of Tennessee

QUALITY+ PARTNERSHIPS

2019 Quality Program Information

BLUEADVANTAGE (PPO)SM

BLUECARE PLUS (HMO SNP)SM

We're Right Here

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BlueCross BlueShield of Tennessee Pay-for-Value Programs

Every sector of the health care industry is in a state of transition as we work to find the right way to pay for medical services on the basis of quality or value. We have three main categories of pay-for-value programs:

- Quality incentives encourage physicians to follow evidence-based guidelines for care and reward them for making sure preventive services and screenings are a priority in their daily work.
- Patient-centered medical homes take a long-term view and apply a team approach to supporting people with chronic conditions like diabetes or asthma, with support from BlueCross-employed care coordinators.
- Total cost of care arrangements empower physicians to strive for value by delivering services more efficiently across a tightly integrated continuum of care while closely managing costs. BlueCross and the physician then share in any savings together.

70% of the primary care providers in our networks participate in at least one pay-for-value program.

41% participate in two or more.

Blue Advantage (PPO)℠ 2019 Quality+ Partnerships

Your Partner in Quality Care

BlueCross BlueShield of Tennessee is committed to ensuring our members have access to a network of high quality providers. Quality care is central to our mission of delivering peace of mind through better health to those we serve.

QUALITY+
PARTNERSHIPS

Recognizing providers who provide quality, value-based care

We know you're already providing high quality care for your patients, and we're here to help make sure your practice gets the recognition it deserves.

You are instrumental in helping our members get important preventive screenings, receive effective treatment and improve access to required health care services. With an emphasis on value-based care, our program establishes provider reimbursements based on STARS quality scores and coding accuracy completed during the measurement period of **January 1 – December 31**.

We believe PCPs should be reimbursed the same way the Centers for Medicare & Medicaid Services pays our Medicare Advantage LPPO product – with the opportunity to earn a Quality Escalator. This rate structure is based on a percentage of Medicare and opportunities for fee schedule adjustment are as high as 110 percent.

Putting members first

Additional incentives are available when you complete Provider Assessment Forms (PAFs). These forms help identify opportunities for care and encourage treatment plan implementation throughout the year. You can earn the highest bonus by completing and submitting the forms in the first part of the year.

- $225 for dates of service between January 1 and June 30
- $175 for dates of service between July 1 and December 31

my healthpath®

Members are also rewarded

2019 My HealthPath® Rewards Program

We are committed to ensuring our members get the care they need from their PCP, so we reward them for making healthy choices. My HealthPath is a program that partners with members as they take steps toward a healthier lifestyle.

Members must opt-in to participate in this program. After they are actively enrolled, members are educated about the importance and completion of preventive screenings while being rewarded for receiving the screenings that apply to them.*

We believe that members should have their care coordinated through an annual wellness visit with their PCP. So, we have included a wellness point incentive for the member to encourage completion of this visit. Members may also be eligible to earn additional wellness points for preventive screenings listed in the member incentive section of this guide. **Wellness points are worth $1 each and can be used to redeem for a gift card** after a single screening or accumulated and used, after other eligible screenings, to redeem a card for a higher value.

*Members must opt-in to the rewards program to be eligible to earn wellness points towards gift cards. Members may earn wellness points for each needed screening only once per year. Date of service must occur within the calendar year.

> Primary care practitioners (PCPs) performing at 4.0 stars or above have the potential to earn as high as 110 percent of the Medicare fee schedule.

2019 Calendar Year

Medicare Advantage Quality Amendment Measures

Measure Name	Measure Type	Weight	Member Incentive Available*
Comprehensive Diabetes Care (CDC) – HbA1c Control (≤8.9%)	Outcome	3	**25 Wellness Points**
Medication Adherence for Cholesterol (Statins)	Outcome	3	—
Medication Adherence for Hypertension (RASA)	Outcome	3	—
Medication Adherence for Diabetes Medications (OAD)	Outcome	3	—
Plan All-Cause Readmissions (PCR)	Outcome	3	—
Statin Use in Persons with Diabetes (SUPD)	Outcome	3	—
Breast Cancer Screening (BCS)	Procedure	1	**75 Wellness Points**
Colorectal Cancer Screening (COL)	Procedure	1	**20, 30, 60 or 80 Wellness Points**
Comprehensive Diabetes Care (CDC) – Retinal Eye Exam	Procedure	1	**50 Wellness Points**
Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy	Procedure	1	**15 Wellness Points**
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Procedure	1	—
Medication Reconciliation Post-Discharge (MRP)	Procedure	1	—
Osteoporosis Management in Women with a Fracture (OMW)	Procedure	1	**50 Wellness Points**
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Procedure	1	**25 Wellness Points**
Measures for Display/Monitoring Status Only			
Annual Wellness Visit (AWV)	Procedure	0	**50 or 30 Wellness Points**
Controlling Blood Pressure (CBP)	Outcome	0	—
High-Risk Medication (HRM)	Outcome	0	—
Use of Opioids from Multiple Providers (UOP)	Outcome	0	—
Use of Opioids at High Dosage (UOD)	Outcome	0	—
Medicare Diabetes Prevention Program Participation for 6 Months	—	0	**100 Wellness Points**

