South Carolina

Medicare Advantage

THE QUALITY CONNECTION

Medicare Advantage Provider Newsletter

Fall 2022 | Issue 6

WHAT'S INSIDE

BENEFIT CHANGES FOR 2023

The annual enrollment period for Medicare beneficiaries began Oct. 15 for the 2023 health plan benefit cycle. We are looking forward to offering great benefits and many supplemental programs to help remove barriers to care. In 2023, we will continue to offer a variety of HMO and PPO plans for beneficiaries in the state of South Carolina. We have $0 premium offerings, expansive provider network coverage and a local concierge customer service team.

Included in 2023 benefit offerings is a unique member incentive. If a member schedules and completes a Medicare annual wellness visit in 2023, an additional $40 will be added to his or her OTC Flex Card to be used for over-the-counter (OTC) supplies, copays or prescriptions.

BlueCross BlueShield of South Carolina Medicare Advantage members in 2023 will enjoy these great benefits:

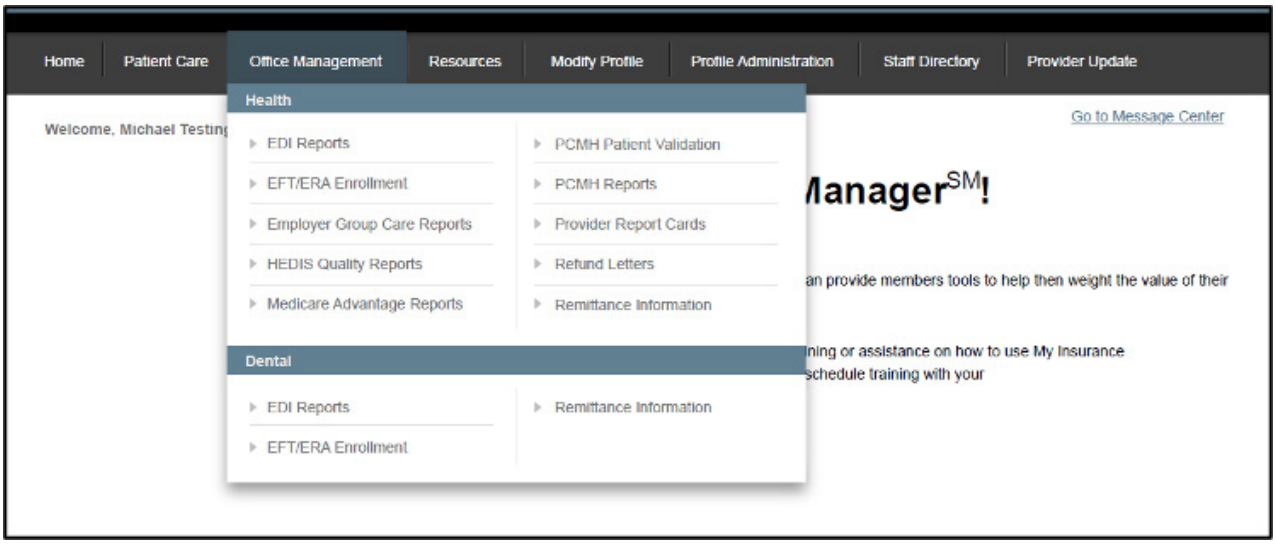
- $0 PCP office copay
- $0 lab copay
- Decreased specialist copays
- $0 mammogram, EKG, colonoscopy and DEXA scan
- $0 for diabetes glucose monitors and testing supplies
- $0 eye exams and eyewear, including contacts
- Up to $3,000 preventive/comprehensive dental benefit*
- Up to $260 in free OTC products*
- Transportation (limited to certain locations, including provider offices, pharmacies, grocery stores and government buildings)
- Gym memberships or home workout kits
- A post-discharge meal program

*Some supplemental benefit offerings vary by plan and location.

MY INSURANCE MANAGER

Coming in 2023!

