Medicare Advantage Update
FEBRUARY 2020

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).

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.

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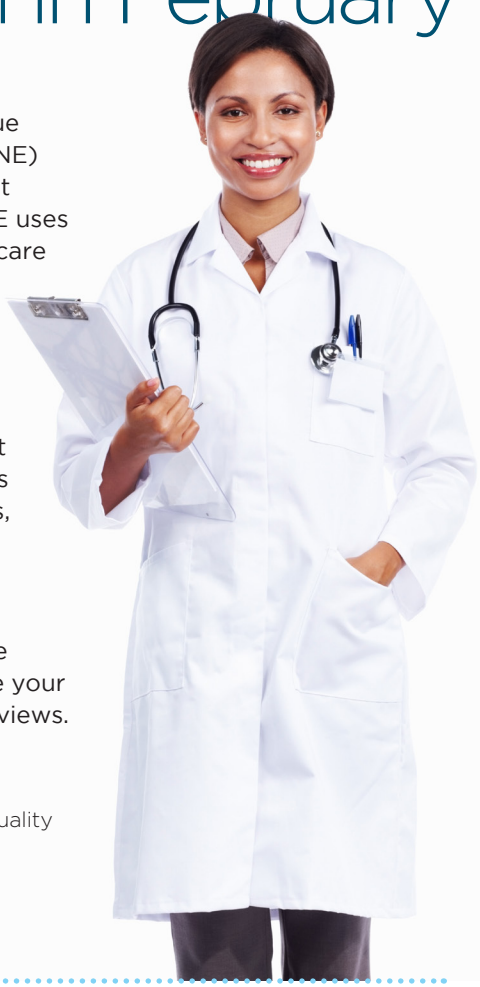
HEDIS® medical record reviews begin in February



Each year from February through May, Blue Cross and Blue Shield of Nebraska (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 medical record 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 records to them. We appreciate your assistance with these important quality reviews.

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

In this issue

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).

2020 HEDIS advanced illness and frailty exclusions guide

In 2018, the National Committee for Quality Assurance (NCQA) allowed additional exclusions to HEDIS star quality measures for patients with advanced illness and frailty.

Services measured by NCQA may not benefit older adults with limited life expectancy and advanced illness. Also, unnecessary tests or treatments could burden these patients or even be harmful.

This guide includes billing codes for:

- Advanced illness exclusions
- Dementia medication
- Frailty exclusions

Use of HEDIS approved billing codes can substantially reduce medical record requests for HEDIS data collection purposes.

Codes must be billed in the measurement year or the year prior, to exclude the patient from the star quality measures in the table below.

Patients age 66 and older can be excluded if they have BOTH advanced illness and frailty	Patients age 81 and older can be excluded with frailty ALONE
• Breast Cancer Screening (BCS) • Colorectal Cancer Screening (COL) • Controlling Blood Pressure (CBP) • Osteoporosis Management in Women Who Had a Fracture (OMW) • Comprehensive Diabetes Care (CDC) • Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) • Statin Therapy for Patients with Cardiovascular Disease (SPC)	• Controlling Blood Pressure (CBP) • Osteoporosis Management in Women Who Had a Fracture (OMW) • Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Advanced illness	
ICD-10 code	**Definition**
F10.96	Alcohol-induced persisting amnestic disorder
G30.0, G30.1, G30.8, G30.9	Alzheimer's disease
G10	Huntington's disease
G12.21	Amyotrophic lateral sclerosis
G20	Parkinson's disease
G31.01	Pick's disease
I09.81, I11.0, I13.0, I13.2, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9	Heart failure
I12.0, I13.11, I13.2, N18.5	Chronic kidney disease, stage five
I50.1	Left ventricular failure, unspecified
J43.0, J43.1, J43.2, J43.8, J43.9, J98.2, J98.3	Emphysema
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J84.10, J84.112, J84.17	Pulmonary fibrosis

Advanced illness	
ICD-10 code	**Definition**
J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J96.90, J96.91, J96.92	Respiratory failure
K70.10, K70.11, K70.2, K70.30, K70.31, K70.40, K70.41, K70.9	Alcoholic hepatic disease
K74.0, K74.1, K74.2, K74.4, K74.5, K74.60, K74.69	Hepatic disease
L89.0-9	Pressure ulcer
N18.6	End stage renal disease

Dementia medications	
Description	**Prescription**
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine

Frailty	
CPT II code	**Definition**
99504	Home visit for mechanical ventilation care
99509	Home visit for assistance with activities of daily living and personal care

