The Provider Assessment Form (PAF) is an important tool for collecting comprehensive information on each patient’s current health status. It shows how all chronic and acute conditions are managed, ensures these conditions are documented and sent to CMS every year, and provides valuable Risk Adjustment data required by CMS.

The PAF data can also close many Quality Measure gaps, impacting your STARS score and future annual fee schedule.

**IMMEDIATE and FUTURE BENEFITS to YOU**

**PAF submission should be billed on your encounter claim for reimbursement.**

- Effective Jan. 1, 2017, you should submit CPT code 96160 in addition to your visit E/M code. No modifier is needed. Note that CPT code 99420 will not be valid for dates of service after Jan. 1, 2017 or later.
- Reimbursement for completion of a PAF is based on date of service:
  - $250 for dates of service between Jan. 1 and March 31
  - $200 for dates of service between April 1 and June 30
  - $175 for dates of service between July 1 and Sept. 30
  - $150 for dates of service between Oct. 1 and Dec. 31

You may also perform the Medicare Annual Wellness Visit at the same time.

- Use G0438, G0402 or G0439 with your E/M codes or E/M codes 99387 or 99397.
- Member incentives are triggered by the codes for the Annual Wellness Visit.

**Note:** In the Annual Wellness Visit or the “Welcome to Medicare” physical exam, members are covered for the following exam once per year:

Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/anticipatory guidance/risk factor reduction interventions.

*Please note that any lab or diagnostic procedures that are ordered during this visit are not covered under this benefit and the member may have a separate copayment for those services.*
IMPORTANT PAF DETAILS

• May only be submitted once per member per calendar year. You do not have to wait 365 calendar days from last PAF submission or Annual Wellness Visit.
• Must be completed during a patient’s face-to-face visit and submitted within 30 days of completion.
• May be completed in conjunction with the Welcome to Medicare or Medicare Annual Wellness Visit.
• Must be thorough, giving a complete picture of the patient’s current health status – and completed in its entirety with acceptable provider authentication. Include documentation of:
  o Patient demographics (auto-filled in electronic version)
  o Conditions list
  o Assessment and management of each issue
  o Plan and follow-up
  o Practitioner Attestation/Signature
• Print and retain as part of the patient’s permanent medical record

PAF COMPLETION OPTIONS

You have two options for completing and submitting PAFs:
• Online via secure BlueAccess℠ portal: http://www.bcbst.com/
• Or access the writeable PDF at the Quality Care Rewards website: http://www.bcbst.com/providers/quality-initiatives.page. Fax the completed form to 1-877-922-2963.

TRAINING AND ASSISTANCE

For training and assistance with PAF and Quality Measure gaps please contact our Provider Quality team:

East Region
Ashley Ward
Manager, Quality Finance
Office Phone: 865-588-4628
Email: ashley_ward@bcbst.com

Middle/West Region
Tamara Matos
Manager, Quality Finance
Office Phone: 615-386-8592
Email: tamara_matos_cruz@bcbst.com

For BlueAccess℠ log in and registration information and/or Technical Support, contact our eBusiness team at 423-535-5717, Option 2 or at ebusiness_service@bcbst.com.
**Question:** What is considered acceptable provider authentication?

**Answer:** Acceptable provider authentication is either a handwritten or electronic signature that includes the practitioner’s name and credentials, and the date signed. If electronic signatures are used as a form of authentication, the system must authenticate the signature at the end of each note. Some examples of acceptable electronic signatures are: “Electronically signed by,” “Authenticated by,” “Approved by,” “Completed by,” “Finalized by,” or “Validated by”. Individuals who may sign/attest to a PAF include the following: MD, DO, NP or PA.

**Question:** How should we code chronic conditions?

**Answer:** If a chronic condition exists it should not be coded as “history of” if treatment is ongoing or if the condition affects the patient’s care, treatment or management. It should be listed as an active problem.

**Question:** What is needed in addition to the completed PAF?

**Answer:** Nothing, but the completed PAF should have:

1. **Problem list** that outlines all of the patient’s problems including any unresolved conditions/diagnoses. This PAF may serve that function.
2. **Assessment** of what issues the problem brings to the patient, i.e.: “Asymptomatic Decreased bone density of hips and spine, DEXA scan with T score of -3 on 12/13/12”
3. **Management** of the problem: If you are not managing the problem you should indicate who is, i.e.: “Patient is on alendronate 35 mg/week, vitamin D and Calcium and is treated by Dr. Endocrine Person. Follow up as required by Dr. Endocrine Person.”
4. **Action Plan:** A description of any unmet needs in regard to this problem and your plan to address them: i.e. “Patient states she can’t afford meds. Will refer to BCBST case manager to assist.” or “Patient needs referral to Dr. Somebody. Will refer and see back in (Follow up time frame or Date).” Action Plan should include medications prescribed and tests ordered.

