South Carolina

Medicare Advantage

THE QUALITY CONNECTION

Medicare Advantage Provider Newsletter

Spring 2020 | Issue 1

WHAT'S INSIDE

WE HAVE THE SAME GOAL!

BlueCross BlueShield of South Carolina appreciates the great partnership with our network providers. Together, we share mutual goals of improving health outcomes and developing the patient relationship in order to promote healthy behaviors and increase the quality of life for each Medicare beneficiary.

Ways to stay connected with each Medicare Advantage beneficiary

During the COVID-19 pandemic, we understand that providers are making adjustments to their office schedules and daily operations while patient care remains top of mind. To ensure that Medicare Advantage (MA) beneficiaries maintain access, there are a few options available right now:

- **Telehealth visit** — The Centers for Medicare & Medicaid Services (CMS) have expanded telehealth regulations to make sure that MA beneficiaries can meet with a physician from the comfort of their own home. Using a technology platform with audio + video capabilities, you can meet with patients to discuss their individual health plans.
  - For billing purposes, please follow the same procedure as you would for an in-person visit and add the necessary modifiers (e.g., 95) to show that a telehealth visit occurred.
- **Electronic communication** — now would be a great time to communicate with members via phone or email to give them health recommendations, exercise tips or give them answers to frequently asked questions
- **At-home services** — BlueCross partners with external vendors that provide at-home services to Medicare Advantage beneficiaries. For example, BlueCross offers at-home health assessments at no cost to the member. Additionally, BlueCross will be distributing at-home testing kits to MA beneficiaries who are due for a colon cancer screening, diabetes A1C checkup or diabetes microalbumin test. If you speak to a member who needs the kit, please send your request to **ma.opsrequest@bcbssc.com** and we will make sure he or she gets one.

Medicare Advantage Quality Navigator Program

Our team of nurses is available to assist with HEDIS® care gap closure, discuss tips for improving clinical documentation, and provide answers about quality activities and BlueCross MA benefits.

A Medicare Advantage Quality Navigator is assigned to every provider in the BlueCross Network. Your nurse navigator will be reaching out to collect medical records, discuss quality care gaps for each of your patients and to capture health risk adjustment information.

If you have questions or would like to get in touch with your Quality Navigator please send an email to **ma.opsrequest@bcbssc.com**.

VIRTUAL VISITS:
Telehealth for Medicare Advantage

Staying connected to your patients and our members is more important now than ever.

Medicare Advantage patients stay safe and connected.
Using technology via telehealth can help people who need routine care, especially vulnerable Medicare beneficiaries. CMS has announced the expansion of telehealth with the 1135 waiver. Medicare can now pay for three types of virtual services (effective March 6, 2020).

During this public health emergency, we encourage our providers to utilize telehealth to reduce potential exposure to COVID-19.

The table below is for informational purposes; for a complete list of telehealth codes, please visit **www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes**.

Type of Service	What Is the Service	HCPCS/CPT Code	Patient relationship With Provider
Medicare Telehealth Visits	You must use an interactive audio and video telecommunications system that permits real-time communication between provider and patient.	◆ G0425–G0427: Telehealth consultations, emergency department or initial inpatient ◆ G0406–G0408: Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs ◆ 99201–99215: Office or other outpatient visits	For new* or established patients
Virtual Check-In	These brief (5 – 10 minute) check-ins include synchronous discussion over a telephone or exchange of information through video or image. These visits may determine if an office visit or other service is needed.	◆ G2012, G2010	For established patients
E-Visits	Patients communicate with their doctors without going to the doctor's office by using online patient portals.	◆ 99421, 99422, 99423, G2061, G2062, G2063	For established patients

*To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

ANNUAL WELLNESS VISIT FOR EVERY MEDICARE PATIENT

Well visits are not just for children. All Medicare beneficiaries qualify for an annual wellness visit once every 12 months.

This visit is an important opportunity to assess and document members' health history and offer time for members to discuss any concerns they have regarding their health. Encouraging your patients to bring a list of all of their medications, including vitamins and supplements, can assist in completing a comprehensive medication review as well as review all providers that are prescribing medications to each patient. Other things to accomplish during this visit would include assessing immunization schedules, a complete health risk assessment, looking at advance directives, functional and cognitive assessments, and addressing preventive screenings.

Although social distancing and sheltering in place have disrupted some normal health care visits, telehealth options have been approved by CMS. Telehealth is a great way to conduct annual wellness exams, even if you are unable to complete a physical assessment or in-person office visit.

