Medicare Advantage Update
OCTOBER 2021

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**.

Our customer service representatives are available 8 a.m. to 9 p.m. (CT) Monday through Sunday from Oct. 1 through March 31 and 8 a.m. to 9 p.m. (CT) Monday through Friday from April 1 to Sept. 30. Call 888-488-9850 for assistance.

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

Member satisfaction survey results

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, conducted annually, asks members about their experiences with our health care plan, drug plan, providers, health care facilities, changes to their health over time and their experience with the medical treatment they receive. BCBSNE contracts with an external company to conduct the CAHPS survey, which was mailed to 1,600 members earlier this year. Here is what they said:

Survey measure	BCBSNE 2021 Results	2021 Benchmark
Rating of Personal Doctor	92%	91%
Doctors Who Communicate Well	92%	91%
Rating of Health Plan	86%	88%
Rating of Drug Plan	85%	87%
Getting Care Quickly	83%	79%
Getting Needed Care (tests, necessary treatment)	86%	83%
Getting Needed Prescription Drugs	92%	91%
Health Plan Customer Service	91%	91%
Care Coordination (office followed up with test results, etc.)	88%	85%
Received Annual Flu Vaccine	81%	75%
Received Pneumonia Vaccine	78%	71%

Thank you for your partnership in caring for our members. We're pleased to share we met or exceeded benchmarks in nine out of the 11 measures.

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). 92-221 (10-11-21)

New preauthorization requirements for 2022:

The following preauthorizations will be added, effective Jan. 1, 2022:

- BiPAP and oral appliances
- Drug-eluting sinus stents
- Neurostimulators
- Skin substitutes
- Mobile cardiac telemetry and loop recorders
- Negative pressure wound therapy
- Peripheral nerve ablation
- Patient-specific cutting guides and custom knee implants
- Computer-assisted musculoskeletal surgical navigational orthopedic procedures

For the most up-to-date list of required medical and Part B Drug preauthorizations, visit NebraskaBlue.com/Providers. Please call 888-488-9850 if you have any questions.

Also, starting Jan. 1, 2022, Durable Medical Equipment (DME) that requires preauthorization will be specifically listed on the preauthorization list rather than using the $500 threshold for DME.

Reminders sent to members

Reminders have gone out to our Medicare Advantage members with open care gaps, encouraging them to schedule an appointment with their provider for their annual preventive services.

Security Corner: Identifying sensitive assets

It's important to identify and protect the tools at your clinic that contain sensitive information. Make a list of equipment, software and data that you use—including laptops, tablets, smartphones and even point-of-sale devices, such as a credit card processor.

Anyone who works with these items should understand your clinic's security policy, including:

- Roles and responsibilities for employees, vendors and anyone else with access to these items
- Steps to take to protect against an incident and to limit the damage if one does occur
- How your information technology and technical partners work to keep these assets secure

Encourage eligible Medicare Advantage patients to get

screened for colorectal cancer

Colorectal cancer is the third-leading cause of cancer death for both men and women in the United States, according to Cancer.org. Screening, early detection and treatments are effective at reducing deaths from this cancer.

The HEDIS® Colorectal Cancer Screening measure assesses patients ages 50–75 who had appropriate screenings for colorectal cancer.

Colonoscopy is the gold standard for colorectal cancer screening. There are alternative options for patients who are hesitant to have one.

The Colorectal Cancer Screening tip sheet provides more information about this measure, including documentation to include in medical records, codes for patient claims and tips for talking with patients.

Improve diabetic patient health

while reducing medical record reviews

The HEDIS® Comprehensive Diabetes Care measure provides a picture of the clinical management of diabetic patients. All comprehensive diabetes care measures are used for HEDIS reporting, which the Centers for Medicare & Medicaid Services (CMS) uses as a star-rating measure to drive improvements in patient health.

Patients with diabetes require consistent medical care and monitoring to reduce the risk of severe complications and improve health outcomes. Interventions to improve diabetes outcomes go beyond glycemic control. That is why the comprehensive diabetes care composite measure includes HbA1c control, retinal eye exams, medical attention for nephropathy and blood pressure control.

Please review the Comprehensive Diabetes Care tip sheet to learn more about what is included in the measure, new exclusions, including advanced illness and frailty, and ways you can close gaps in care for patients with diabetes. The tip sheet also covers required medical record documentation and claims coding to reduce the need for medical record reviews.

How to code for breast cancer

Cancer is a chronic condition that is often coded inaccurately. In honor of Breast Cancer Awareness Month, we're sharing how to accurately code the condition and thank you for the care you provide our members battling this disease.

Providers who are treating breast cancer may see the member in follow up many times throughout treatment and recovery, as testing may be done after treatment and may occur for many years thereafter.

Risk adjustment code capture for breast cancer follows the official coding guidelines. Documentation by the health care provider must show current presence of disease to code an active cancer diagnosis and must show evidence of current or ongoing treatment. There is a distinct difference between a member on active treatment versus a member who no longer has evidence of disease (NED).

Breast cancer should be actively coded when:

- The member is receiving active treatment
- The breast cancer has reoccurred
- The member elects not to treat breast cancer
- The member/health care provider chooses not to treat or selects palliative care

Clear and detailed documentation of the member's cancer by the health care provider is needed for true and accurate reporting. Documentation should include the following:

- Location of cancer cell type, or behavior
- Treatment type(s)
- Metastatic site(s) if applicable
- Complications of treatment
- Related conditions due to neoplasm

Active breast cancer documentation example:

The member is being seen in follow up today after 15/30 fractions of radiation therapy.She is tolerating treatments well, apart from a sunburn like rash on her skin, which she will receive a topical dexamethasone cream prescription for.

Diagnosis codes:

- C50.11 Malignant neoplasm of central portion of breast, female
- L58.0 Acute Radiodermatitis

As a general rule, documentation in the medical record should match the ICD-10 codes submitted on a claim.

Historical breast cancer documentation example:

The member had a bilateral mastectomy two years ago and was treated with radiation therapy, no recurrence of disease.

Diagnosis codes:

- Z85.3 Personal history of malignant neoplasm of breast
- Z90.13 Acquired absence of bilateral breasts and nipples

When a malignancy has been excised or eradicated and there is no further treatment of the malignancy, a code from the Z85 category should be assigned, which represents personal history of malignant neoplasm. Once treatment is complete, a member should not be assigned a current, active cancer code if the disease no longer requires treatment.

When documenting in the medical record, remember to paint a picture or tell a story of the current medical condition of the member.

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.