South Carolina

Medicare Advantage

PROVIDER PARTNERSHIP PROGRAM 2022

Help Us Build a Healthier South Carolina

www.SouthCarolinaBlues.com

A MESSAGE FROM OUR CHIEF MEDICAL OFFICER

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Chief Medical Officer,
Medicare Advantage
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Dear Colleague,

We are excited to partner with your practice in providing care for BlueCross BlueShield of South Carolina Medicare Advantage (MA) members.

We are a team of professionals — nurses, care managers, pharmacists, social workers and physicians — dedicated to expanding the impact of your practice for BlueCross MA members. The BlueCross MA team will enhance your practice with resources like comprehensive data about your patients. We can expand your capacity to care for your BlueCross MA members with case management, disease management, pharmacy review and information about care gaps, as well as comprehensive information about the health services used by your patients since their last visits.

We are your partner in care, helping your practice excel in quality and risk assessment and ensuring all your BlueCross MA members will be well and stay well.

Sincerely,

PROVIDER PARTNERSHIP PROGRAM

Provider Partnership Program

BlueCross BlueShield of South Carolina is committed to building a long-term quality partnership with our Medicare Advantage members and providers. Quality care is an integral part of our mission, and we appreciate the effort you make as a provider to improve health outcomes and create a positive health experience for your patients.

To help sustain your quality efforts, use this booklet as a go-to reference for available BlueCross resources, information on commonly used codes and quality documentation tips.

MEET YOUR QUALITY NAVIGATORS

We Are Here for You

The goal of our provider partnership program is to help Medicare Advantage providers deliver the highest quality of care to our members, increase our members' compliance and adherence to their plans of care, and promote general wellness to the population. Our quality team comprises quality specialists, risk coding specialists and quality nurse navigators who will be a liaison to your office to discuss quality improvement activities, share member care gap reports and collect medical record documentation.

What You Can Expect From Us

A Medicare Advantage quality nurse navigator is assigned to your office and will be your main contact for information related to the Medicare Advantage program. The quality nurse navigator will help to relieve your administrative burden by collecting medical records and will be available to discuss the needs of your BlueCross Medicare Advantage patients. The quality nurse navigator will be a resource for your office to help improve quality outcomes.

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KEY CONTACTS AND HELPFUL TIPS

- Provider website: **www.SouthCarolinaBlues.com/web/public/brands/sc/providers/**
- Member website: **www.SCBluesMedAdvantage.com/**
- **Medicare Advantage Provider Manual**
- Names and key contacts

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Tips on Using This Manual

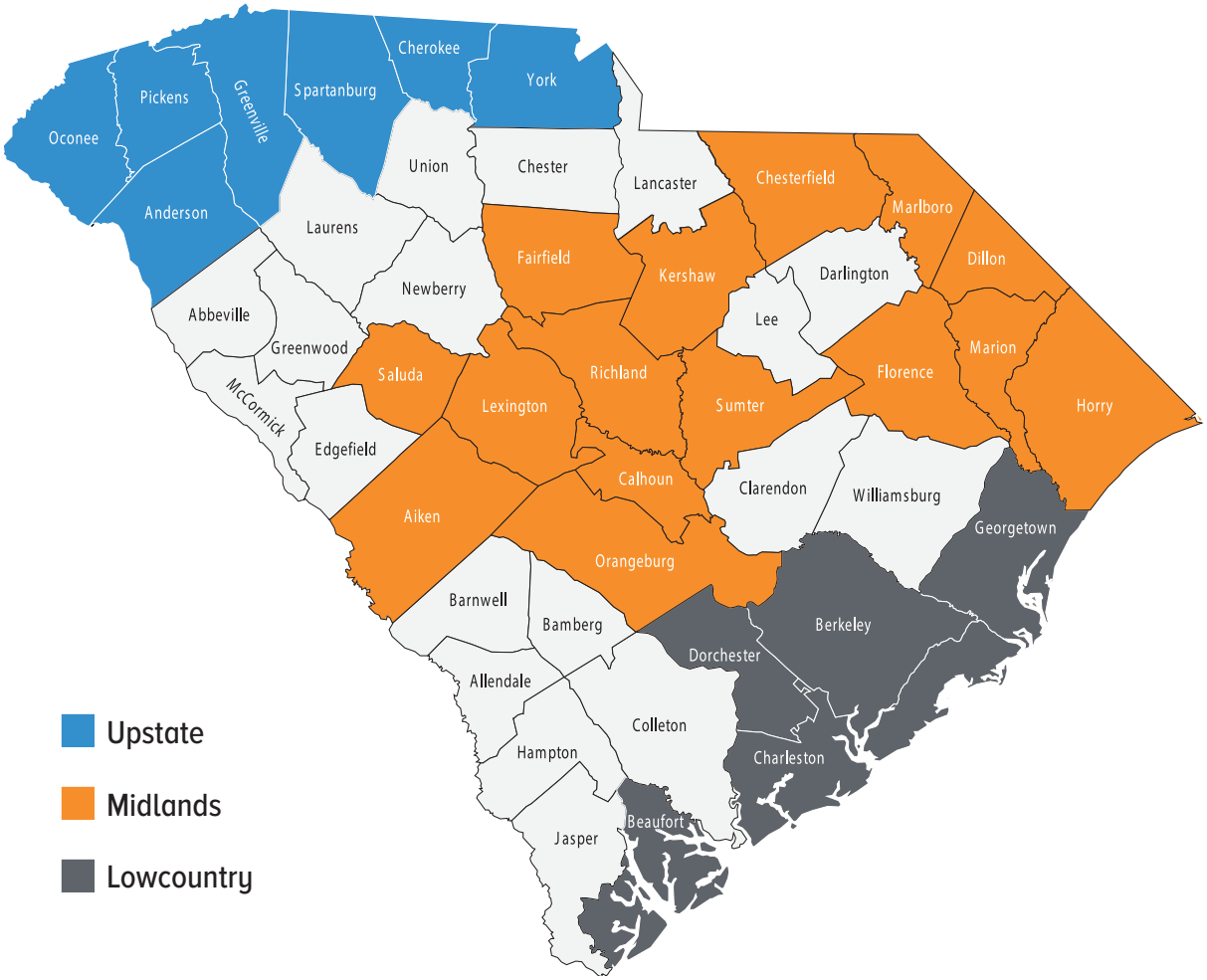
- When using the electronic version, you can search the document using Ctrl + F. Type the keyword, and then select Enter.
- Quality refers to quality metrics for Healthcare Effectiveness Data and Information Set (HEDIS) (e.g., colon cancer screening).
- Risk refers to risk adjustment documentation and coding items (e.g., ICD-10).
- Member refers to the patient.
- **You**, **your** or **provider** refers to any health care provider subject to this manual, including physicians, health care professionals, facilities and ancillary providers.
- **We**, **us** or **our** refers to BlueCross and its other affiliates for the products and services discussed in this guide.