Service	Details	Submission Codes
Welcome to Medicare Visit	Covered for Medicare Advantage members. Allowed within first 12 months of Medicare enrollment (once per lifetime benefit).	G0402
Annual Wellness Visit	Covered for Medicare Advantage members. Available every calendar year.	G0438 (first visit) G0439 (subsequent visit)
Annual Routine Physical Exam	Covered for Medicare Advantage members. Available every calendar year.	99385, 99386, 99387, 99395, 99396, 99397

TIPS FOR ANNUAL WELLNESS VISIT DOCUMENTATION

Health risk evaluation of each patient

Proper risk adjustment documentation ensures that CMS can make appropriate payments for enrollees with differences in expected health care costs. BlueCross BlueShield of South Carolina depends on our network providers to accurately document the acute and chronic health conditions of each MA beneficiary. Every submitted claim should match with the medical record for diagnoses and also be clearly documented in the medical record.

Tips for accuracy:

- During an annual wellness visit, document a complete medical history, including all known medical conditions and "history of" conditions and include all diagnoses on the claim.
- Be as specific as possible when adding diagnoses to medical records and claims.
- Try using a specific code rather than an "unspecified" diagnosis code.
- Include laboratory interpretations in medical record documentation.

ELEMENTS OF THE MEDICARE ADVANTAGE PROGRAM

The goals and structure of the Medicare Advantage program are intended to improve health outcomes and optimize the health experience for every Medicare Advantage beneficiary. The program consists of various metrics that evaluate the completion of clinical services, consider medication adherence, capture patient satisfaction and summarize the patient self-reported health status. Below is a brief summary of the metrics and tips on what you can do to become a high-performing quality provider.

HEDIS® Measures HEDIS® = Healthcare Effectiveness Data and Information Set	HEDIS® is a measurement tool that quantifies the completion of health tests and services. For example, this includes colon cancer screening, breast cancer screening, BMI assessment and more. **Provider Action:** Addressing all HEDIS® measures the patient is due for will improve your quality performance and improve health outcomes.
CAHPS® Measures CAHPS® = Consumer Assessment of Healthcare Providers and Systems	Capturing the voice of Medicare beneficiaries is necessary to improve the beneficiary experience. CAHPS surveys are distributed annually for beneficiaries to provide anonymous ratings of their health plan, physicians and health systems. **Provider Action:** Strive to keep timely office appointments, set expectations during and after the patient visit, and make sure the beneficiary clearly understands the care plan by answering all questions before ending the visit.
Clinical Pharmacy Measures Part D medication and adherence measures	Clinical pharmacy measures are designed to track patient adherence to taking prescribed medications and ensure access to drugs for their individual health needs. The pharmacy measures include diabetes adherence, hypertension adherence, cholesterol adherence as prescribed by physicians. **Provider Action:** Make sure to always review medication protocols with patients and help them maintain an 80 percent adherence level based on the total amount of days covered within a year. Ninety-day fills are a great way to maintain adherence.
HOS Measures HOS = Health Outcome Surveys	Once every two years, MA beneficiaries can respond to a CMS survey and rate their individual mental and physical health. This includes their risk of falling, bladder control, sadness, energy and other physical abilities. **Provider Action:** Address activities of daily living with each beneficiary and help him or her set expectations for individual health progression along with ideas to keep a positive outlook on life.

MEDICARE ADVANTAGE NETWORK SHARING

A Medicare Advantage Preferred Provider Organization (PPO) plan allows members who enroll to access providers outside of the contracted network of providers.

Network sharing allows MA PPO members from other Blue Plans to get in-network benefits when traveling or living in the service areas of other MA PPO plans. Medicare Advantage PPO shared networks are available in 39 states and Puerto Rico. Members traveling from other Blue Plans that qualify for the same in-network benefits when traveling here will have this symbol on their ID cards:

MA | PPO
MEDICARE ADVANTAGE

The BlueCross BlueShield Medicare Advantage Quality Improvement and STARS team is provided with HEDIS quality information for some shared network Blue Plans for MA PPO members who are known to travel or live part of the year in South Carolina. This information will be included on member care gap reports and quality reporting to our network providers, when applicable.

For our providers, this means:

- You will receive member care gap reports monthly for members associated to your practice via claims data.
- These reports will include all BlueCross BlueShield of South Carolina Medicare Advantage members as well as Medicare Advantage members from other Blue Plans.
- You may receive a medical record request from a different BlueCross BlueShield plan than South Carolina or be asked to submit a medical record to BlueCross BlueShield of South Carolina for another Blue Plan.

Tips for accuracy:

- Continue to verify eligibility for out-of-area MA PPO members. This can be done via the BlueCard® Eligibility Line or on the web through My Insurance Manager®.
- Continue to submit claims for all BlueCross BlueShield members, regardless of state, to BlueCross BlueShield of South Carolina.
- Frequently review member care gap reports.
- Pay attention to open quality care gaps and patient health concerns.
- Ensure documentation of completed services while patients are visiting from other states.

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