**Question:** What if the visit was preventive only?

**Answer:** There may still be needs that should be documented. For example, consider whether you should document any of the following: immunizations that are not up to date; whether the patient needs advice on diet or exercise; if they need help with cholesterol level or drug or alcohol use; if the living will is not up to date; if they need to know how to prevent osteoporosis; if they need a colon screening, mammogram, pap smear or prostate screening; if depression is an issue. Determine if anticipatory guidance is needed.
**Question:** How should we code Medicare Advantage claims?

**Answer:** Problems should be listed to their highest level of specificity, i.e., “Type 1 diabetes mellitus with mild non-proliferative diabetic retinopathy with macular edema,” AND you should include the ICD10 code to the fourth or fifth digit as required on the claim form. In the case of Diabetes, the detailed coding will tell if the patient is controlled or uncontrolled/unknown. It is important to differentiate between acute/unspecified versus chronic. Consider using CPT Category II codes (CPTII). Use of these codes enables your office to monitor internal performance of key measures throughout the service year. By identifying opportunities for improvement, interventions can be implemented to improve overall quality of care.

**Question:** Why should I do this coding?

**Answer:** CMS is becoming more stringent around Medicare, requiring that services and conditions are coded to the correct level of specificity. This information is used by CMS to determine the reimbursement for services and whether programs should be developed to address particular problems. BlueCross BlueShield of Tennessee is required to ensure that coding is performed correctly. BlueCross also uses the information to plan for future programs.

**Question:** As a contracted BlueCross BlueShield of Tennessee provider, am I required to complete a PAF on all my patients?

**Answer:** Absolutely not. Of course, we would like to encourage you to participate for the overall health and well-being of our senior population. You also have the opportunity to earn an incentive for each PAF you complete. Additionally, by identifying and closing members’ gaps in care during the PAF completion, you are positively impacting your STARS score, which in turn, positively affects your fee schedule.

**Question:** How often will I need to complete the PAF for each member?

**Answer:** The PAF will only need to be completed once every calendar year and it can be performed at the same time of the Welcome to Medicare or Medicare Annual Wellness Visit.

**Question:** What steps must I take to ensure payment for completion of the PAF?

**Answer:** Complete the PAF during the patient’s visit.

- Submit the appropriate E/M code for the reason for the visit.
- Submit E/M code 96160 (administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument).
- Submit the PAF via fax or online within 30 days of the face-to-face visit.

**Question:** If I have my own form, can I submit it for the PAF?

**Answer:** You may contact a member of our Provider Quality team to submit your form for review as an acceptable PAF.

**Question:** What do I do with the PAF after completion?

**Answer:** CMS requires the original PAF to be a part of the patient’s permanent medical record. You may provide a copy to the patient as well. Forms completed online are available to be printed upon completion.

**Question:** How does the PAF close gaps in care?

**Answer:** Providers completing the PAF online have the opportunity to attest to gaps in care in the Provider Quality Care Rewards module as they complete the PAF. Faxed PAFs are reviewed by BlueCross staff and if
information is found in the PAF to close gaps in care, our staff will submit an attestation to close those gaps in the Provider Quality Care Rewards module on behalf of the provider.

**Question:** How long does it take for BlueCross to review a faxed PAF and the gaps in care to close?
**Answer:** BlueCross strives to review a faxed PAF within 30 - 45 days of receipt. Due to the timing of monthly systems processing, attestations submitted to close gaps in care in the Provider Quality Rewards module on behalf of a provider from the PAF should be given at least four weeks to update in the system once submitted.

**Question:** How can I find out how many PAFs I’ve submitted and how many gaps in care my PAFs have closed?
**Answer:** Providers can view the number of PAFs completed online as well as gaps in care attestations/closures via the Provider Quality Care Rewards module in BlueAccess. Reports on faxed PAFs and gaps in care closures from faxed PAFs must be requested through the Provider Quality Field Support Team.

**Question:** If I want to submit the form only for preventive screenings or gaps in care, can I just complete part of the PAF?
**Answer:** The PAF’s primary purpose is for Risk Adjustment. This is the process and payment model by which CMS reimburses Medicare Advantage plans, based on the health status of our members. Due to the importance of receiving a complete PAF, incomplete PAFs will be returned to the provider with a request to complete and return to BlueCross BlueShield of Tennessee within 30 days. PAFs remaining incomplete after that time will be subject to PAF incentive payment recoupment. Incomplete PAFs may also not be reviewed for gaps in care information.