**Please see Member Incentive table for more information.*

Healthcare Effectiveness Data and Information Set (HEDIS®)

The Centers for Medicare and Medicaid Services (CMS) measures BlueCross utilizing HEDIS measures. Developed by the National Committee for Quality Assurance (NCQA), HEDIS is the most widely used set of performance measures in the managed care industry. It contains measures that show health plans those areas where a stronger focus could lead to improvements in member health. HEDIS reporting is mandated by NCQA for compliance and accreditation.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Breast Cancer Screening (BCS) Percentage of women 50-74 years old who had a mammogram **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 and over with frailty and advanced illness	**Mammogram** between 10/1/2017 - 12/31/2019 for all women 52-74 years **NOTE**: All of the following types and methods of mammogram qualify: • screening • diagnostic • film • digital • digital breast tomosynthesis Do not count biopsies, breast ultrasounds or MRIs.	**Encounter/Claim with Codes:** **CPT®:** 77055, 77056, 77057, 77061-77063, 77065-77067 **HCPCS:** G0202, G0204, G0206,	Any time during member's history through 12/31/19: **Bilateral mastectomy** **ICD-10-CM:** 0HTV0ZZ, Z90.13 **OR Unilateral mastectomy:** **CPT®:** 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307 **ICD-10-CM:** 0HTU0ZZ, 0HTT0ZZ Billed twice with service dates 14 days or more apart With bilateral modifier: 50, codes must be on the same claim