My Insurance Manager will offer Medicare Advantage reporting to providers who have attributed BlueCross BlueShield of South Carolina Medicare Advantage memberships. Visible in My Office Management, all providers will be able to view a HEDIS Care Gap Report and a Provider Score Card. You can find these by selecting the Medicare Advantage Reports link.



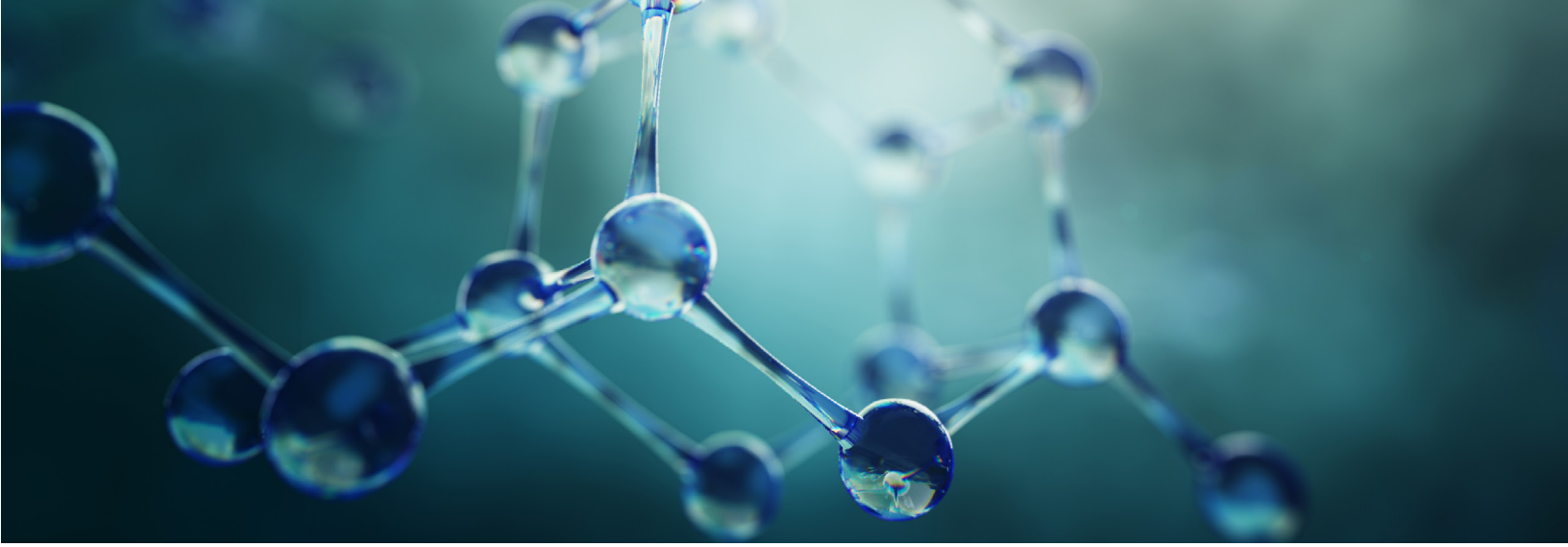
Please remember, our Quality Nurse Navigator team is available to assist with these reports, member targeting and any education you may need to improve your scores and the closure of care gaps.

PRIOR AUTHORIZATION REQUESTS

To continue offering appropriate benefits for our members, we routinely make updates and changes to services requiring prior authorization.

For Medicare Advantage, our list of services requiring prior authorization may differ from other commercial plans at BlueCross BlueShield of South Carolina.

Prior to scheduling or performing a service, review the member's eligibility and review our prior authorization website. Questions and authorization requests can be submitted through phone, fax or My Insurance Manager.