A LOCAL PRESENCE

We have an amazing opportunity to create a positive health experience for our members because they are all residents of South Carolina and BlueCross is local, too!

The Medicare Advantage line of business at BlueCross BlueShield of South Carolina began in January 2018. Since its inception, the program has grown its membership exponentially each year. Our beneficiaries consist of Medicare-aged members, as well as members under age 65 who are eligible due to disability.

The BlueCross Medicare Advantage team includes dedicated customer service representatives, data specialists, care managers and clinical staff who are focused on the needs of each Medicare Advantage member. Our members have diverse backgrounds and are located throughout the state. Each person has his or her own wonderful story to share.



2022 MEDICARE ADVANTAGE MEMBER BENEFITS

BlueCross BlueShield of South Carolina offers several Medicare Advantage benefit packages that are designed to meet the needs of South Carolina beneficiaries. The information below is a sample of benefits for our **Total PPO policy**, our most comprehensive plan. Prior to any services, verify benefit eligibility for each patient.

These members are identified by a ZHP alpha prefix on their BlueCross identification cards.

The following services are covered with no coinsurance, copay or deductible to the member if completed at an in-network provider:

- **Medicare annual wellness visit**
- **Annual physical exam**
- Bone density screening
- Breast cancer screening
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Glaucoma screening
- Diabetic eye exam
- Electrocardiogram

Primary Care Providers	
In Network	$5 per visit
Out of Network	$30 per visit
Specialists (no referral required)	
In Network	$45 per visit
Out of Network	$55 per visit
Telehealth	
All Options	$5 per visit for Blue CareOnDemand℠. Normal office copays apply for telehealth appointments with a primary care physician

Diagnostic Tests	
In Network	$0 to $275 per service
Out of Network	40% of the cost
Lab Services	
In Network	$10 per lab service
Out of Network	40% of the cost
Diagnostic Radiology Services	
In Network	$0 up to $275 copay for Medicare-covered diagnostic radiology tests and procedures other than MRI and CT scans
Out of Network	40% of the cost

X-Rays	
Outpatient X-Rays	$10 per X-ray

Hearing Aids	
$699 – $999	One per ear per year

More services available to BlueCross members not covered by traditional Medicare:

- Case management and chronic condition management This benefit is provided by BlueCross for any member wishing to participate in telephone coaching and assistance by a nurse.
- Transition of Care program: A specialized team of case managers that focuses on readmission avoidance and post hospital discharge care. Some members also qualify for a free meal program after discharge from a hospitalization.
- At-home services for health screenings (e.g., colon cancer, A1C and microalbumin home testing kits), in-home health assessments and community health events scheduled in various locations each year throughout the state
- Dental services from a Medicare-approved dentist: Two preventive dental visits per year, oral exam, cleaning, and bitewing x-rays.

MEDICARE ADVANTAGE STAR RATINGS

Medicare Advantage Star Ratings

The Centers for Medicare & Medicaid Services (CMS) has mandated that all Medicare Advantage organizations have a quality improvement program in place. Health plans are rated on a 1 – 5 scale, with 5 being the highest performing. The Star Rating comprises different data sources, including HEDIS quality measure compliance, pharmacy data, member survey responses and health plan operations performance. Performance in these areas directly impacts member benefits, provider incentives and consumer perception.

Provider Scorecard

Our performance as a health plan is directly affected by the care delivered by our network of physicians. To give your offices a tangible sense of individuatl performance, our quality nurse navigators will present updated provder scorecards to your office. The quality nurse navigators will also help track care gap completion, share industry standard documentation tips, and assist with quality initiative changes to help boost provider star ratings.

The Healthcare Effectiveness Data and Information Set

HEDIS is one of health care's most widely used performance improvement tools. The National Committee for Quality Assurance (NCQA) established this set of baseline metrics for measuring quality of health care and rewarding performance. Every year, there are updates and changes made to the specifications and the performance scales. These metrics are broken into the following categories:

1. Effectiveness of Care
2. Access/Availability of Care
3. Utilization
4. Risk Adjusted Utilization

MEMBER SURVEYS

There are two health care surveys distributed throughout the year to Medicare Advantage beneficiaries. These surveys are conducted by third-party companies, and the results are returned to the health plan. CMS highly values member experience, so survey results are heavily weighted on the performance scale.