Helpful Tip: Clearly document in the medical record the date the mammogram or mastectomy/mastectomies were performed.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Colorectal Cancer Screening (COL) Percentage of members 50-75 years of age who had one of these screenings for colorectal cancer: • Fecal occult blood test • Flexible sigmoidoscopy • Colonoscopy • CT Colonography • FIT DNA Test (Cologuard®) **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 and over with frailty and advanced illness	**Fecal occult blood test** (gFOBT, iFOBT) during 2019 • gFOBT requires 3 returned samples • iFOBT/FIT requires 1 returned sample **AND/OR** • **Flexible sigmoidoscopy** during 2019 or last 4 years **AND/OR** • **Colonoscopy** during 2019 or last 9 years • **CT Colonography** during 2019 or during the last 4 years • **FIT-DNA** Test during 2019 or during the last 2 years **NOTE:** Clear documentation of gFOBT/ iFOBT, colonoscopy, sigmoidoscopy, CT colonography or FIT-DNA test, including year performed, is required. • Do not count FOBT screenings performed from sample collected in provider office. • Clearly document type of FOBT screening performed with exact date(s) of sample(s) returned.	Encounter/Claim with Codes: **Fecal occult blood test** between 1/1/2019 - 12/31/2019 **CPT®:** 82270, 82274 **HCPCS:** G0328 **Flexible sigmoidoscopy** between 1/1/2019 - 12/31/2019 **CPT®:** 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45346, 45347, 45349, 45350 **HCPCS:** G0104 **Colonoscopy** between 1/1/2010 - 12/31/2019 **CPT®:** 44388-44394, 44397, 45355, 45378-45393, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45398 **HCPCS**: G0105, G0121 **CT Colonography** between 1/1/2015 and 12/31/2019 **CPT®**: 74261-74263 **FIT-DNA Test** between 1/1/2017 and 12/31/2019 **CPT®:** 81528 **HCPCS:** G0464 **LOINC:** 77353-1, 77354-9	Any time during member's history through 12/31/2019: **Colorectal cancer** **ICD-10-CM:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 **HCPCS:** G0213-G0215, G0231 **AND/OR** **Total Colectomy** **CPT®:** 44150-44153, 44155-44158, 44210-44212 **ICD-10-CM:** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Osteoporosis Management in Women with Fracture (OMW) Percentage of women 67-85 years of age 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 finger, toe, face and skull are not included in this measure **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 to 80 with frailty and advanced illness • Members age 81 and older with frailty	• Perform **bone mineral density testing** within **six** months on members 67-85 years old who experience a fracture **AND/OR** • Prescribe a **medication to treat osteoporosis** within six months of a fracture **NOTE:** Calcium alone does not meet criteria to close the gap in care	**Encounter/Claim with Codes: Bone Mineral Density Testing** **CPT®:** 76977, 77078, 77080, 77081, 77082, 77085, 77086 **HCPCS:** G0130 **ICD-10-PCS:** BP48ZZ1, BP49ZZ1, BP4GZZ1-BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **AND/OR** **Pharmacy Claim for Osteoporosis Drug Therapy:** **HCPCS:** J0630, J0897, J1740, J3110, J3487, J3488, J3489, Q2051 **Codes to Identify Fractures:** **CPT®:** 21811-21813, 21820, 21825, 22310, 23500, 23505, 23515, 23570, 23575, 23585, 23600, 23605, 23615, 23616, 23620, 23625, 23630, 24500, 24505, 24515, 24516, 24530, 24535, 24538, 24545, 24546, 24560, 24565, 24566, 24575-24577, 24579, 24582, 24650, 24655, 24665, 24666, 24670, 24675, 24685, 25500, 25505, 25515, 25520, 25525, 25526, 25530, 25535, 25545, 25560, 25565, 25574, 25575, 25600, 25605-25609, 25622, 25624, 25628, 25630, 25635, 25645, 25650, 25651, 25652, 25680, 25685, 26600, 26605, 26607, 26608, 26615, 27200, 27202, 27215, 27220, 27222, 27226-27228, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248, 27254, 27267-27269, 27500-27503, 27506-27511, 27513, 27514, 27520, 27524, 27530, 27532, 27535, 27536, 27538, 27540, 27750, 27752, 27756, 27758-27760, 27762, 27766-27769, 27780, 27781, 27784, 27786, 27788, 27792, 27808, 27810, 27814, 27816, 27818, 27822-27828, 28400, 28405, 28406, 28415, 28420, 28430, 28435, 28436, 28445, 28450, 28455, 28456, 28465, 28470, 28475, 28476, 28485, 29850, 29851, 29855, 29856	**Bone mineral density testing** during 24 months prior to fracture: **CPT®:** 76977, 77078, 77080-77082 **HCPCS:** G0130 **ICD-10-PCS:** BP48ZZ1, BP49ZZ1, BP4GZZ1-BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, B104ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **AND/OR** **Osteoporosis therapy** during 12 months prior to fracture: **Injectables** **HCPCS:** J0630, J0897, J1740, J3110, J3487-J3489, Q2051 **AND/OR** **Dispensed or active oral prescription to treat osteoporosis** during 12 months prior to fracture: • Listing of Approved therapies (next page)

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Osteoporosis Management in Women with Fracture (OMW) Continued		**HCPCS:** S2360 **ICD-10-CM:** M48.40XA-M48.48XA, M80.00XA-M80.88XA, M84.311A-M84.38XA, M97.01XA-M97.42XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A-S12.151B, S12.190A-S12.201B, S12.230A-S12.231B, S12.24XA, S12.24XB, S12.250A-S12.251B, S12.290A-S12.301B, S12.330A-S12.351B, S12.390A-S12.9XXA, S22.000A-S22.9XXB, S32.000A-S32.9XXB, S42.001A-S42.92XB, S49.001A-S49.199A, S52.001A-S52.92XC, S59.001A-S59.299A, S62.001A-S62.92XB, S72.001A-S72.92XC, S79.001A-S79.199A, S82.001A-S82.92XC, S89.001A-S89.399A, S92.001A-S92.909B	

Helpful Tips:

- Document or obtain reports of fractures in patient's medical record.
- Encourage bone mineral density screenings and/or prescribe and encourage fill of a medication to treat osteoporosis in women 67-85 who have had a fracture in the last 6 months.
- Approved osteoporosis therapies include:
  - **Biphosphonates**: alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid
  - **Other agents**: albandronate, calcitonin, denosumab, raloxifene, teriparatide