CHANGES TO MEDICATION FORMULARY FOR 2023

Insulin Savings Program

For calendar year 2023, BlueCross BlueShield of South Carolina will continue to participate in the Insulin Savings Program. For our members, this means they can receive a 30-day supply of the following brands of insulin for as little as $30:

- Humalog®
- Humulin®
- Lantus®
- Levemir®
- Lyumjev®
- Novolin®
- NovoLog®
- Toujeo®
- Tresiba®
- Soliqua® 100/33

Oral Diabetes, Hypertension, Cholesterol Management and Osteoporosis Treatments

Many medications related to HEDIS medication adherence measures and osteoporosis treatment are available to all Medicare Advantage members for $0 for a 30- or 90-day supply at a preferred pharmacy or through mail order. For all members, these medications are listed in our newly formed Tier 6 on the formulary. This means members can refill these medications earlier than those in other tiers. This new tier includes:

- Generic angiotensin 2 receptor antagonists.
- Generic ACE inhibitors.
- Generic statins.
- Alendronate/ibandronate.

We encourage all members to take their medications as prescribed and to refill before running out of medication. As a provider, you should write your prescription as you would have the patients take the medication. Avoid writing prescriptions for different doses with instructions to split pills. This can be confusing to members and poses risk of wrongful medication dosing. Encourage your patients to use the convenience of automatic refills at the pharmacy or through mail order to avoid late or missed fills.

RISK ADJUSTMENT PROGRAM AND MEDICAL RECORD AUDITS

Recently, the Office of the Inspector General (OIG) has completed several audits of Medicare Advantage health plans and found fraudulent medical diagnoses submitted on claims to the Centers for Medicare & Medicaid Services (CMS).

It is imperative that you, as a provider, code appropriately for your patients' medical diagnoses.

Areas for billing teams and providers to pay special attention to are:

- Conditions that are acute versus chronic (e.g., acute stroke).
- Cancers in remission.
- Historical diagnoses that are no longer active.
- Diagnoses that require specific treatment that is not ordered (e.g., embolism and anticoagulants).
- Submitting codes in a timely manner with the correct rendering provider matching the date of service.

Through internal auditing of medical records and claims, your office will be notified of any claims that may be inaccurate or medical records that may appear incomplete. You may be asked to review and resolve claims. If you receive a medical record request, please respond quickly to help identify early issues and allow appropriate time for any potential corrections to be made.

As we near the annual HEDIS audit, your office may receive additional medical records requests. We ask that you respond in a timely manner, either providing the medical records or indicating you do not have the medical records requested.

NEW CLAIMS PROCESSING — DX GAP ADVISOR

We work with Change Healthcare for all risk adjustment and other submissions to CMS. A new program being offered to our providers is the Dx Gap Advisor. This new program for providers submitting claims through the Change Healthcare clearinghouse alerts them to potentially missing historical diagnosis codes. When the clearinghouse receives a claim, you may receive a rejection and alert message asking you to review the claim for additional diagnoses.

What To Do if Your Office Receives a Rejection Message

Once Dx Gap is enabled, your office may receive a message. At that time, you should take the following actions:

- Engage a qualified coder or appropriate professional to review the patient's medical record to confirm the diagnoses coded on the claim are complete and accurate.
- If the coding on the claim is complete as is, resubmit the claim for clearinghouse processing using the original claim ID.
- If changes are necessary, make the changes and resubmit the claim using the original claim ID.
- If a diagnosis is added to the claim, the provider should ensure all affected fields are addressed, including the "order of the diagnoses reported" and the "Diagnosis Pointer," per CMS Form 1500 and ICD 10-CM coding guidelines

Additional Details

A Dx Gap Advisor message does not suggest alternative codes or coding practices. To ensure compliance with the False Claims Act and other federal and state laws and coding guidelines, providers must never modify a diagnosis code based on the message alone.

Change Healthcare may monitor the number and types of changes a provider makes. If patterns suggest changes are not based on a thorough medical record review, an audit process may be implemented.

Change Healthcare is an independent organization that submits risk adjustment and other submissions to CMS on behalf of BlueCross.

Additional Resources

To enable a smooth transition, we encourage you to visit **Inspire.ChangeHealthcare.com/DxGapAdvisor*** for a more detailed overview of the program.