Frailty	
HCPCS code	**Definition**
E0100, E0105	Cane
E0130, E0135, E0140, E0141, E0143, E0144, E0147-9	Walker
E0163, E0165, E0167-71	Commode chair
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-7, E0301-4	Hospital bed
E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-4	Oxygen
E0462	Rocking bed with or without side rails
E0465, E0466	Home ventilator
E0470-2	Respiratory assist device
E0561, E0562	Humidifier used with positive airway pressure device
E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295-8	Wheelchair
G0162, G0299, G0300, G0493, G0494	Skilled RN services related to home health/hospice setting
S0271	Physician management of patient home care, hospice
S0311	Management and coordination for advanced illness
S9123, S9124, T1000-5, T1019-22, T1030, T1031	Nursing, respite care and personal care services

Frailty	
ICD-10 code	**Definition**
L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90	Pressure ulcer
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified state
M62.81	Muscle weakness (generalized)
M62.84	Sarcopenia
R26.0	Ataxic gait
R26.1	Paralytic gait
R26.2	Difficulty in walking, not elsewhere classified
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R41.81	Age-related cognitive decline
R53.1	Weakness
R53.81	Other malaise
R53.83	Other fatigue
R54	Age-related physical debility
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight
R64	Cachexia
W01.0XXA – W01.198S W06.XXXA – W10.9XXS W18.00XA – W19.XXXS	Fall
Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
Z59.3	Problems related to living in residential institution
Z73.6	Limitation of activities due to disability
Z74.01	Bed confinement status
Z74.09	Other reduced mobility
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z91.81	History of falling
Z99.11	Dependence on respirator (ventilator) status
Z99.3	Dependence on wheelchair
Z99.81	Dependence on supplemental oxygen
Z99.89	Dependence on other enabling machines and devices

HEDIS® quality measure changes

In October 2019, the National Committee for Quality Assurance (NCQA) released value set changes for the following HEDIS® quality measures:

- Comprehensive Diabetes Care (CDC): HbA1c control
- Comprehensive Diabetes Care (CDC): Retinal eye exam
- Controlling High Blood Pressure (CBP)

Important changes

CDC: HbA1c control

- Two new codes, 3051F and 3052F, were added to better capture HbA1c values.
- Code 3045F (HbA1c level 7.0–9.0%) should no longer be used.
- Submit the HbA1c value on the claim with the appropriate CPT® II code:

CPT® II Code	Most recent HbA1c value
3044F	<7%
3051F	>7% and <8%
3052F	>8% and <9%
3046F	>9%

CDC: Retinal eye exam

- One new procedure code, 2023F, was added to capture negative eye exam results.
- The code descriptor for 2022F was revised to indicate its use for a positive eye exam.
- Submit the results on a $0.01 claim with the appropriate CPT II code:

CPT® II Code	Retinal eye exam findings
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy**
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **without evidence of retinopathy**
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

CBP: Controlling high blood pressure

- The measure has been revised to allow for administrative closure of quality care gaps through claims.
- Submit the appropriate blood pressure CPT II codes on the claim for each patient encounter.

CPT® II Code	Most recent systolic blood pressure
3074F	<130 mm Hg
3075F	130-139 mm Hg
3077F	≥ 140 mm Hg
CPT® II Code	**Most recent diastolic blood pressure**
3078F	<80 mm Hg
3079F	80-89 mm Hg
3080F	≥ 90 mm Hg

For more information about the CDC and CBP HEDIS quality measures, please refer to the 2020 CDC quality tip sheet and 2020 CBP quality tip sheet.

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HEDIS® measures: Health Outcomes Survey

The Medicare Health Outcomes Survey (HOS) measures patient-reported outcomes for two functional health measures and three HEDIS Effectiveness of Care measures:

- Fall risk management
- Management of urinary incontinence in older adults
- Physical activity in older adults
- Improving or maintaining mental health
- Improving or maintaining physical health

This survey, which runs from April to July, asks randomly selected Medicare Advantage members questions about how providers discuss these important topics with them.

Please review the HOS tip sheet to learn more about the survey questions and how you can address care opportunities with your patients.

New modifiers to identify occupational therapy and physical therapy services provided by a therapy assistant

Effective Jan. 1, 2020, the Centers for Medicare & Medicaid Services (CMS) has established two modifiers, CQ and CO, to be used for services furnished in whole or in part by a physical therapy assistant (PTA) and occupational therapy assistant (OTA).

Place the modifier on the claim line of service alongside the respective GP or GO therapy modifier to identify PTA and OTA services furnished under a PT or OT plan of care. The modifiers are defined as follows:

CQ modifier: Outpatient physical therapy services furnished in whole or in part by a PTA

CO modifier: Outpatient occupational therapy services furnished in whole or in part by an OTA

When practitioners paid under the physician fee schedule (PFS) submit professional claims, the CQ/CO modifiers apply only to services of physical and occupational therapists in private practice (PTPPs and OTPPs). The modifiers do not apply to therapy services furnished by or incident to the services of physicians or nonphysician practitioners (NPPs), including nurse practitioners (NPs), physician assistants (PAs) and clinical nurse specialists (CNSs). This is because PTAs and OTAs do not meet the qualifications and standards of physical or occupational therapists, as required by §§ 410.60 and 410.59, respectively.

When providers paid at the PFS rate submit institutional claims for their outpatient PT and OT services, the CQ and CO modifiers apply to the following: outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities (CORF).

However, the CQ and CO modifiers are not applicable to claims from critical access hospitals because they are paid on a reasonable cost basis or from other providers for which payment for OT services is not made under the PFS rates. The CQ modifier must be paired to the GP therapy modifier and the CO modifier with the GO therapy modifier. Claims not paired will be rejected/returned.

The below table illustrates acceptable use of CQ and CO modifier on claims for PT and OT services. Such PT and OT services shall not be considered duplicates by the contractors.

Code	Therapy modifier	Service unit	Assistant modifier
97110	GP	1	
97110	GP	1	CQ
97535	GP	1	
97535	GP	1	CQ
97530	GO	1	
97530	GO	1	CO

For additional information, visit the online CMS Manual System.

Medicare Advantage 2020 preventive and annual wellness visits

The welcome to Medicare preventive visit and the annual wellness visit play an important role in helping you develop personalized plans to help your patients improve and maintain their health.

To encourage BCBSNE Medicare Advantage members to get either a welcome to Medicare visit or an annual wellness visit, we are sending them a brochure that promotes these visits. The brochure offers members a $50 gift card for completing a welcome to Medicare visit, an annual wellness visit or a routine physical exam. Your patients will receive the gift card six to eight weeks after we receive the claim for the visit.

The Centers for Medicare & Medicaid Services (CMS) requires one year and one day between two consecutive annual wellness visits.

Please use the billing codes listed below, as appropriate, when submitting a claim.

When a patient schedules an appointment, please note that they may refer to the:

- Annual wellness visit as a yearly wellness visit.
- Routine physical exam as an annual physical exam.

Welcome to Medicare visit – $0 patient copay
Or Initial Preventive Physical Examination (IPPE)

G0402 – Within first 12 months of Medicare Part B coverage (once per member lifetime)

Annual wellness visits (AWV) – $0 patient copay
Or Personalized Prevention Plan of Service (PPPS)
(Also referred to as the yearly wellness visit)

- G0438 – First AWV (once per member lifetime)
- G0439 – Subsequent AWV

Note: G0438 or G0439 cannot be billed within 12 months of:

- A G0402 (IPPE) billing
- The last recorded G0438 or G0439

Routine physical exam – $0 patient copay
(Also referred to as the annual physical exam)

- New patient (once per calendar year):
  - 99386 (ages 40-64)
  - 99387 (age 65 and older)
- Established patient (once per calendar year):
  - 99396 (ages 40-64)
  - 99397 (age 65 and older)

Service can be billed along with the welcome to Medicare visit or AWV via Modifier - 25.

Best practices for documenting diabetes mellitus related complications

Diabetic patients may develop complications due to disease progression. Specific documentation to accurately capture the patient's current clinical status is very important.

For example:

- Diabetic nephropathy can be documented as:
  - Diabetic nephropathy **with** diabetes
  - Diabetic nephropathy **and** diabetes
  - Diabetic nephropathy **related to** diabetes

When a complication is not due to diabetes, be sure to document the disease to which it is related.

For example:

- CKD stage three related to hypertension

When documenting the clinic encounter, please record the diabetic complication even if you are not the one following the complication.

For example:

- Diabetic retinopathy, patient follows with ophthalmologist

The documentation of "uncontrolled diabetes" is no longer specific enough for accurate code assignment. Instead, the presence of "hyperglycemia" or "hypoglycemia" must be specified.

For additional information, please review the commonly captured HCC codes document.

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.