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Controlling High Blood Pressure (CBP) Percentage of members 18-85 years old who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during 2019 **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 to 80 with frailty and advanced illness • Members age 81 and older with frailty	The **most recent** BP in 2019 for members age 18-85 whose BP was **≤139/89** mm Hg. **NOTE:** The **last** documented BP reading in the measurement year must be in the compliant range above in order to close the gap in care for HEDIS.	**Chart Documentation of Member's Blood Pressure** Document the **actual blood pressure** reading in the member's medical record **ICD-10-CM** diagnosis code for identifying hypertension: I10	**ESRD or kidney transplant** anytime on or before 12/31/2019: **CPT®:** 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512; 50300, 50320, 50340, 50360, 50365, 50370, 50380 **HCPCS:** G0257, S9339; S2065 **ICD-10-CM (ESRD):** N18.5, N18.6, Z91.15, Z99.2, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z **ICD-10-CM (kidney transplant):** Z94.0, 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2 **AND/OR** **Female members with pregnancy** anytime during 2019: **ICD-10-CM:** O00.0-O04.89, O07.0-O16.9, O20.0-O26.93, O28.0-O36.93X9, O40.1XX0-O48.1, O60.00-O77.9, O80, O82, O85, O86.0-O92.79, O98.011-O99.89, O9A.111-O9A.113, O9A.119, O9A.12, O9A.13, O9A.211-O9A.53, Z03.71-Z03.75, Z03.79, Z33.1, Z33.2, Z34.00-Z34.93, Z36 **AND/OR** • A non-acute inpatient admission during 2019

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Disease-modifying Anti-rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis (ART) Percentage of members diagnosed with rheumatoid arthritis who were dispensed at least one DMARD during 2019 **NOTE:** DMARDs include: • Aminoquinolines: Hydroxychloroquine • 5-Aminosalicylates: Sulfasalazine • Alkylating agents: Cyclophosphamide • Anti-rheumatics: Auranofin, gold sodium thiomalate, leflunomide, methotrexate, penicillamine • Immunomodulators: Abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, tocilizumab • Immunosuppressive agents: Azathioprine, cyclosporine, mycophenolate • Tetracyclines: Minocycline • Janus kinase (JAK) inhibitor: Tofacitinib **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 to 80 with frailty and advanced illness • Members age 81 and older with frailty	Assess all members with diagnosis of rheumatoid arthritis for **DMARD treatment** in 2019	**Encounter/Claim with Codes: Rheumatoid Arthritis** **ICD-10-CM**: M05.00-M06.89, M06.9 **AND/OR** **Pharmacy Claim for DMARD in 2018:** **HCPCS:** J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, Q5102, Q5103, Q5104	**HIV** anytime on or before 12/31/2019: **ICD-10-CM:** B20, Z21, B97.35, 079.53 **AND/OR** **Female members with Pregnancy** anytime during 2019: **ICD-10-CM:** O00.0-O04.89, O07.0-O16.9, O20.0-O26.93, O28.0-O36.93X9, O40.1XX0-O48.1, O60.00-O77.9, O80, O82, O85, O86.0-O92.79, O98.011-O99.89, O9A.111-O9A.113, O9A.119, O9A.12, O9A.13, O9A.211-O9A.53, Z03.71-Z03.75, Z03.79, Z33.1, Z33.2, Z34.00-Z34.93, Z36

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Comprehensive Diabetes Care (CDC)

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Diabetes Care - Retinal Eye Exam (CDC) Percentage of diabetic members 18-75 years old who have had an eye screening for diabetic retinal disease **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 and over with frailty and advanced illness	A **retinal or dilated eye exam by an optometrist or ophthalmologist** in 2019 **OR** A **retinal or dilated eye exam negative for retinopathy by an optometrist or ophthalmologist** in 2018 **OR** **Bilateral eye enucleation** anytime during the member's history through 12/31/2019 Encourage and/or refer member to see an eye care professional for a comprehensive eye exam in 2019. **Obtain and place copy of all 2018 or 2019 eye exams in the member's medical record.** **In order to count 2018 exams, documentation in the medical record must clearly indicate results were negative for retinopathy.**	**Encounter/Claim with Codes:** **Retinal or Dilated Eye Exams** **CPT®:** 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, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 **CPT® II:** 2022F, 2024F, 2026F, 3072F **HCPCS:** S0620, S0621, S3000 **NOTE:** Providers performing retinal imaging in office and sending results to eye care professionals to review and interpret should use CPTII codes 2026F or 3072F. **Unilateral Eye Enucleation with a bilateral modifier OR Left Unilateral Eye Enulceation and Right Unilateral Enucleation on the same or different dates of service OR Two Unilateral Eye Enucleations with service dates 14 days or more apart.** **CPT®:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **ICD-10-PCS:** 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B1XZX, 08B1XZZ, 08B00ZX, 08B00ZZ, 08B03XZ, 08B03ZZ, 08B0XZX, 08B0XZZ	**Non–diabetic members** during 2018 and 2019 with: **Gestational or steroid-induced diabetes** during 2018 or 2019: **ICD-10-PCS:** 024.410-024.439

