations:

- Acute hospital admissions
- 30-day bundling for readmission
- Post-acute admissions
- Part B medication
- Durable medical equipment > $500
- Genetic testing
- Investigational treatment
- Spinal fusion

The Access PPO plan has additional prior authorization requirements which include:

- Spinal fusion/pain management
- High tech radiology
- Intensity-modulated radiation therapy/stereotactic body radiation therapy

The Core (HMO) and Choice (HMO-POS) plans have additional prior authorizations which include:

- Spinal fusion/pain management
- High tech radiology
- Intensity-modulated radiation therapy/stereotactic body radiation therapy

New prefix for Medicare Advantage members

With the introduction of a PPO plan for Jan. 1, 2020, when submitting claims, remember to include the new prefix that's show on the member's ID card. This will help ensure prompt payment. The two prefixes are:

- YMA for the Core (HMO) and Choice (HMO-POS) plans
  - Member ID example: YMAN12345678
- Y2M for the Access (PPO) plan
  - Member ID examples: Y2MN12345678 or Y2M012345678

Prior authorizations for these services may be requested through the AIM portal or by calling **866-745-3265**.

Annual surveys for Medicare Advantage members

CMS uses member survey results from the Medicare Health Outcomes Survey (HOS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to rate Medicare Advantage health plans.

The HOS survey is sent to randomly selected BCBSNE Medicare Advantage members and 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 the following areas:

- Physical health
- Maintaining mental health
- Bladder control
- Risk for falls

Medicare Advantage members may also receive the CAHPS survey. This survey measures the patient's perception of access to care from their health plan, their primary care and specialty care providers and health care facilities. This survey asks questions about 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 their health insurance and prescription drug plan

Here are 10 practical ways you can impact your patients' perception of access to timely care:

1. Make patients feel welcome in your practice.
2. Ensure patients receive appointments within acceptable time frames.
3. Maintain adequate staffing levels.
4. Be courteous and helpful.
5. Validate your patients' understanding of their health condition(s) and the service(s) required for maintaining a healthy lifestyle.
6. Educate patients during each visit about their preventive health care needs and disease management goals.
7. Provide clear directions and thorough explanations.
8. Ensure the patient understands your answers to their questions.
9. Try to see your office as the patient might see it.
10. Try to identify system and flow problems.

Management of rheumatoid arthritis and osteoporosis to limit disability

Musculoskeletal conditions are the second largest contributor to disability, according to the World Health Organization. HEDIS quality measures related to musculoskeletal diagnoses are:

- Disease-modifying anti-rheumatic drug therapy (DMARD) for rheumatoid arthritis (ART).
  - This HEDIS quality measure assesses patients 18 years of age and older who were diagnosed with rheumatoid arthritis and filled at least one ambulatory prescription for a DMARD.
- Osteoporosis management in women who had a fracture (OMW).
  - This HEDIS quality measure assesses women 67-85 years of age who suffered a fracture and had either a bone mineral density test or received a prescription to treat osteoporosis within six months of the fracture.

Please review the ART tip sheet and the OMW tip sheet to learn more about these measures, required medical record documentation and ICD-10 codes to include on claims.

If you have questions or would like more information about the articles in this newsletter, please contact your Provider Executive at **877-435-7258** 8 a.m. to 4:30 p.m. CT, Monday through Friday.