South Carolina

Medicare Advantage

PROVIDER PARTNERSHIP PROGRAM 2024

Help Us Build a Healthier South Carolina

www.SouthCarolinaBlues.com

A MESSAGE FROM OUR MEDICARE ADVANTAGE QUALITY TEAM

Dear Provider,

We are excited to enter another year as your partner in providing care for BlueCross BlueShield of South Carolina Medicare Advantage members.

Our dedicated professional team is here to expand and enhance the impact you have on the physical and mental well-being of our Medicare Advantage beneficiaries. We understand the importance of creating a positive experience for our members as they navigate the ever-changing world of health care. We work diligently to remove barriers to care.

Our Provider Quality Guide helps in the documentation of care provided to Medicare patients. It also ensures the documentation meets regulatory guidance from the Centers for Medicare & Medicaid Services. Our team of quality nurses is available to help with additional questions. They are meant to be a liaison to your office for getting more member needs taken care of quickly.

We appreciate the quality provided to our members. We look forward to another year as the only local Medicare Advantage team in South Carolina.

Sincerely,

Medicare Advantage Quality Team

Codes and other information in this manual may change throughout the year. This guide is for information only and does not guarantee coverage or payment of such codes.

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 who care for them. 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 reference for available BlueCross resources, information on commonly used codes, and quality documentation tips for risk adjustment and HEDIS compliance.

MEET YOUR QUALITY NAVIGATORS

We Are Here for You

The goal of our provider partnership program is to assist Medicare Advantage providers in delivering 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 work with 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 improve quality outcomes.

CONTENTS

KEY CONTACTS AND HELPFUL TIPS

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

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Tips on Using This Manual

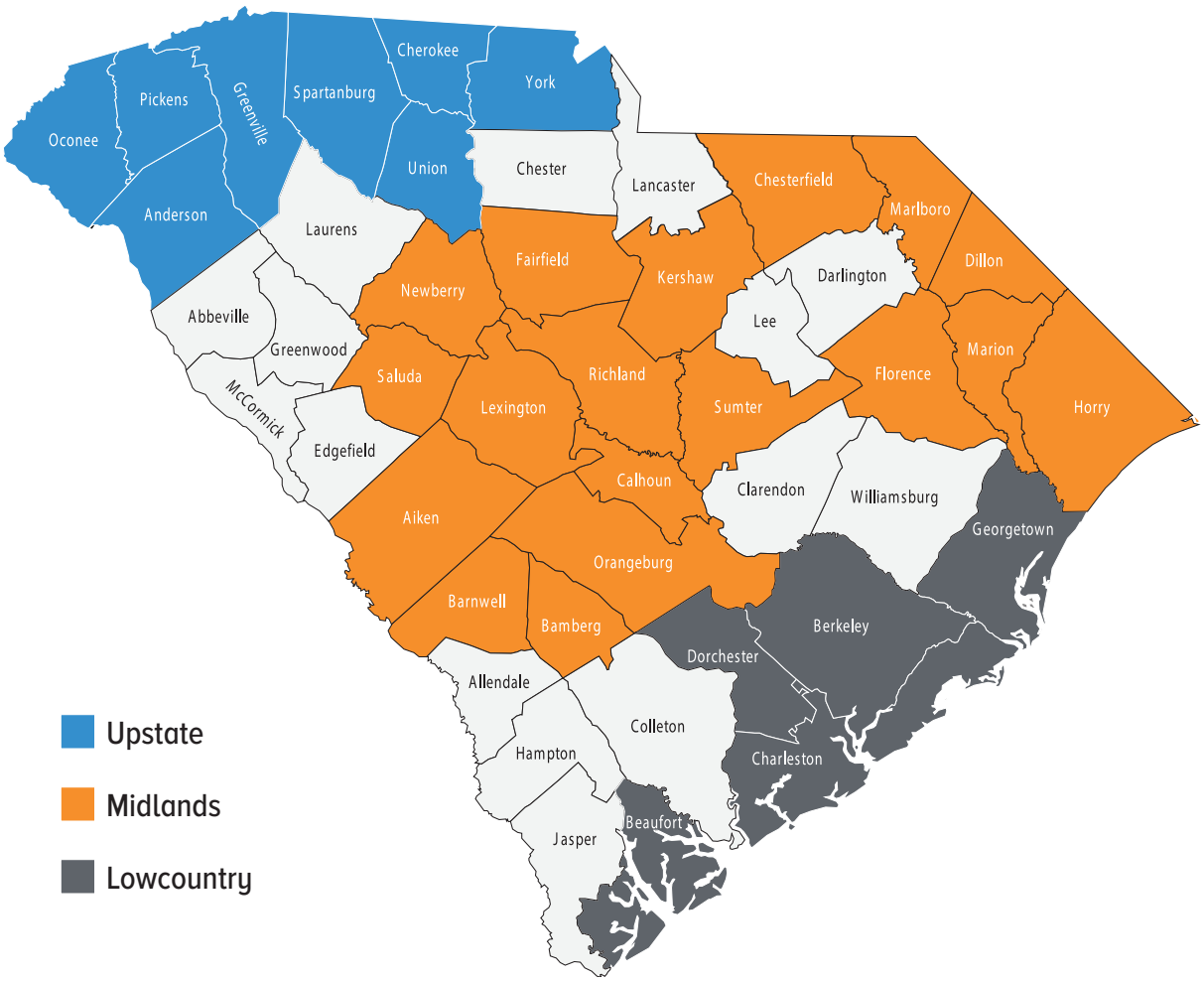
- When using the electronic version, you can search the document using Ctrl + F. Type the keyword, and then select Enter.
- **Quality** refers to quality metrics for Healthcare Effectiveness Data and Information Set (HEDIS) (e.g., colon cancer screening).
- **Risk** refers to risk adjustment documentation 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 began in January 2018. Since its inception, the program has grown its membership exponentially each year. Our beneficiaries consist of Medicare-aged members and members under age 65 who are eligible due to disability. We serve members in 29 counties across the state.