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Diabetes Care - Nephropathy (CDC) Percentage of diabetic members 18-75 years old who received medical attention for nephropathy (nephropathy screening test or evidence of nephropathy) **Note that approved ACE Inhibitors/ARBs are:** • **Angiotensin converting enzyme inhibitors:** Benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolapril • **Angiotensin II inhibitors:** Azilsartan, candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan • **Combinations of these with antihypertensive(s)** **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 and over with frailty and advanced illness	Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy in 2019: **A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet criteria:** • 24-hour urine for albumin or protein • Timed urine for albumin or protein • Spot urine for albumin or protein • Urine for albumin/creatinine ratio • 24-hour urine for total protein • Random urine for protein/creatinine ratio **Documentation of a visit to a nephrologist** **Documentation of a renal transplant** **Documentation of medical attention for any of the following:** • Diabetic nephropathy • ESRD • Chronic renal failure (CRF) • Chronic kidney disease (CKD) • Renal insufficiency • Proteinuria • Albuminuria • Renal dysfunction • Acute renal failure (ARF) • Dialysis, hemodialysis or peritoneal dialysis **Evidence of ACE inhibitor/ARB therapy.** Documentation in the medical record must include evidence that the member received ACE inhibitor/ARB therapy during 2019. Documentation must show clear evidence that a preacription for an ACE inhibitor/ARB was written, filled or taken by the member during 2019.	**Laboratory Claim/Encounter with Codes:** **CPT®:** 82042, 82043, 82044, 84156 **CPT® II:** 3060F, 3061F **AND/OR** Physician Encounter/Claim with Codes: **CPT®:** **Urine macroalbumin test:** 81000-81003, 81005 **ESRD:** 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90935, 90937, 90940, 90945, 90947, 90951-90970, 90989, 90993, 90997, 90999, 99512 **Kidney transplant**: 50300, 50320, 50340, 50360, 50365, 50370, 50380 **CPT® II:** **Positive urine macroalbumin test:** 3062F **Nephropathy treatment:** 3066F, 4010F **HCPCS:** **ESRD:** G0257, S9339 **Kidney transplant**: S2065 **ICD-10-CM:** **Nephropathy treatment**: E08.21, E08.22, E08.29, E09.21, E09.22, E09.29, E10.21, E10.22, E10.29, E11.21, E11.22, E11.29, E13.21, E13.22, E13.29 **CKD:** I12.0, I12.9, I13.0, I13.10, I13.11, I13.2 **CKD Stage 4**: N18.4 **ESRD:** N18.5, N18.6, Z91.15, Z99.2, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z **Kidney Transplant:** Z94.0, 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2 **AND/OR** Pharmacy Claim for **ACE/ARB Therapy** **All testing and results should be dated and documented in the member's medical record**	**Non–diabetic members** during 2018 and 2019 with: **Gestational or steroid-induced diabetes** during 2018 or 2019: **ICD-10-CM:** 024.410-024.439

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Diabetes Care - HbA1c Control (CDC) Percentage of diabetic members 18-75 years old who have evidence of: • HbA1c testing • HbA1c controlled ≤8.9% **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 and over with frailty and advanced illness	**HbA1c testing** on all diabetic patients in 2019 **AND** Diabetes management so that all members have the most recent **HbA1c in 2019 ≤8.9%**	**Encounter/Claim with Codes:** **CPT®:** 83036, 83037 **CPT® II:** 3044F, 3045F, 3046F **NOTE:** In order to pass, HbA1c must be ≤8.9% A copy of all lab results should be kept in member's medical record	**Non–diabetic members** during 2018 and 2019 with: **Gestational or steroid-induced diabetes** during 2018 or 2019: **ICD-10-CM:** 024.410-024.439

Helpful Tips: The last documented A1C of the measurement year must be ≤8.9% in order to close the gap in care.