For questions about a claim status message or general program questions, please call Change Healthcare Customer Service at 1-844-592-7009, option 3.

*This link leads to a third-party website. Change Healthcare is solely responsible for the content and privacy policies on its site.

HYPERTENSION AND HEDIS MEASURE CONTROLLING BLOOD PRESSURE (CBP)

According to the South Carolina Department of Health and Environmental Control, 1 in 3 South Carolinians have been told they have high blood pressure or diagnosed with hypertension.

NCQA recommends patients between 18 and 85 years of age have a blood pressure assessment annually and indicates a controlled blood pressure is one that is less than 140 systolic and less than 90 diastolic. NCQA's definition also requires the most recent blood pressure following two documented diagnoses of hypertension be the blood pressure reading that is measured for compliance to the CBP measure.

Tips for our providers:

- Check blood pressure on all patients at all visits.
- Document whole number values and do not round up.
- If the blood pressure reading is elevated, recheck and redocument additional blood pressures in the same medical record.
- Do not document ranges or average blood pressure readings.
- During a telehealth appointment, ask the member to check his or her blood pressure if he or she has access to an automated cuff at home.
- Document CPT® 2 codes for additional incentive.

Medical coding for hypertension should focus on the level of progressive disease for each patient. It may no longer be appropriate to code using ICD-10 code I10 for someone who has progressed into chronic kidney disease or heart failure because of poorly controlled hypertension. It is also inappropriate to document I10 for a member who is not being treated for hypertension.

Please see the table for additional codes.

Disease State	Correct Hypertension Code	Additional Codes, If Needed
Hypertension, Controlled	I10	
Hypertension With Heart Disease (i.e., cardiomegaly, heart failure, myocardial degeneration, myocarditis)	I11	Category I50 to classify the level of heart disease involvement
Hypertensive Chronic Kidney Disease	I12	Category N18 to classify the level of kidney disease
Hypertensive Heart and Chronic Kidney Disease	I13	Category I50 to identify the type of heart failure AND Category N18 to classify the stage of kidney disease
Transient Hypertension	R0.30	
Dependence on Renal Dialysis	Z99.2	

The above ICD-10 codes are provided as a guide for physician reporting and are not intended to constitute required documentation or otherwise.

SPOTLIGHT ON HEDIS MEASURES: KIDNEY EVALUATION FOR PATIENTS WITH DIABETES (KED)

Recently, we have received a lot of questions related to the changes to the kidney health quality measure and why the care gap remained open after completing testing that was previously accepted as compliant.

In 2022, NCQA changed the reportable compliance standards for evaluating kidney health for patients with diabetes. It removed the visit with nephrologist, ACE/ARB therapy and urinalysis test as options for compliance.

To be considered compliant for 2022 and beyond, members must receive both an eGFR annually and a uACR test annually. The uACR test can be compliant with both a quantitative urine albumin test and a urine creatinine test done on the same urine sample.

At least one eGFR

Estimated Glomerular Filtration Rate Lab Test (eGFR)
CPT
80047, 90048, 80050, 80053, 80069, 82565
LOINC
48642-3, 48643-1, 5044-77, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 88293-6, 88294-4, 94677-2, 96591-3, 96592-1, 98979-8, 98980-6
SNOMED CT US Edition
12341000, 18207002, 241373003, 444275009, 444336003, 446913004, 706951006, 763355007

At least one uACR identified the following:

Urine Creatinine Lab Test
CPT
82570
LOINC
20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
SNOMED CT US Edition
8879006, 36793009, 271260009, 444322008

AND

Quantitative Urine Albumin Lab Test
CPT
82043
LOINC
14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7
SNOMED CT US Edition
104486009, 104819000