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.



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 scale of 1 to 5, with 5 being the highest performing. The Star Rating is comprised of different data sources, including HEDIS quality measure compliance, pharmacy data, member survey responses and health plan operations performance. Performance in these areas directly affects 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 individual performance, our quality nurse navigators will present updated provider 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

2024 MEDICARE ADVANTAGE MEMBER BENEFITS

BlueCross offers several Medicare Advantage benefit packages 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	$0 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℠ Powered by MDLIVE® Normal office copays apply for telehealth appointments with a primary care physician.

X-Rays	
Outpatient X-rays	$10 per X-ray
Hearing Aids	
$699 – $999	One per ear per year

Diagnostic Tests	
In Network	$0 to $275 per service
Out of Network	40% of the cost
Lab Services	
In Network	$0 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

MDLIVE is an independent company that provides a telehealth platform on behalf of BlueCross.

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 focuses on readmission avoidance and post-hospital discharge care. Some members also qualify for a free meal program after discharge from a hospitalization.
- Accessible care — Members can get at-home services for health screenings (e.g., colon cancer, A1C) and in-home health assessments. Community health events are scheduled in various locations throughout the state.
- Dental services from a Medicare-approved dentist — Members get two preventive dental visits per year, oral exam, cleaning and bitewing X-rays.

Our 2024 benefits include additional supplemental benefits to help meet special needs for members.

Not everyone will need or use these benefits, but they are available to all members.

Over-the-counter benefits:

- Members now get a flex card. They can use it like a debit card at retail pharmacies and other stores to buy healthy food options. Items include first-aid supplies, hygiene supplies, vitamins, mobility devices, home safety equipment and more.

Annual wellness incentive:

- Any member who has an annual wellness visit or annual physical in 2024 will get $40 added to his or her over-the-counter flex card.

Social support:

- Members can receive home modifications, digital literacy support, meal delivery and other nonclinical support through The Helper Bees at no cost. The Helper Bees is an independent organization that connects services to empower independence with our beneficiaries.