- Perform A1C screening earlier in the year to allow time for interventions to decrease result to ≤8.9%.
- Repeat screenings for readings greater than 8.9%.
- Encourage lifestyle changes and adherence to treatment regimens that will help bring A1C under control.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Medication Reconciliation Post-Discharge (MRP) Percentage of patients 18 years of age and older discharged from acute or non-acute inpatient facilities (hospital, rehab facility, LTACH or skilled nursing facility) to the community setting who had their **medications reconciled within 30 days of discharge**. Primary care practices have 30 days from the date of discharge (31 days total) to have a prescribing practitioner, clinical pharmacist or registered nurse review and reconcile a patient's medications. **NOTE:** Patients with multiple discharges during the year must have a medication reconciliation within 30 days of each discharge. If a discharge was within 30 days of another discharge, the most recent discharge date should be used.	The outpatient medical record must include documentation that the prescriber (or appropriate clinician) **reconciled current and discharged medications**, along with the date. Any of the following will meet the criteria **within 30 days after discharge**: • Documentation of the current medications with a notation that the provider reconciled the current and discharge medications. • Documentation of current medications with a notation that references the discharge medications (e.g. no changes, discontinued all discharge medications, no changes in medications since discharge). • Documentation of the patient's current medications with a notation that the discharge medications were reviewed. • Documentation of current medication list, discharge medication list, and notations that both lists were reviewed on the same date of service. • Documentation of current medications with evidence that the patient was seen for post-discharge hospital follow-up, and evidence of medication reconciliation or review. • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge or within 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge.	**Encounter/Claim with Codes:** **CPT® II:** 1111F **CPT®:** 99495, 99496, 99483 • Clearly document **date of service and credentials** (prescribing practitioner, pharmacist, or registered nurse). Ensure that reconciliation matches pre-admission medications to discharge medications. • Use CPT Category II code 1111F for **medication reconciliation**. Use the **Transition of Care** CPT codes 99495-96 if the member was contacted within 48 hours of discharge and during the ensuing face-to-face visit medication reconciliation was performed (see TCM billing requirements for additional information and billing requirements). • Only patients **discharged home** are counted in this measure. Discharges between facilities are not tracked. • Medication reconciliation must clearly tie a patient's discharge medications to the medications they were taking **before** an inpatient admission. Simply documenting "medications reviewed" will not meet the compliance standard. • Only documentation in the **outpatient chart** meets the intent of the measure, but a face-to-face visit is not required. If medication reconciliation is performed over the phone or during a home visit, documentation of its completion must be included in the outpatient chart.	**Members in Hospice**

Helpful Tip: Documentation in the medical record must include evidence that the practitioner had knowledge of the in-patient stay.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Medication Adherence for Cholesterol (Statins) Percentage of members 18 years and older with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80 percent or more of the time they are supposed to be taking the medication.	Assess all members with a prescription for a **cholesterol medication** for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage compliance.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**ESRD** **Members in Hospice**
Medication Adherence for Hypertension (RASA) Percentage of members 18 years and older with a prescription for a blood pressure medication (ACE, ARB or direct renin inhibitor drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **Medications in the angiotensin system (RAS) antagonist class:** • Angiotensin converting enzyme inhibitor (ACEI) • Angiotensin receptor blocker (ARB) • Direct renin inhibitor	Assess all members with a prescription for a **blood pressure medication** for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage compliance.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**ESRD** **sacubitril/ valsartan (Entresto™)** **Members in Hospice**
Medication Adherence for Diabetes Medications (OAD) Percentage of members 18 years and older with a prescription for diabetes medication (biguanide drug, sulfonylurea drug, thiazolidinedione drug, DPPIV inhibitor, incretin mimetic drug, meglitinide drug or SGLT2 inhibitor) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **NOTE: Members taking insulin are not included in this measure.** **This measure is applicable to the following classes of Diabetes Medications:** • Biguanides • DPP-IV inhibitors • SGLT2 inhibitors • Sulfonylureas • Incretim mimetics • Thiazolidinediones • Meglitinides	Assess all members with a prescription for **diabetes medication** for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage compliance.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**ESRD** **Insulin** **Members in Hospice**