Surveys collect data based on a member's self-reported interactions with their health care providers, hospitals and health plans in addition to self-reported ratings of their overall mental and physical health. As CMS emphasizes the highly valued member experience surveys, it is essential that providers pay close attention to the health experience of each patient.

CAHPS Survey

Every year, CMS collects information from the member perspective by conducting surveys of beneficiaries. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey covers topics that are important to consumers and focuses on aspects of quality related to providers and health care services, including:

Personal Health: Emergency care, follow-up appointments and rating their health care

Your Personal Doctor: How many times do you visit a primary care physician (PCP)? How often did he or she listen to you? Did he or she have your medical records at visits? How long did you wait to see a physician at a scheduled appointment time?

Getting Health Care From Specialists: Did you need to see a specialist? How often? How many specialists?

Your Health Plan: Did the plan's customer service team give you the answers you needed? Rate your health plan.

Your Prescription Drug Plan: How difficult is it to get needed prescriptions? How would you rate ease of pharmacy and mail-order pharmacy use?

About You: Members' ratings of their own health, education, ability to care for themselves and preventive medicine practices

HOS Survey

CMS also conducts the Health Outcomes Survey (HOS) annually to gather information on health status of Medicare beneficiaries. HOS assesses the ability of the health plan and providers to maintain or improve the health of members across a two-year period.

Currently, there are five HOS measures included in the Star Ratings:

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health
- Monitoring Physical Activity
- Reducing the Risk of Falling
- Improving Bladder Control

It is important for our providers to understand their role in providing care for Medicare beneficiaries. Although these topics do not necessarily pertain to all Medicare beneficiaries' plan of care, it is important that our members are offered the time to discuss these topics. Medicare annual wellness visits are the perfect time to touch on these topics with all patients.

How You Can Help Improve the Member Experience

We are committed to providing the highest level of care to our members. We value their opinions and use survey responses to help improve their overall experience. We believe that our partnership with providers is an opportunity to align on the members' individual plans of care and ensure our members are receiving the care they need, when they need it. Our quality nurse navigators will share results with our providers to identify and work together on improving the overall satisfaction of our members. Here are a few things to consider when creating process changes for increased patient satisfaction:

- Simple and clear communication with members will help improve health outcomes. Ensure members leave your office with written and oral instructions.
- Front office staff can make a great first impression and help the member feel comfortable. Please encourage front office staff to create a welcoming environment with clear expectations for the appointment, wait time and billing (e.g., copays).
- Discuss activities of daily living with each member, including urinary incontinence, durable medical equipment, reducing risk of falls, medication organization, food preparation and mental health status.
- Discuss all open care gaps and complete an updated risk assessment. Help the patient understand methods of self-management and how he or she can live a full and satisfying life.

PROVIDER INCENTIVES

At BlueCross BlueShield of South Carolina, we know you strive to deliver high quality of care to our members. We want to reward your efforts to successfully engage with BlueCross members and provide services that positively impact quality measures.

We have designed a provider incentive program to financially reward providers for accurately assessing and educating patients on the importance of evidence-based preventive measures, in addition to sending the appropriate clinical documentation to BlueCross. The current incentive pays $150 for each Quality Assessment Report (QAR) completed per patient and a CPT® coding incentive pays bonus dollars when providers include appropriate CPT codes on a claim.

Our QAR was designed to be completed when you have an encounter with the patient to address quality care gaps and risk documentation for chronic health conditions. For 2022, you will receive a $150 payment for each QAR you successfully complete and return to BlueCross with a medical record.

A QAR form will be provided to you for each of the Medicare Advantage members you see. Your assigned quality nurse navigator will keep you informed on your completion rate throughout the year in your provider scorecard.

The CPT incentive program is eligible for providers who submit proper CPTII coding following an encounter. Payment for the CPTII code will only be applicable for the attributed provider that properly submits the code. For more information, please see the table of codes and incentive amounts for each quality measure.

HEDIS Measurements					
Product	**HEDIS Measure and Claim Specifications**		**CPT II Code Definition**	**CPT II Code**	**Incentive Amount**
Medicare Advantage	Diabetes Care Diabetes Care CPTII codes must be submitted on a claim with an ICD-10 diagnosis code for Diabetes: E10.9 – 13.9, O24.011 – O24.33, O24.811 – O24.83.	Retinal Eye Exam	Eye exam **with** evidence of retinopathy	2022F, 2024F, 2026F	$15
			Eye exam **without** evidence of retinopathy	2023F, 2025F, 2033F	
			Diabetic retinal screening in prior year	3072F	
		HbA1C Control	HbA1C level less than 7.0%	3044F	$10
			HbA1C level 7.0% – 8.0%	3051F	$10
			HbA1C level 8.0% – 9.0%	3052F	$10
			HbA1C level greater than 9.0%	3046F	$5
	Hypertension Management Hypertension management CPTII codes must be submitted on a claim with an ICD-10 diagnosis for Essential Hypertension: I10.	Controlling Blood Pressure	Systolic blood pressure less than 130	3074F	$5
			Systolic blood pressure 130 – 139	3075F	$5
			Systolic blood pressure greater than 140	3077F	$2.50
			Diastolic blood pressure less than 80	3078F	$5
			Diastolic blood pressure 80 – 89	3079F	$5
			Diastolic blood pressure greater than 90	3080F	$2.50
	Transitions of Care	TRC — Medication Reconciliation	Discharge medications reconciled with the current medication list in outpatient medical record	1111F	$50


530
22
22

HEDIS 2022

As previously stated, NCQA makes updates and changes to the HEDIS quality measures every year. The following pages will outline specific quality measures, the qualifying tests, and member benefits related to the measures.

We have also included documentation tips for medical record review and commonly used CPT II codes used to close care gaps through claims without medical record review.

The commonly used billing reference codes can be found throughout the next pages with the appropriate HEDIS measure. Documentation of quality gaps should be determined based on the provider's encounter with the Medicare beneficiary.

Please note: Any members receiving hospice care or palliative care during the measurement year are excluded from all measures, as these plans of care differ from traditional preventive and treatment-based medical plans of care.

Medicare Advantage partners with various venders through the year to assist our providers in completing HEDIS screenings. We will be providing at-home screening kits for HbA1C, and colorectal cancer (FIT) testing kits to eligible members throughout the year. As a network provider, you are able to request a kit be sent to a member or encourage members to call us to receive their no-cost kits. Any result received from an at-home kit will be sent to the PCP of the member for his or her records.

HEDIS 2022 (continued)

Breast Cancer Screening

Measure Definition

Women 50 – 74 years of age who had a mammogram completed between Oct. 1, 2020, and Dec. 31, 2022

Exclusions

- History of bilateral mastectomy

Qualifying Studies

- Screening mammography
- Diagnostic mammography
- Film mammography
- Digital mammography
- Digital breast tomosynthesis

Description	CPT	HCPCS
Breast Cancer Screening	77055 – 77057, 77061 – 77067	G0202, G0204, G0206

Exclusion Description	ICD-10-CM	ICD-10-PCS
Bilateral Mastectomy		0HTV0ZZ
History of Bilateral Mastectomy	Z90.13	

Does Not Qualify

- Biopsies
- Breast ultrasounds
- Breast MRI

Documentation Tips

Document the date of the last completed breast cancer screening test. This measure does not require a result for compliance.

Commonly Used CPT II Code

Description	CPT II Code
Screening mammography results reviewed and documented	3014F

Controlling Blood Pressure (BP)

Measure Definition

Percentage of members ages 18 – 85 years who had a diagnosis of hypertension and whose BP was adequately controlled during 2022. Compliant range for blood pressure is less than 140/90.

Exclusions

- ESRD diagnosis
- Kidney transplant
- Pregnancy

Exclusion Description	ICD-10-CM	CPT
Evidence of ESRD	N18.5, N18.6, Z91.15, Z99.2	36147, 36800, 36810, 36815, 36818 – 36821, 36831 – 36833, 90935, 90837, 90940, 90945, 90947, 90951 – 90970, 90989, 90993, 90997, 90999, 99512
Kidney Transplant	Z94.0	50300, 50320, 50340, 50360, 50365, 50370, 50380
Pregnancy	O00.0 – O9A53, Z03.71 – Z36.9	

Documentation Tips

Do not round blood pressure values. Use exact blood pressure numbers. This is especially important for manual blood pressures. If a blood pressure is 138/70, it is compliant, but if it is rounded to 140/70, it is no longer compliant. Some members may feel anxious during visits and exhibit "white coat hypertension." Best practice outlines rechecking blood pressure values at the end of a visit for members with elevated blood pressures in the beginning of a visit and documenting both values in the medical record.

Telehealth Tip: When completing telehealth visits with members, please ask if they have a device to capture BP readings at home. If yes, then document the blood pressure readings in the medical record.

Commonly Used CPT II Codes

Systolic	
Description	CPT II Code
Systolic value less than 130	3074F
Systolic value 130 – 139	3075F
Systolic value greater than 140	3077F

Diastolic	
Description	CPT II Code
Diastolic value less than 80	3078F
Diastolic value 80 – 89	3079F
Diastolic value greater than 90	3080F

HEDIS 2022 (continued)

Colorectal Cancer Screening

Measure Definition

All members 50 – 75 years of age who completed a colorectal cancer screening

Qualifying Studies

- Colonoscopy completed after Jan. 1, 2013
- Flexible sigmoidoscopy completed after Jan. 1, 2018
- CT colonography completed after Jan. 1, 2018
- FIT-DNA test completed after Jan. 1, 2020
- FIT/FOBT completed after Jan. 1, 2022

Exclusions

- History of colorectal cancer
- History of total colectomy

Description	CPT	HCPCS
Colonoscopy	44388 – 44394, 44397,44401 – 44408, 45355, 45378 – 45393, 45398	G0105, G0121
CT Colonography	74261 – 74263	
Flexible Sigmoidoscopy	45330 – 45335, 45337 – 45342, 45345 – 45347, 45349 – 45350	G0104
FIT-DNA Test	81528	G0464
Fecal occult blood test	82270, 82274	G0328

Documentation Tips

Be specific in documenting the type of test completed and the date it was completed, even if it was completed by another provider. Instead of documenting "colorectal cancer screening completed," be specific on the type of test completed. Compliance for this measure does not require a result.

Tip: When documenting a completed colorectal cancer screening, please be sure to record the specific type of test (e.g., FIT kit, colonoscopy, sigmoidoscopy) and the date of the test.

Commonly Used CPT II Code

Exclusion Description	ICD-10-CM	CPT
Colorectal Cancer	C18.0 – C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048	
Total Colectomy		44150 – 44153, 44155 – 44158, 44210 – 44212

Comprehensive Diabetes Care

Diabetic Retinal Eye Exam

Measure Definition

All diabetic members 18 – 75 years of age who had a dilated eye screening for retinopathy by an optometrist or ophthalmologist

Qualifying Studies

- Retinal or dilated eye exam by an optometrist or ophthalmologist in 2022
- Retinal or dilated eye exam by an optometrist or ophthalmologist in 2021 or 2022 that was **negative for retinopathy**
- Documentation of bilateral eye enucleation in member's medical history

Description	CPT	CPT II Code	HCPCS
Diabetic Retinal Screening	67028, 67030, 67031, 67036, 67039 – 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225 – 92228, 92230, 92235, 92240, 92250, 92260, 99203 – 99205, 99213 – 99215, 99242-99245	2022F 2024F 2025F 2026F 2033F	S0620, S0621, S3000

Exclusions

- Gestational Diabetes
- Steroid-Induced Diabetes

Exclusion Description	ICD-10-CM
Gestational/Steroid-Induced Diabetes	E08.00 – E09.9, O24.410 – O24.439, O24.911 –O24.93
Bilateral Eye Enucleation	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114

Documentation Tips

Documentation of "diabetes without retinopathy" in a diagnostic field is not sufficient for compliance with this measure unless there is documentation from an optometrist or ophthalmologist of a retinal exam.

Include in your assessment the provider where the member receives eye care.

HEDIS 2022 (continued)

Comprehensive Diabetes Care (continued)

HBA1C Testing and Control

Measure Definition

Diabetic members 18 – 75 years of age who have evidence of HbA1C testing with a result < 9.0

Qualifying Results

- Ensure all diabetic members receive HbA1C testing during the year 2022.
- Encourage lifestyle changes and medication management in order to have result < 9.0 before the end of the calendar year.

Important Tip

The last measurement in the year is counted for compliance for this measure, though tracking throughout the year can help with earlier identification of poor compliance.

Encourage members to develop healthy lifestyles throughout the year or encourage members to participate in their free diabetic health programs through BlueCross to lower their A1C values.

Commonly Used CPT II Codes

HbA1C Testing	
HbA1C Testing	**CPT**
Diabetic Retinal Screening	83036, 83037

HbA1C Value	
HbA1C Value	**CPT II Code**
Less than 7.0%	3044F
Between 7.0% and 7.9%	3051F
Between 8.0% and 8.9%	3052F
9.0% or above	3046F

FMC and TRC Measures

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions

This is a new HEDIS and Medicare Star measure for 2022!

Measure Definition
Percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit

Exclusions
If the date of service of the ED visit results in an inpatient admission, that ED visit would not be considered for this measure.

The high-risk chronic conditions must have been documented in the medical record PRIOR TO the ED visit for the member to be considered for this measure. The conditions are as follows:

- COPD and asthma
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Tips for Success

- Schedule post-ED visit appointments three to five days after the visit. These appointments can be completed via an office visit, telehealth appointment or telephone call.
- Encourage members to have regular office visits with their PCPs to monitor and manage chronic disease conditions.
- Encourage patients to call their PCP office's after-hours line when conditions change or they have an ED visit outside of regular business hours.
- Submit claims promptly and include all appropriate diagnosis codes for members for early identification.

HEDIS 2022 (continued)

FMC and TRC Measures (continued)

Transition of Care

This is a revised and more comprehensive measure related to hospital inpatient encounters.

Measure Definition
The percentage of inpatient discharges for members ages 18 and older who had each of the four following indicators during the measurement year:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation after discharge

Note: This measure is based on unique inpatient encounters, so members may be in the measure more than one time per measurement year.

The four indicators above are all required for compliance for this measure.

Tips for Success
Date and time-stamp any communication received from hospitals or health plans related to admissions and upload all documentation to the member's medical record. Encourage patients to alert their providers before any planned admissions and after all discharges from the hospital. Documentation should include the reason for visit being "hospital follow-up," not "post-surgery," "postoperative," etc.

1. Notification of Inpatient Admission
Documentation in the outpatient medical record must include evidence, with a date and time stamp, of receipt of notification of inpatient admission on the day of admission through two days after admission. Examples include:

- Communication with the hospital emergency department via phone call, email or fax.
- Communication from hospital via ADT feed.
- Communication to the member's PCP from the member's health plan.
- Indication a specialist admitted the member and notified the PCP.
- Indication the admission was elective and the member's PCP was notified or performed a preadmission exam.

Note: Documentation showing the member or the member's family notified the provider does not count for compliance.

2. Receipt of Discharge Information
Documentation in the outpatient medical record must include evidence, with a date and time stamp, of receipt of discharge information on the day of discharge through two days after discharge.

At a minimum, the qualifying discharge information for compliance must include all of the following:

- Name of practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnosis at discharge
- Current medication list
- Test results, documentation of any pending tests or note that no tests are pending
- Instructions to the PCP or ongoing care provider for patient care

3. Patient Engagement After Discharge
Documentation of patient engagement must be in the outpatient medical record within 30 days after discharge.

This engagement can be captured via a claim for a service conducted by:

- Office visit.
- Telephone visit.
- Telehealth visit.
- E-visit or virtual check-in.

HEDIS 2022 (continued)

FMC and TRC Measures (continued)

4. Medication Reconciliation Post-Discharge

Documentation in the outpatient medical record showing a medication reconciliation was completed on the day of discharge through 30 days after discharge must be completed by a prescribing practitioner, clinical pharmacist or registered nurse.

For medical record review, any of the following is considered for compliance:

- Documentation of the current medications with a note that says the provider reconciled current and discharge medications
- Documentation of the current medications with a note that references review of discharge medications
- Documentation of a current medication list, a discharge medication list, and notation that both lists were received and reviewed during the date of service
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record
- Notation that no medications were prescribed or ordered upon discharge

Member Benefit

BlueCross BlueShield of South Carolina has a transition-of-care case management team that focuses on avoiding readmission of members who are admitted to a hospital setting. These nurses visit with members while they are in the hospital, complete follow-up care conversations and complete a medication review after discharge. That document will be provided to the member's PCP upon completion. Please keep this medication review and any other communication from BlueCross in the member's medical record for help with medication reviews during appointments.

Important Tip
Medication reconciliation can also be completed without an office visit. It can be completed via phone call or telehealth visit but must be documented by a registered nurse, pharmacist, nurse practitioner, physician's assistant or physician.

Commonly Used CPT II Code (this list is not all-inclusive)

Description	CPT II Code
Outpatient Visits	99201 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411 – 99412, 99429, 99455 – 99456, 99483
Telephonic Visits	98966, 98967, 98968, 99441, 99442, 99443
Medication Review After Discharge	1111F (CPTII), 99483, 99496, 99495

HEDIS 2022 (continued)

Statin Use in Persons With Diabetes

Measure Definition

Members ages 40 – 75 who were dispensed at least two prescriptions for a hypoglycemic agent, including insulin, who also received a single prescription for a statin medication

Exclusions

Members with end-stage renal disease (ESRD) diagnosis

Exclusion Description	ICD-10-CM	CPT
Evidence of ESRD	N18.5, N18.6, Z91.15, Z99.2	36147, 36800, 36810, 36815, 36818 – 36821, 36831 – 36833, 90935, 90837, 90940, 90945, 90947, 90951 – 90970, 90989, 90993, 90997

One of the following medications must be prescribed and dispensed by a pharmacy:

- Atorvastatin
- Lovastatin
- Pravastatin
- Rosuvastatin
- Simvastatin
- Fluvastatin
- Atorvastatin/amlodipine
- Simvastatin/ezetimibe

Statin Therapy for Patients With Cardiovascular Disease

Measure Definition

Male members ages 21 – 75 and female members ages 40 – 75 who were diagnosed with atherosclerotic cardiovascular disease and received at least one prescription for a high- or moderate-intensity statin medication.

Exclusions

- Members with ESRD diagnosis
- Members with cirrhosis diagnosis
- Members with medical diagnosis of severe allergy to statins, including myalgia, myositis, myopathy, rhabdomyolysis

Exclusion Description	ICD-10-CM	CPT
Evidence of ESRD	N18.5, N18.6, Z91.15, Z99.2	36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90935, 90837, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997

One of the following medications must be prescribed and dispensed by a pharmacy:

- Atorvastatin 10 mg or more daily
- Fluvastatin 80 mg or more daily
- Lovastatin 40 mg or more daily
- Pravastatin 40 mg or more daily
- Rosuvastatin 5 mg or more daily
- Simvastatin 20 mg or more daily

HEDIS 2022 (continued)

Medication Adherence

Measure Definition

Percentage of members ages 18 years and older with a prescription for medication and who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication — for any of the following medications:

- Oral diabetic medications
- Hypertension medications (RAS antagonists, ACE/ARB)
- Cholesterol medications (statins)

Compliance for these measures is measured by data from pharmacy claims and cannot be substantiated by medical records alone.

Member Benefit

BlueCross has a specific transition-of-care case management team that focuses on avoiding readmissions of members who are admitted to a hospital setting. These nurses will complete a medication review post discharge and that document will be provided to the member's PCP upon completion. Please retain this medication review in the member's medical record for assisting with medication reviews during appointments.

Important Tips

To help improve medication adherence rates, best practice includes writing prescriptions as you want them to be taken (no half pills, etc.). Encourage 90-day refills vs. 30-day refills, which may keep members from forgetting their refills; and encourage members not to stop taking medications without consulting their providers. Always review medications at every visit.

There is a $0 copay for a 90-day supply of Tier 1 medications.

Osteoporosis Management in Women Who Had a Fracture

Measure Definition

Members ages 67 – 85 who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture

Note: Fractures of the fingers, toes, face and skull are not included in this measure.

Documentation Tips

Be specific about the location of any fracture for females. Assess the member's history and encourage bone mineral density testing for any at-risk female. BlueCross is able to complete a bone mineral density test for eligible members in the comfort of their homes. Our nurse team will call any member who falls into this measure to offer a free bone mineral density test after a claim is received. Encourage members to take advantage of this free benefit or refer members to have testing completed.

Providers have a very important role in risk adjustment that starts with identifying the overall health status of their patient. CMS identifies each member's overall health status and potential medical needs on the conditions documented in his or her medical record and submitted as a diagnosis code on claims. Each condition needs to be documented thoroughly so an accurate ICD 10-CM code is reported.

UNDERSTANDING YOUR ROLE AS A PROVIDER IN RISK ADJUSTMENT

Providers are encouraged to code and document to the highest specificity when building their patients' health profiles. It is important to document the severity, comorbidities, manifestations and anything else that has an impact on the given condition. All continuing chronic conditions should be reported annually at minimum. It is important to know that these conditions **do not** carry over year to year. A patient is considered completely healthy until his or her provider rebuilds the patient health profile for that new calendar year through medical record documentation and submitted medical claims..

We want providers to give great quality of care so our members can have a great quality of life. When CMS developed the Medicare annual wellness visit, the aim was to provide medical providers the opportunity to meet with their patients to review the full medical record, plan of care and preventive health screenings the patient may need to have completed. This annual appointment is no cost to members and is historically underutilized by our providers. The claim submitted should include all medical diagnoses for appropriate risk adjustment purposes. Annual wellness visits help identify and readdress all ongoing health conditions.

The 10th revision of the International Classification of Diseases (ICD-10-CM) helps you provide a greater level of specificity with more than 70,000 diagnosis codes to choose from. To aid with proper coding and documentation, here are a few tips:

- Document all coexisting conditions related to the patient's health status.
- Document the current status of the patient's condition.
- Document the manifestation and/or complication.
- Document the severity of the illness.
- Document all signs, symptoms and date of onset.
- Always refer to your ICD-10-CM books for additional coding and documentation guidelines.

Annual Wellness Exam: G0402 (initial) OR G0439 (annually)

Annual Physical: 99381-99387 (new patient) OR 99391 – 99397 (established patient)

PROPER DOCUMENTATION FOR RISK ADJUSTMENT

Utilizing M.E.A.T. in Documentation

The **M.E.A.T.** method is the heart of risk adjustment. It stands for **monitor**, **evaluate**, **access** and **treat**. These four factors help providers establish a diagnosis during a patient encounter. They also help with proper documentation. Always remember that complete documentation acts as evidence of a diagnosis. If it's not documented, then it does not exist. For success with documentation, we encourage all providers to adhere to the M.E.A.T. method. See the steps listed below for additional guidance:

MONITORING

- How is the individual doing?
- Are there new signs or symptoms?
- This conceptually represents ongoing surveillance of the condition(s).

EVALUATION

- What is the current state of the condition?
- What is the provider's judgment of the condition currently?
- This can be the review of results or the treatment outcomes.

ASSESSMENT

- How will the condition(s) be evaluated or estimated?
- This can be documenting of prior records review, counseling or ordering further studies.

TREATMENT

- What care is being offered or what is being done to help the patient with the condition(s)?
- This can be a medication, a diagnostic study or a therapeutic service.

By using this method as a provider, you should feel confident that your documentation will meet CMS expectations.

We want to ensure our network providers feel supported in their efforts to use proper documentation and coding to the appropriate specificity. Please reach out to your quality navigator if you feel you need any additional support or resources for coding for risk adjustment in your practice.

ICD-10-CM DOCUMENTATION AND CODING GUIDELINES

Documentation Must Be Specific

Documentation should be thorough and specific so that the appropriate diagnosis code can be assigned.

Include descriptors such as these:

- Acuity
- Stage/severity
- Underlying cause
- Complications/ associated conditions
- Anatomic site/ laterality
- Episode of care

Reporting Active Conditions

The **CMS-HCC Risk Adjustment** process requires the documentation and reporting of active conditions at least **once per year**. In practice, coexisting conditions should be documented and reported each time they affect care, treatment decisions, etc.

Important Tips

- Use standard medical abbreviations.
- Incorporate and document lab and diagnostic results into progress note.
- Link medications to the condition(s) they treat to show ongoing care/management.
- Review/update medication and problem list.

Coding Must Reflect Medical Record

As noted in the **ICD-10-CM Official Coding Guidelines**, a diagnosis can only be coded if it is stated explicitly in the documentation. Coders cannot presume a given condition exists based on symptoms or lab results.

For example, abnormal GFR levels cannot be interpreted to be CKD unless confirmed and documented by the provider. A clinician is the only one who can interpret results and assign a final diagnosis.

"History of" Codes

As noted in the **ICD-10 Official Coding Guidelines**, the term "history of" indicates a historical condition that no longer exists. If a condition is being managed, treated or monitored, it is considered an active disease; therefore, the term "history of" should not be used for active conditions.

Don't Forget!

CMS signature requirements:

- Electronic — Authentication, provider name, credential and date signed.
- Manual signature — Legible signature with credential or a signature with provider name and credential preprinted on note.
- Stamped/typed signatures are not acceptable.

Cancer Coding Reminders

- **Active cancer** — Cancer should be documented and coded as active when:
  - The patient is undergoing treatment directed at the malignancy for curative or palliative purposes.
  - The patient has failed all treatment options, and no other options remain.
  - Patient has elected to waive treatment.
- **Personal history of cancer** — After cancer has been excised/eradicated, all active treatment has ceased, and there is no evidence of current disease, a "history of" Z code is appropriate.
- **Metastatic cancer** — Clearly document the primary site and the metastatic site to avoid reporting multiple primary sites.

CVA and Stroke Coding Reminders

A CVA is a critical event that requires treatment in the acute care setting. Following discharge from the hospital or rehabilitation center, report any residual deficits (sequelae) related to the CVA:

- I69.3xx — Sequelae of cerebral infarction *5th and 6th digits identify nature of late effect

In the absence of late effects, report:

- Z86.73 — Personal history of TIA, and CVA without residual deficit

ICD-10-CM CODES FOR CHRONIC CONDITIONS

Chronic Kidney Disease

Stages: 1 – 5 and ESRD

Type: Acute or chronic

Status of Conditions: Stable, worsening, etc.

Underlying Cause (if known): Diabetes, hypertension and be sure to use linking terminology, e.g., Stage 4 CKD due to diabetes or diabetic nephropathy

ICD-10	Stage	Severity	GFR Value
N18.1	Stage 1	Normal	GFR > 90 ml
N18.2	Stage 2	Mild	GFR 60-89 ml
N18.30	Stage 3	Moderate	
N18.31	Stage 3a	Moderate	GFR 45-59 ml
N18.32	Stage 3b	Moderate	GFR 30-44 ml
N18.4	Stage 4	Severe	GFR 15-29 ml
N18.5	Stage 5	Kidney Failure	GFR < 15 ml
N18.6	Stage 5	End-Stage Renal	GRF requires dialysis or transplant

Major Depressive Disorder

Episode: Single or recurrent

Severity: Mild, moderate, severe with or without psychotic features

Clinical Status of Current Episode: Partial or full remission

F32.0 MDD, single episode, mild

F32.1 MDD, single episode, moderate

F32.2 MDD, single episode

F32.3 MDD, single episode, severe, w/psychotic features

F32.4 MDD, single episode, partial remission

F32.5 MDD, single episode, full remission

F33.0 MDD, recurrent, mild

F33.1 MDD, recurrent, moderate

F33.2 MDD, recurrent, severe w/o psychotic episodes

F33.3 MDD, recurrent, severe w/psychotic symptoms

F33.40 MDD, recurrent, remission, unspecified

F33.41 MDD, recurrent, partial remission

F33.42 MDD, recurrent, full remission

Remember to use PHQ-9 to assist in identifying the severity level.

Vascular Disease

I70- Atherosclerosis

I70.0 Atherosclerosis of aorta

I70.1 Atherosclerosis of renal artery

I70.2- Atherosclerosis of native arteries of the extremities

I70.3- Atherosclerosis of unspecified type of bypass graft(s) of the extremities

I71.2 Thoracic aortic aneurysm, without rupture

I71.4 Abdominal aortic aneurysm, without rupture

I73 Other peripheral vascular disease

I73.0 Raynaud's syndrome

I73.00 without gangrene

I73.01 with gangrene

I73.8 Other specified peripheral vascular diseases

I73.89 Other specified peripheral vascular diseases

I73.9 Peripheral vascular disease, unspecified

I82- Other venous embolism and thrombosis

I82.409 Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity

Diabetes

Type: 1 or 2

Control: Controlled, poorly controlled, uncontrolled, out of control

Type 1	Type 2	Description
E10.8	E11.8	DM with unspecified
E10.9	E11.9	DM with complications
E10.21	E11.21	DM with diabetic nephropathy
E10.22	E11.22	DM with chronic kidney disease
E10.29	E11.29	DM with other diabetic kidney complications
E10.40	E11.40	DM with diabetic nephropathy, unspecified
E10.42	E11.42	DM with diabetic poly neuropathy
E10.43	E11.43	DM with diabetic autonomic (poly) nuero
E10.59	E11.59	DM with other circulatory complications
E10.621	E11.621	DM with foot ulcer
E10.65	E11.65	DM with other specified complications
E10.69	E11.69	DM with other specified complications

Remember Yearly Screenings — A1C, Retinal Eye Exam, Nephropathy

Chronic Conditions That Need To Be Addressed Yearly

Z93.9	Artificial opening (ostomy)
Z21	HIV status
B20	HIV
Z79.4	Insulin dependent (if Type 2 diabetic)
Z89.4-/ Z89.5-	Lower limb amputee
Z99.2	Renal dialysis
Z91.15	Non-compliant with renal dialysis
Z99.11	Respirator dependence
Z93.0	Tracheostomy

Specified Heart Arrhythmia

I47	Paroxysmal tachycardia
I47.0	Re-entry ventricular arrhythmia
I47.1	Supraventricular tachycardia
I47.2	Ventricular tachycardia
I48	Atrial fibrillation and flutter
I48.0	Paroxysmal atrial fibrillation
I48.1	Persistent atrial fibrillation
I48.2	Chronic atrial fibrillation
I48.20	Chronic atrial fibrillation, unspecified
I48.91	Unspecified atrial fibrillation
I48.92	Unspecified atrial flutter

This coding reference can be used as a guideline to establish a valid diagnosis code per CMS-ICD-10-CM Guidelines. Please note that all codes must be selected at the discretion of the provider and/or medical coder.

Arthritis

M05.79	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M05.9	Rheumatoid arthritis with rheumatoid factor, unspecified
M06.4	Inflammatory poly-arthropathy
M06.00	Rheumatoid arthritis without rheumatoid factor, unspecified site
M06.9	Rheumatoid arthritis, unspecified
M06.09	Rheumatoid arthritis without rheumatoid factor, multiple sites
M32.9	Systemic lupus erythematosus, unspecified
M35.00	Sicca syndrome, unspecified
M35.3	Polymyalgia rheumatica
M46.1	Sacroiliitis, not elsewhere classified

CHF (Congestive Heart Failure)

Acuity: Acute, chronic, acute on chronic

Type: Diastolic, systolic, combined systolic and diastolic

Due to or associated with — cardiac or other surgery, HTN, vascular disease, rheumatic heart disease (endocarditis, pericarditis, myocarditis) and others.

I11	Hypertensive heart disease
I11.0	Hypertensive heart disease with heart failure
I11.9	Hypertensive heart disease without heart failure
I50.1	Left ventricular failure
I50.21	Acute systolic CHF
I50.22	Chronic systolic CHF
I50.23	Acute on chronic systolic CHF
I50.31	Acute diastolic CHF
I50.32	Chronic diastolic CHF
I50.33	Acute on chronic diastolic CHF
I50.41	Acute combined systolic and diastolic CHF
I50.42	Chronic combined systolic and diastolic CHF
I50.43	Acute on chronic combined systolic and diastolic CHF
I50.9	Heart failure, unspecified

COPD (Chronic Obstructive Pulmonary Disease)

J44.0	COPD with acute lower respiratory infection
J44.1	COPD with acute exacerbation
J44.9	COPD, unspecified
J43.8	Other emphysema
J43.9	Emphysema, unspecified

Use additional reporting codes when applicable (e.g, tobacco use Z72.0, nicotine dependence F17.-, history of tobacco dependence Z87.891, exposure to tobacco smoke Z77.22)

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