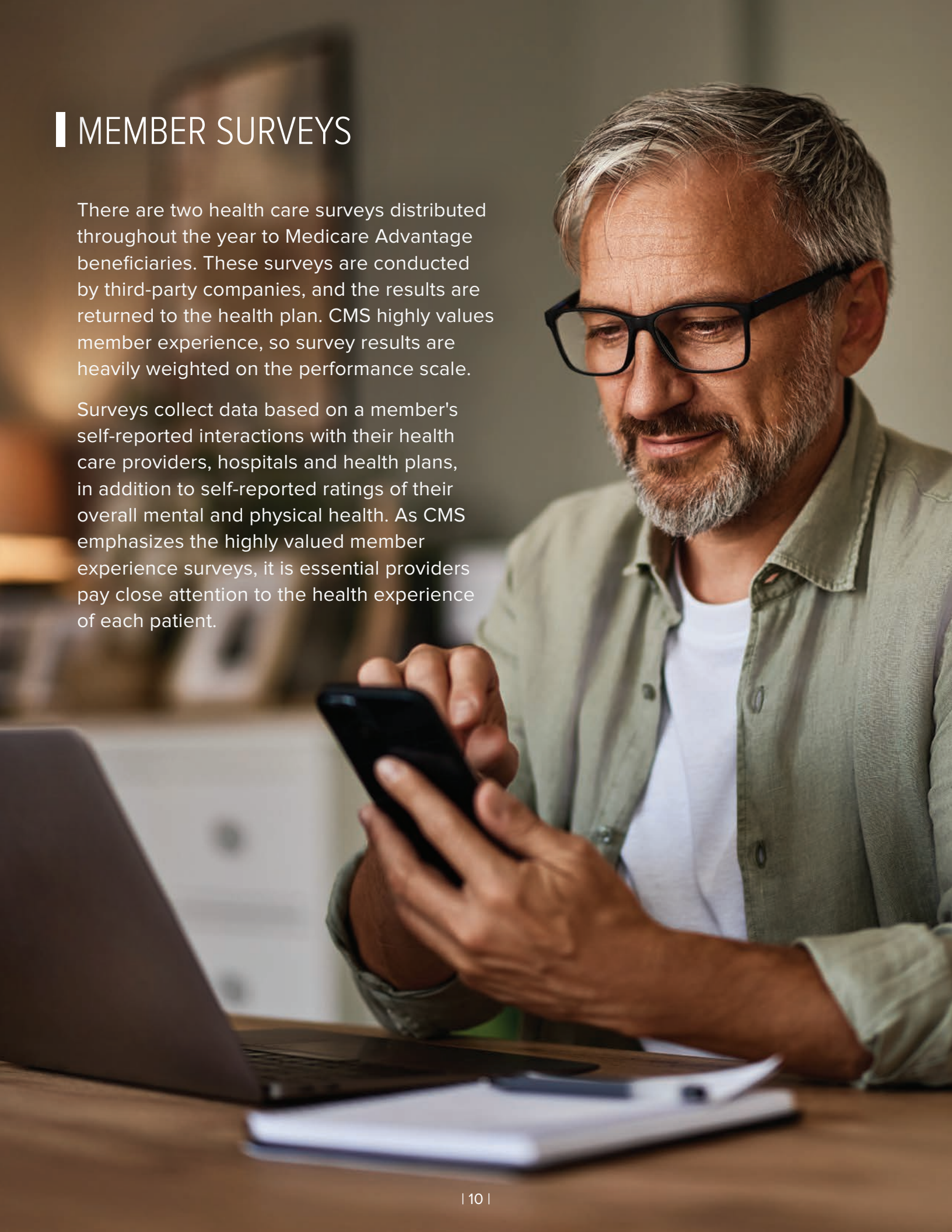
Transportation:

- Members can get 24 free one-way ride to doctors' offices, the pharmacy, grocery stores and other qualified destinations. Miles are limited by county.

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 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 important to consumers and focuses on aspects of quality related to providers and health care services, including:

Personal Health: The survey asks about emergency care and follow-up appointments and asks members to rate 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 rate 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' plans of care, it is important our members are offered the time to discuss these topics. Medicare annual wellness visits are the perfect time to discuss these topics with all patients.

How You Can 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 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.

CPT II CODE INCENTIVE

At BlueCross, 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 affect quality measures.

The CPT incentive program is eligible for providers who submit proper CPT II coding following an encounter. Payment for the CPT II 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.

The attached grid lists the HEDIS measures and applicable codes that, when billed correctly, will result in an incentive payment. Incentive payments will be made to the PCP or specialist who completed the service, according to claims. For any discrepancies in claims and codes submitted, the attributed PCP will receive the incentive payment.

The incentive program is subject to changes NCQA makes in HEDIS specifications. BlueCross may change the incentive at its discretion.

CPT Category II Codes				
HEDIS Measure and Claim Specifications		**CPT II Code Definition**	**CPT or CPT II Code**	**Incentive Amount**
Diabetes Care These CPT II 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.	HbA1C Control	HbA1C Level Less Than 7.0	3044F	$10
		HbA1C Level Greater Than or Equal to 7.0 and Less Than 8.0	3051F	$10
		HbA1C Level Greater Than or Equal to 8.0 and Less Than or Equal to 9.0	3052F	$10
	Retinal Eye Exam Only one code per member is paid annually.	Automated Eye Exam Imaging With Retinal Camera	92229	$15
		Eye Exam With Evidence of Retinopathy	2022F 2024F 2026F	$15
		Eye Exam Without Evidence of Retinopathy	2023F 2025F 2033F	$15
	Kidney Disease Monitoring Codes must be billed together.	Quantitative Urine Albumin Lab Test	82043	$10
		Urine Creatinine Lab Test	82570	
Hypertension Management These CPT II codes must be submitted on a claim with an ICD-10 diagnosis for Essential Hypertension: I10.	Controlling Blood Pressure Code for one blood pressure reading per date of service. If multiple blood pressure readings are taken on the same date of service, code for lowest values.	Systolic Blood Pressure Less Than 130 mmHg	3074F	$5
		Systolic Blood Pressure 130 – 139 mmHg	3075F	$5
		Diastolic Blood Pressure Less Than 80 mmHg	3078F	$5
		Diastolic Blood Pressure 80 – 89 mmHg	3079F	$5
Transitions of Care	Medication Reconciliation	Discharge medications are reconciled with the current medication list in the outpatient medical record.	1111F	$50

Please note the codes listed above will result in closure of an identified care opportunity. This is not a guarantee of benefits or payment of claims. Benefits are always subject to the terms and limitations of the plan.

If you have any questions about the CPT incentive, please speak with your Medicare Advantage quality nurse navigator.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HEDIS 2024

NCQA makes updates to the HEDIS quality measures every year. The following pages will outline specific quality measures, 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 the plan of care differs from traditional preventive and treatment-based medical plans of care.

Medicare Advantage partners with various vendors 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 2024 (continued)

Breast Cancer Screening (BCS)

Measure Definition
Women 50 – 74 years of age who had a mammogram completed between Oct. 1, 2022 and Dec. 31, 2024

Exclusions
- History of bilateral mastectomy

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

Does Not Qualify
- Biopsies
- Breast ultrasounds
- Breast MRI

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

Description	CPT	HCPCS
Breast Cancer Screening	77061 – 77063, 77065 – 77067	

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

Provider Tip: Once a mammogram has been ordered, follow up with the patient to confirm it has been completed.

Controlling Blood Pressure (CBP)

Measure Definition

Percentage of members ages 18 – 85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled during 2024. 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, Z99.2	90935, 90937, 90945, 90947, 90997, 90999
Kidney Transplant	Z94.0	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. 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 blood pressure 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 2024 (continued)

Colorectal Cancer Screening (COL)

Measure Definition

All members 45 – 75 years of age who completed a colorectal cancer screening

Qualifying Studies

- Colonoscopy completed on or after Jan. 1, 2015
- Flexible sigmoidoscopy completed after Jan. 1, 2020
- CT colonography completed after Jan. 1, 2020
- FIT-DNA test completed after Jan. 1, 2022
- FIT/FOBT completed after Jan. 1, 2024

Exclusions

- History of colorectal cancer
- History of total colectomy

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

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.