Helpful Tips: Prescriptions should be written to accurately reflect the regimen the prescriber and patient have agreed upon. Schedule follow-up visits before prescriptions expire. Encourage 90-day supply or mail order for stable chronic medication regimens. Members can get a 90-day prescription through a preferred pharmacy or mail-order for a $1 copay (Tier 1 medications). Educate and encourage patients about the purpose and effectiveness of their medications.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Statin Therapy for Patients with Cardiovascular Disease (SPC) Percentage of **male members 21-75** years of age and **female members 40-75** years of age who were identified as having **atherosclerotic cardiovascular disease (ASCVD)** and **received** at least one prescription for a **high or moderate intensity statin**. **NOTE:** Heart disease is identified through medical claims for the following diagnoses: • Ischemic vascular disease • Myocardial infarction, coronary artery bypass grafting, or a revascularization event such as percutaneous coronary intervention **NOTE:** This measure may not apply to the following members anytime during the measurement year: • Members in Hospice • Members age 66 and over enrolled in an institutional SNP or living long-term in an institution • Members age 66 and over with frailty and advanced illness	One of the following medications must be **prescribed and dispensed** by a pharmacy: • Atorvastatin ≥10 mg daily • Fluvastatin ≥80 mg daily • Lovastatin ≥40 mg daily • Pravastatin ≥40 mg daily • Rosuvastatin ≥5 mg daily • Simvastatin ≥20 mg daily	The data for this measure comes from pharmacy claims.	**Members in Hospice** Any of the following in 2018 or 2019: • Female members with a diagnosis of **pregnancy** • **In vitro fertilization** • Dispensed at least one prescription for **clomiphene** • **ESRD** • **Cirrhosis** Any of the following in 2019: • **Myalgia** • **Myositis** • **Myopathy** • **Rhabdomyolysis**

Helpful Tips: Muscle pain is a commonly reported adverse effect of statins. Assess the patient for drug interactions via CYP 3A4 or 2C9 metabolic pathways, hypothyroidism, or vitamin D deficiency, which may be contributing factors.

Treating underlying disorders, removing interacting drugs if possible, switching to a more hydrophilic statin (rosuvastatin or pravastatin), or trying alternate-day dosing with a long-acting statin may be alternatives for patients who report statin intolerance.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Statin Use in Persons with Diabetes (SUPD) Percentage of members age **40** to **75** who were dispensed at least **two prescriptions** for a **hypoglycemic agent** (including insulin) and also **received** a single prescription for a **statin medication**.	One of the following medications must be **prescribed and dispensed** by a pharmacy: Statin Medications: • Tier 1: ▪ Atorvastatin ▪ Lovastatin ▪ Pravastatin ▪ Rosuvastatin ▪ Simvastatin • Tier 2: ▪ Fluvastatin Statin Combination Products: • Tier 1: ▪ Atorvastatin/amlodipine • Tier 2: ▪ Simvastatin/ezetimibe	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**Members in Hospice** **ESRD**

Helpful Tips: Muscle pain is a commonly reported adverse effect of statins. Assess the patient for drug interactions via CYP 3A4 or 2C9 metabolic pathways, hypothyroidism, or vitamin D deficiency, which may be contributing factors.

Treating underlying disorders, removing interacting drugs if possible, switching to a more hydrophilic statin (rosuvastatin or pravastatin), or trying alternate-day dosing with a long-acting statin may be alternatives for patients who report statin intolerance.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions

Use of Opioids at High Dosage (UOD)
 	
Proportion of members **18** years and older, receiving prescription opioids for **≥15 days** during the measurement year at a **high dosage** (average milligram morphine dose [MME] **>120 mg**).
 	
NOTE: A lower rate indicates better performance.
	CMS is focusing more on the opioid use in the Medicare population. Measures such as this may be included in the STAR program in future years	This measure looks at members with at least **two or more** opioid dispensing events on different dates of service with **≥15** total days covered by opioids whose average MME was **>120 mg** MME during the treatment period.
		
		UOD Opioid Medications:
		
		• Butorphanol
		• Codeine
		• Dihydrocodeine
		• Fentanyl
		• Hydrocodone
		• Hydromorphone
		• Levorphanol
		• Meperidine
		• Methadone
		• Morphine
		• Opium
		• Oxycodone
		• Oxymorphone
		• Pentazocine
		• Tapentadol
		• Tramadol
		
		The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare
			Members in Hospice
			
			Members with either of these conditions any time during the measurement year:
			
			- **Cancer**
			- **Sickle cell disease**
			
			The Opioid Medications List excludes:
			
			- Injectables
			- Opioid cough and cold products
			- Single-agent and combination buprenorphine products used to treat opioid use disorder for medication assisted treatment
			  • Buprenorphine sublingual tablets
			  • Buprenorphine subcutaneous implant
			  • Buprenorphine/naloxone combination products
			- Ionsys® (fentanyl transdermal patch)

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Use of Opioids from Multiple Providers (UOP) Proportion of members **18** years and older, receiving prescription opioids for **≥15 days** during the measurement year who received opioids from **multiple providers**. **Three rates are reported**: • Multiple Prescribers - **Four or more** different prescribers • Multiple Pharmacies - **Four or more** different pharmacies • Multiple Prescribers and Multiple Pharmacies - **Four or more** different prescribers **and four or more** different pharmacies **NOTE:** A lower rate indicates better performance for all three rates.	CMS is focusing more on the opioid use in the Medicare population. Measures such as this may be included in the STAR program in future years.	This measure looks at members with at least **two or more** opioid dispensing events on different dates of service with **≥15** total days covered by opioids. **UOD Opioid Medications:** • Buprenorphine (transdermal patch and buccal film) • Butorphanol • Codeine • Dihydrocodeine • Fentanyl • Hydrocodone • Hydromorphone • Levorphanol • Meperidine • Methadone • Morphine • Opium • Oxycodone • Oxymorphone • Pentazocine • Tapentadol • Tramadol The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare	**Members in Hospice** **The Opioid Medications List excludes:** - Injectables - Opioid cough and cold products - Single-agent and combination buprenorphine products used to treat opioid use disorder for medication assisted treatment • Buprenorphine sublingual tablets • Buprenorphine subcutaneous implant • Buprenorphine/naloxone combination products - Ionsys® (fentanyl transdermal patch)

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Plan All-Cause Readmissions (PCR) Percentage of members **18** and older discharged from an acute hospital stay who were **readmitted** (acute, unplanned) to a hospital within 30 days, either for the same condition as their recent hospital stay or or a different reason. Patients may have been readmitted back to the same hospital or to a different one. **NOTE: Members in Hospice are excluded from the eligible population.**	Collaborate with hospitals in order to be notified of your patients' admissions and discharges. Ensure comprehensive follow-up visit, including medication reconciliation is completed within 7-10 days post-discharge. Arrange for post-hospital care as appropriate.	This measure is derived from hospital-based claims. For additional information, ask your Provider Outreach Consultant listed in the front of this guide.	**Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date** **Exclude hospital stays for the following reasons:** • The member died during the stay • Female members with the principal diagnosis of pregnancy • The principal diagnosis of a condition originating in the perinatal period **Exclude non-acute inpatient stays** **Exclude any hospital stay as an Index Hospital Stay if the admission date of the first stay within 30 days meets any of the following criteria:** • A principal diagnosis of maintenance chemotherapy • A principal diagnosis of rehabilitation • An organ transplant • A potentially planned procedure without a principal acute diagnosis.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

The following measures apply to Medicare Special Needs Plans Only (DSNP)

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Medication Review Percent of plan members age 66 years and older whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. **(This information about a yearly review of medications is collected for Medicare Special Needs Plans only.)**	**Medication Review** in 2019 includes any of the following: **Medication list** in the record **AND notation in the medical record of medication review** in 2019 by the prescribing practitioner or clinical pharmacist **AND the date the medication review was performed** **OR** **Medication list signed and dated** in 2019 by practitioner or pharmacist in the medical record **OR** Notation in the medical record in 2019 that the member is **not taking any medication AND the date it was noted.** **NOTE**: Services provided in an acute inpatient setting are not counted.	**CPT®:** **Medication Review:** 90863, 99605, 99606, 99483 **CPT® II:** 1159F, 1160F **Transitional Care Management:** 99495, 99496 **HCPCS:** G8427	**Members in Hospice**

Helpful Tips: A review of side effects for a single medication at the time of prescription alone is NOT sufficient to meet criteria of the medication review. Ensure prescribing provider does an annual review of patient's medications and signs note. Medications must be listed. Notating "medications reviewed" alone is not sufficient.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Functional Status Assessment Percent of plan members age 66 years and older whose doctor has done a functional status assessment to see how well they are able to do "activities of daily living" (such as dressing, eating, and bathing). **(This information about the yearly assessment is collected for Medicare Special Needs Plans only.)**	Documentation of a Functional Status Assessment must include **evidence of a complete functional status assessment performed** in 2019 **AND the date the functional status assessment was performed.** Any of the following can be considered a complete functional status assessment: Notation in the medical record that **Activities of Daily Living** (ADLs) were assessed or at least 5 of the following were assessed: • Bathing • Dressing • Eating • Transferring • Toileting • Walking **OR** Notation in the medical record that **Instrumental Activities of Daily Living** (IADLs) were assessed or at least 4 of the following were assessed: • Shopping for groceries • