Medicare Advantage Update
AUGUST 2020

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**.

Encouraging Medicare Advantage patients to complete their annual wellness visits

As health care evolves during these challenging times, Blue Cross and Blue Shield of Nebraska (BCBSNE) encourages providers to reach out to BCBSNE Medicare Advantage patients to remind them of their options for completing their annual wellness visit. This benefit is free to your patients, and they may choose to schedule their appointment as:

- A traditional face-to-face visit in your office.
- An online telehealth visit using a smartphone, computer or tablet with audio and video capability.
- A telephone-only visit for patients who do not have video capability.

Providers are eligible to receive a $50 annual wellness visit incentive from BCBSNE when their patients complete their visit.

This incentive applies to only one attributed patient per visit per provider, no matter if the visit is conducted in-person, virtually or over the phone. Use CPT **code G0438** for all three options.

If you have any questions about the annual wellness visit, please contact your BCBSNE Provider Executive.

In this issue

BCBSNE contracts with Quest HealthConnect™ to provide in-home and virtual health assessments

BCBSNE has contracted with Quest HealthConnect™ , a Quest Diagnostics service, to provide in-home and virtual health assessments to our Medicare Advantage members. These health assessments are offered as part of our members' benefits and are optional.

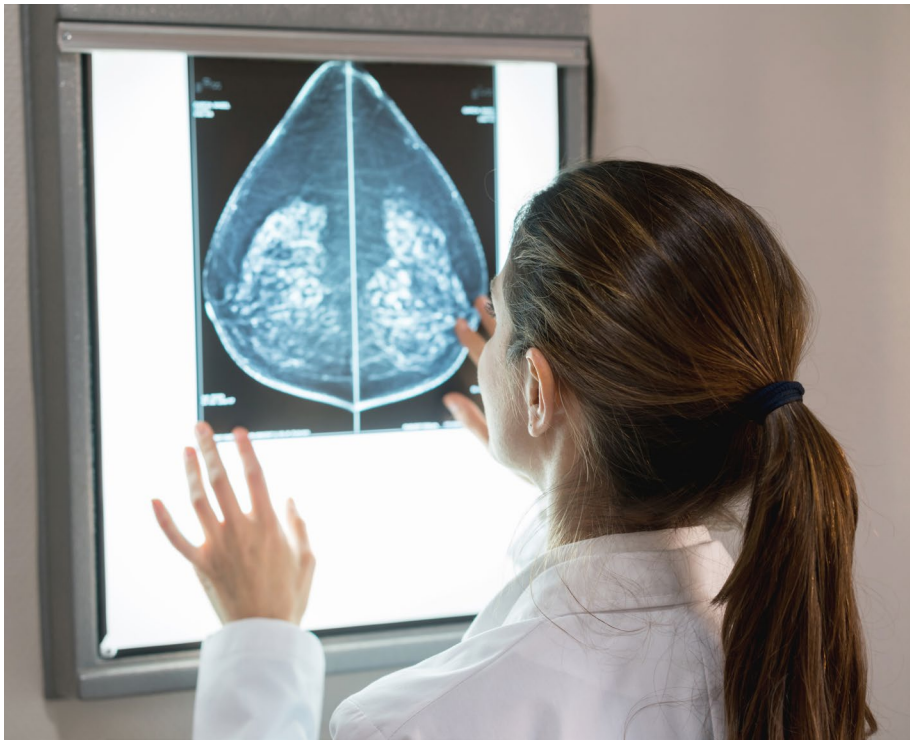
The Quest HealthConnect visit doesn't replace the care you provide, the member's annual wellness visit or any other appointments with you.

During the visit, Quest HealthConnect gathers current information about each patient's clinical status and documents existing medical conditions. A licensed Quest HealthConnect physician, nurse practitioner or physician assistant will perform the in-home assessment, which includes a medical history review and a brief physical exam. The visiting health care professional will not write prescriptions, make referrals or treat any medical conditions. They will provide identification to the member at the time of the visit. Virtual health assessments will be conducted through telehealth. Members must have a device with audio and video capability to choose this option.

We will share the health assessment findings with you and encourage you to consider placing the assessment in your patient's medical record. If your patient needs immediate follow-up care, the Quest HealthConnect professional will alert your office during the visit.

Education, behavior modification and early detection

Quest HealthConnect connects members, providers and health insurers.



Colorectal cancer is the second leading cause of cancer death for both men and women, and breast cancer is the second leading cause of cancer death in women in the United States[1].

Encourage your Medicare Advantage patients to

get screened for colorectal and breast cancers

Screening, early detection and treatments are effective for reducing deaths from these cancers. For members who are hesitant to pursue a colonoscopy, alternative options for colorectal cancer screening are now available.

The HEDIS® Colorectal Cancer Screening measure is used by the Centers for Medicare & Medicaid Services (CMS) as a star rating measure. CMS and HEDIS guidelines recommend that appropriate screenings be completed for Medicare Advantage members ages 50 to 75.

The HEDIS® Breast Cancer Screening measure is used by CMS as a star rating measure also. CMS and HEDIS guidelines recommend that routine mammogram screenings be completed every 24 months for women ages 50 to 74.

The National Committee for Quality Assurance (NCQA) excludes members with advanced illness and frailty from the HEDIS star quality measures. NCQA acknowledges that preventive services most likely would not benefit such patients.

For more information on the details of these measures, documentation to be included in the patients' medical record, CPT codes and tips for talking with patients, please view the Colorectal Cancer Screening and Breast Cancer Screening tip sheets.

[1] cancerstatisticscenter.cancer.org

Avoid coding confusion

Proceed with caution when documenting the terms "History of" for reporting a current condition

Coding current conditions as "History of" can cause confusion for both the health care and the coding professional. In order to avoid missed opportunities in reporting hierarchal condition codes (HCC) for risk adjustment, specific documentation is key to clarifying if a medical condition is part of a member's past or a current problem.

Risk adjustment coding requires health care professionals and coding professionals to work together to capture the health status of their members.

The health care professional must ensure that documentation demonstrates medical conditions are being monitored, evaluated, assessed and/or treated. Risk adjustment coding professionals must follow best-practice guidelines to ensure accurate coding and reporting of HCCs. Working together ensures compliance and optimal financial results under HCC risk adjustment models.

The past medical history of a member is important and often influences medical decision making when it comes to the member's plan of care, diagnostic testing, treatments or biologicals.

To avoid confusion, it is critical for the health care professional to distinguish between a condition that no longer exists from one that is current/active to enable the coder to extract the proper diagnosis for risk adjustment.

By coding definition, "History of" indicates a condition occurred in the past that has been **resolved and no longer exists**. In other words, the patient is not receiving any type of treatment.

For example, history of congestive heart failure (CHF) means the member used to have heart failure but has since undergone a heart transplant or other procedure and no longer has CHF.

If the member is on medication chronically, they have active, chronic CHF.

Instead of documenting:	Document with more specificity, such as:
History of CHF	Compensated CHF, stable with Lasix
History of diabetes	Member with Type 2 diabetes mellitus since 2005
History of rheumatoid arthritis (RA)	RA since 2010, follows their doctor's orders

It is always best practice to be as specific as possible when documenting. Indicate if a condition is acute, recurrent, chronic, acute on chronic or in remission and include a date of onset if known. Coders are unable to make assumptions regarding the acuity of a condition; it must be explicitly stated in the medical record documentation by the health care professional. This level of detail will enable the health care professional and coder to work together toward the goal of accurate coding and provide a true picture of the member's overall health.

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.