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	
Fecal Occult Blood Test	82270, 82274	G0328

Eye Exam for Patients With Diabetes (EED)

Measure Definition

All diabetic members 18 – 75 years of age who had a retinal eye exam

Qualifying Studies

- Retinal or dilated eye exam by an optometrist or ophthalmologist in 2024 with any result
- Retinal or dilated eye exam by an optometrist or ophthalmologist in 2023 that was negative for retinopathy
- Documentation of bilateral eye enucleation in member's medical history

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.

If you take retinal pictures in your office, please use CPT code 92229.

Commonly Used CPT and CPT II Codes

Description	CPT	CPT II Code	HCPCS
Diabetic Retinal Screening	67028, 67030, 67031, 67036, 67039 – 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220,67221,67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92227, 92228, 92229, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213 – 99215, 99242 – 99245	2022F, 2023F, 2024F, 2025F, 2026F, 2033F	S0620, S0621, S3000

HEDIS 2024 (continued)

Kidney Health Evaluation for Patients With Diabetes (KED)

Measure Definition

Diabetic members 19 – 85 years of age who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year

Exclusions

- Members with end-stage renal disease (ESRD) or who received dialysis treatment
- Members who used hospice or palliative care services during the year

Exclusion Description	ICD 10	CPT
Evidence of ESRD	N18.5, N18.6, Z91.15, Z99.2	36147, 36800, 90935, 90937, 90945, 90947, 90997, 90999

Documentation Tips

Members must have all three tests completed within the year to be compliant. The urine studies must be completed within four days of each other. Most providers do the two urine tests on the same urine sample and bill together.

Test Description	CPT Code
Estimated Glomerular Filtration Rate (eGFR)	80047, 80048, 80050, 80053, 80069, 82565
Urine Creatinine	82570
Quantitative Urine Albumin	82043

Glycemic Status Assessment for Patients With Diabetes (GSD)

Measure Definition

Diabetic members 18 – 75 years of age whose most recent glycemic status (hemoglobin A1C [HbA1C] or glucose management indicator [GMI]) was 9.0 or less in the measurement year

Qualifying Results

- Ensure all diabetic members receive HbA1C testing during the year 2024.
- Encourage lifestyle changes and medication management in order to have result less than 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**
Hemoglobin A1C Testing	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 (This CPT II code will not close the care gap, since value is too high.)

HEDIS 2024 (continued)

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

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.

Transition of Care (TRC)

Measure Definition

The percentage of inpatient discharges for members ages 18 and older who had each of the following:

- Notification of inpatient admission
- Receipt of discharge information
- Patient engagement after inpatient discharge
- Medication reconciliation post-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.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system.
- Indication that the member's PCP or ongoing care provider admitted the member to the hospital.
- Indication a specialist admitted the member and notified the PCP.
- Indication the admission was planned and the member's PCP was notified or performed a preadmission exam.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.

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

HEDIS 2024 (continued)

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.

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
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review and includes documentation that indicates the provider was aware of the member's hospitalization or discharge

Member Benefit

BlueCross 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 Codes (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 (CPT II), 99483, 99496, 99495

HEDIS 2024 (continued)

Statin Use in Persons With Diabetes (SUPD)

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
- Members with rhabdomyolysis or myopathy diagnosis
- Pregnancy or PCOS diagnosis
- Members with pre-diabetes 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 (SPC)

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 and rhabdomyolysis
- Members who had dialysis
- Pregnancy, in vitro fertilization or members dispensed prescription for clomiphene

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 2024 (continued)

Medication Adherence (ADH)

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.

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 the types of medications listed.

Osteoporosis Management in Women Who Had a Fracture (OMW)

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 or any female who has had a recent fracture.

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.

MAXIMIZING PATIENT CARE AND COMPLIANCE: A GUIDE TO ANNUAL WELLNESS VISITS

Annual wellness visits (AWVs) play a pivotal role in the Medicare Advantage program, offering a preventive service to members that focuses on health promotion and disease detection.

AWVs are distinct from traditional physical exams, as they provide an opportunity for clinicians to update health risk assessments, develop or update personalized prevention plans, and screen for various conditions. For patients, AWVs are instrumental in the early identification and management of chronic diseases, improving long-term health outcomes. Effective AWVs can lead to enhanced patient satisfaction and better health outcomes, which are key metrics in provider performance evaluations. Hierarchical condition category (HCC) codes are a component of the Medicare risk adjustment model, which create a "narrative" for the health status of our enrollees. Common HCC codes encountered during AWVs include those for diabetes, heart failure and chronic kidney disease. When it comes to coding AWVs, accuracy is crucial. A comprehensive AWV should include a review of the patient's medical and family history; a list of current providers and prescriptions; measurement of height, weight, body mass index and blood pressure; and a cognitive function screening. Providers should also take this opportunity to address any suspected conditions and close care gaps, such as ensuring vaccinations and cancer screenings are up to date. AWVs are more than just a preventive measure; they are a cornerstone of quality patient care in the Medicare Advantage program.

Reminder: An AWV can be completed on the same day as a physical exam.

Annual Wellness Exam: G0402, G0438 or G0439

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

ANNUAL WELLNESS VISIT CHECKLIST

Patient Education and Communication

- ☐ Educate patients about the benefits of AWVs.
- ☐ Explain the difference between AWVs and standard physical exams.

Coding Knowledge and Compliance

- ☐ Review previous HCC captures and revalidate for current year.
- ☐ Review if patient is being seen by a specialist, remembering to review and assess those conditions.

Pre-Visit Preparation

- ☐ Develop and use a previsit checklist for AWVs.
- ☐ Review patient's medical history and medication list before the visit.
- ☐ Review open quality care gaps and alert staff to schedule during visit.

Technology Use

- ☐ Use electronic health records (EHRs) effectively.
- ☐ Meet with contact for EHR updates and education regarding updates.

Assessment and Screening

- ☐ Conduct comprehensive health risk assessments.
- ☐ Cover all preventive health areas, including mental and functional assessments.

Documentation Practices

- ☐ Document each aspect of the AWV in detail.
- ☐ Ensure documentation aligns with the HCC coding requirements (MEAT — see page 32).

Managing Suspect Conditions

- ☐ Identify and document suspect conditions accurately.
- ☐ Record medical evidence and treatment plans for HCC conditions.

Follow-Up and Coordination

- ☐ Establish a clear follow-up plan for any issues identified.
- ☐ Coordinate care with specialists and other health care providers.

PROPER DOCUMENTATION FOR RISK ADJUSTMENT

Using MEAT in Documentation

The **MEAT** 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 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 MEAT 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 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 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

HCC CODING GUIDE: V28 MODEL UPDATE AND CHANGES

The Centers for Medicare & Medicaid Services is adding or updating dozens of hierarchical condition categories (HCCs) in its new HCC model, V28. You may notice that your patients' risk scores change as the new model is implemented over the next few years. Here are some key payment HCCs that are important to primary care. Successful implementation of AWVs, accurate HCC coding and quality care gap closure require a dedicated approach focused on patient education, continuous learning and meticulous documentation. By following these tips, providers can enhance patient care and improve health outcomes.

DIABETES DISEASE GROUP

New

HCC 35 (Pancreas Transplant Status)

Updated

HCC 36 (Diabetes With Severe Acute Complications)

HCC 38 (Diabetes With Glycemic, Unspecified, or No Complications)

GASTROINTESTINAL DISEASE GROUP

New

HCC 80 (Crohn's Disease [Regional Enteritis])

HCC 81 (Ulcerative Colitis)

Updated

HCC 77 (Intestine Transplant Status/Complications)

MUSCULOSKELETAL DISEASE GROUP

New

HCC 94 (Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders)

Updated

HCC 92 (Bone/Joint/Muscle/Severe Soft Tissue Infections/ Necrosis)

HCC 93 (Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders)

COGNITIVE DISEASE GROUP

Updated

HCC 125 (Dementia, Severe)