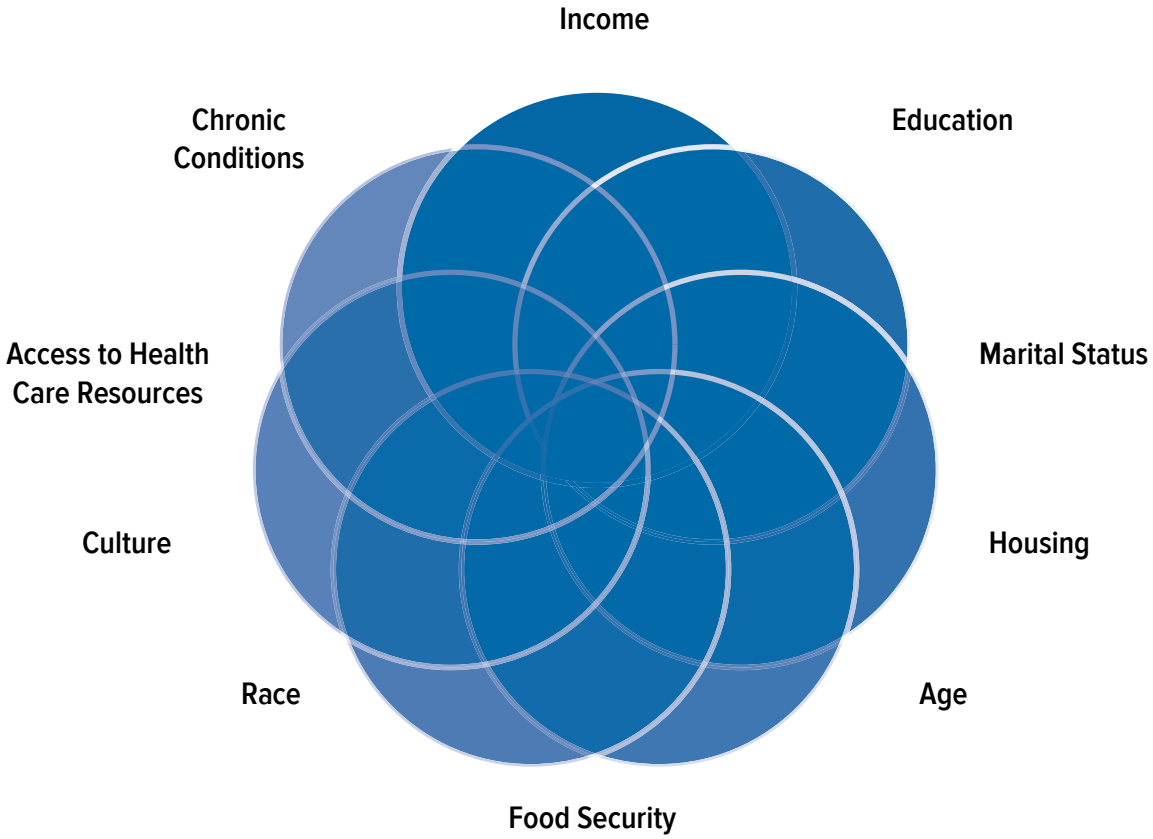
The uACR tests above must have service dates four days or less apart

We understand these changes will create a need for new processes and workflows.

Please work with your quality teams or billing teams to appropriately test and code for the new NCQA standards for kidney health testing for your diabetic patients.

ADDRESSING THE HOS SURVEY

The Health Outcomes Survey (HOS) is sent by CMS annually to Medicare beneficiaries. The survey questions are intended to get members' subjective feedback about the health care they receive and the way they rate their personal mental and physical health. The results are used in Medicare Advantage plans' Star Ratings, and the information is used to drive quality improvement activities, network oversight, public reporting, and improved health of beneficiaries through supplemental benefits and programs.



As Medicare beneficiaries age, it may become more difficult to cope with disease processes, multiple conditions and treatments. As a Medicare provider, you should assess the physical and mental health needs of your patients in addition to addressing social determinants of health that may affect your patients' ability to cope with disease and manage health conditions for overall physical and mental well-being.

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