Medicare Advantage Update

DECEMBER 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**.

Happy Holidays!

Thank you for your continued partnership as you care for our Medicare Advantage members during this particularly difficult year. You are truly appreciated.

BCBSNE wishes you, your families and staff a happy and healthy holiday season!

In this issue

What Providers Need to Know

COVID-19 Vaccinations for Medicare Advantage Members

Billing Requirements

Through 2021, Medicare payment for the COVID-19 vaccine and its administration will be made through the original fee-for-service Medicare program for members enrolled in Medicare Advantage plans. This means if you administer the vaccine to a Blue Cross and Blue Shield of Nebraska (BCBSNE) Medicare Advantage member, you must bill the Medicare Administrative Contractor, not BCBSNE.

If you are currently enrolled as a Medicare provider, it's likely you can bill your Medicare Administrative Contractor for Medicare Advantage members without further action. Some providers currently enrolled in Medicare but excluded from billing for administering vaccines will need to enroll as a Mass Immunizer. If you are not enrolled as a Medicare provider, you will need to enroll as a Mass Immunizer to bill the Medicare Administrative Contractor for BCBSNE Medicare Advantage members. Find more information on the Centers for Medicare & Medicaid Services (CMS) website.

Cost to Members

Medicare Advantage beneficiaries will pay nothing for the COVID-19 vaccine; their copayment/coinsurance will be waived.

Notes

You must record details of the COVID-19 vaccination into your system of record within 24 hours and into the applicable public health system within 72 hours.

For vaccines that require multiple doses, communicate to your patients to get both doses of the same vaccine.

Additional Resources

- COVID-19 information from CMS
- COVID-19 vaccine Information from CMS
- COVID-19 information from BCBSNE

2021 Medicare Advantage

Preventive and Annual Wellness Visits

The new year will bring new and returning BCBSNE Medicare Advantage members to your medical practice for their annual wellness visits. Annual wellness visits play an important role in developing plans to help your patients maintain and improve their health. These visits are available to BCBSNE members at no cost, and members will receive a $50 gift card for completing them.

Annual wellness visits will continue to be included on the provider's monthly member level detail gap report.

The types of annual wellness visits that will close this gap include:

- Welcome to Medicare exam
- Annual wellness exam
- Physical exam

CMS requires a gap in time of one year and one day between two consecutive annual wellness visits. Please remember to schedule your patient's next annual wellness visit accordingly.

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

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)

(Include telehealth coding information when applicable – adding POS 02/Modifier 95 to the CPTII code)

Annual wellness visit (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

(Include telehealth coding information when applicable – adding POS 02/Modifier 95 to the CPTII code)

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)

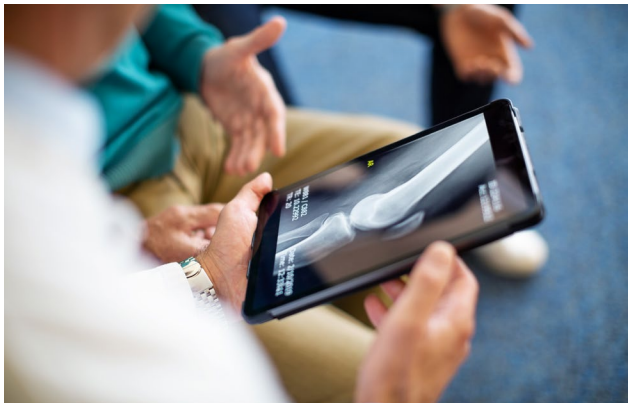
- New patient (once per calendar year):
  - 99386 (ages 40-64)
  - 99387 (age 65 and older)
- Established patient (once per calendar year):
  - 99396 (ages 40-64)
  - 99397 (age 65 and older)

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

Servicing Change to Plan Radiology and Pain Management Preauthorizations

Starting Jan. 1, 2021, AIM Specialty Health will review all Medicare Advantage radiology and interventional pain management preauthorizations. Until now, Medicare Advantage HMO plans have been handled through AIM, and in the new year, all PPO plans will also follow this same process.

Authorization requests can be submitted on the AIM provider portal or by calling 866-745-3265 Monday through Friday 8:00 a.m. to 5:00 p.m. CT. All other authorizations should be requested via fax at 866-422-5120 or by calling 877-399-1671, Monday through Friday 8:00 a.m. to 4:30 p.m. CT.



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 disease-modifying DMARD.

Osteoporosis management (OMW) in women who had a fracture

This HEDIS quality measure assess 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 view 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.

.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Annual Surveys

for Medicare Advantage Members

The Centers for Medicare & Medicaid Services (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 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. CMS is placing increased emphasis on the patient experience with their health care providers and their health plan. 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 drug plan

10 Ways to Impact Your Patients' Experience

- Make your practice look and feel engaging. Patients will judge your practice before they even meet you
- Ensure patients receive appointments within acceptable timeframes
- Maintain adequate staffing levels
- Be courteous and helpful
- Validate your patients' understanding of their health condition(s) and the service(s) required for maintaining a healthy lifestyle
- Educate patients during each visit about their preventive health care needs and disease management goals
- Improve communication by providing clear directions and thorough explanations
- Listen to your patients' questions and ensure patients understand your answers to their questions
- Try to see your office as the patient might see it
- Identify system and flow problems

Renal Insufficiency vs. Chronic Kidney Disease in Risk Adjustment

Renal insufficiency is a generic term not specific enough for risk adjustment. Health care professionals must be specific in documenting and coding kidney disease, as it is essential for compliance. Please use the following tips.

Chronic kidney disease (CKD) is defined as an abnormality of kidney structure, or glomerular filtration rate (GFR) of 60 or less that is present for greater than at least three months (90 days). GFR is the benchmark test used in the diagnosis of kidney disease and measures its stage through simple lab testing.

Kidney disease increases a member's risk for other comorbidities, such as heart disease or stroke. It is critical that members with CKD see their doctor on a regular basis to monitor and manage this condition.

Members who have hypertension or diabetes mellitus, or who are overweight or smoke, are at a higher risk for CKD. There are many consequences of CKD, which can be severe, such as:

- Hyperparathyroidism
- Anemia
- Fluid overload
- Hypertensive CKD
- Heart disease
- Hyperkalemia

Coding professionals are not able to abstract the stage of kidney disease based on GFR lab results alone, making it imperative for the health care professional to clearly document the actual stage (one to five) of kidney disease or end stage renal disease (ESRD).

ICD-10 CM assumes a causal relationship between CKD and several associated conditions. When both are present, it is appropriate to link the conditions using combination codes, such as in the examples below.

Diabetes with CKD =
E11.22 + N18.XX (Stage of CKD)

Hypertension with CKD =
i12.XX + N18.XX (Hypertensive CKD)

Hypertension with heart disease and CKD =
i13.XX + I50.XX+ N18.XX (Hypertensive Heart and CKD)

For members with ESRD, remember to document the presence of arteriovenous shunt for dialysis, type of dialysis, the level of compliance and any complications the member may experience. If a member has had a kidney transplant, document the transplanted kidney status as Z94.0.

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.