HCC 126 (Dementia, Moderate)

HCC 127 (Dementia, Mild or Unspecified)

BLOOD DISEASE GROUP

All New or Updated

HCC 107 (Sickle Cell Anemia [Hb-SS] and Thalassemia Beta Zero)

HCC 108 (Sickle Cell Disorders, Except Sickle Cell Anemia [Hb-SS] and Thalassemia Beta Zero; Beta Thalassemia Major)

HCC 109 (Acquired Hemolytic, Aplastic, and Sideroblastic Anemias)

HCC 111 (Hemophilia, Male)

HCC 112 (Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions)

HCC 114 (Common Variable and Combined Immunodeficiencies)

HCC 115 (Specified Immunodeficiencies and White Blood Cell Disorders)

SUBSTANCE USE DISORDER DISEASE GROUP

New

HCC 135 (Drug Use With Psychotic Complications)
HCC 136 (Alcohol Use With Psychotic Complications)
HCC 137 (Drug Use Disorder, Moderate/Severe, or Drug Use With Nonpsychotic Complications)
HCC 138 (Drug Use Disorder, Mild, Uncomplicated, Except Cannabis)
HCC 139 (Alcohol Use Disorder, Moderate/Severe, or Alcohol Use With Specified Nonpsychotic Complications)

PSYCHIATRIC DISEASE GROUP

New

HCC 153 (Personality Disorders; Anorexia/Bulimia Nervosa)

Updated

HCC 152 (Psychosis, Except Schizophrenia)
HCC 154 (Bipolar Disorders Without Psychosis)
HCC 155 (Major Depression, Moderate or Severe, Without Psychosis)

HEART DISEASE GROUP

New

HCC 221 (Heart Transplant Status/Complications)
HCC 222 (End-Stage Heart Failure)
HCC 223 (Heart Failure With Heart Assist Device/ Artificial Heart)
HCC 224 (Acute on Chronic Heart Failure)
HCC 225 (Acute Heart Failure [Excludes Acute on Chronic])
HCC 226 (Heart Failure, Except End-Stage and Acute)
HCC 227 (Cardiomyopathy/Myocarditis)

VASCULAR DISEASE GROUP

New

HCC 267 (Deep Vein Thrombosis and Pulmonary Embolism)

LUNG DISEASE GROUP

New

HCC 276 (Lung Transplant Status/Complications)
HCC 279 (Severe Persistent Asthma)

Updated

HCC 278 (Idiopathic Pulmonary Fibrosis and Lung Involvement in Systemic Sclerosis)
HCC 280 (Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders and Other Chronic Lung Disorders)
HCC 283 (Empyema, Lung Abscess)

NEOPLASM DISEASE GROUP

Updated

HCC 17 (Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic)
HCC 18 (Cancer Metastatic to Bone, Other and Unspecified Metastatic Cancer; Acute Leukemia Except Myeloid)
HCC 19 (Myelodysplastic Syndromes, Multiple Myeloma, and Other Cancers)

METABOLIC DISEASE GROUP

New

HCC 49 (Specified Lysosomal Storage Disorders)

Updated

HCC 50 (Amyloidosis, Porphyria, and Other Specified Metabolic Disorders)
HCC 51 (Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders)

LIVER DISEASE GROUP

New

HCC 62 (Liver Transplant Status/Complications)
HCC 68 (Cholangitis and Obstruction of Bile Duct Without Gallstones)

NEUROLOGICAL DISEASE GROUP

Updated

HCC 191 (Quadriplegic Cerebral Palsy)
HCC 192 (Cerebral Palsy, Except Quadriplegic)
HCC 193 (Chronic Inflammatory Demyelinating Polyneuritis and Multifocal Motor Neuropathy)
HCC 195 (Myasthenia Gravis With [Acute] Exacerbation)
HCC 196 (Myasthenia Gravis Without [Acute] Exacerbation and Other Myoneural Disorders)
HCC 199 (Parkinson and Other Degenerative Disease of Basal Ganglia)
HCC 200 (Friedreich and Other Hereditary Ataxias; Huntington Disease)

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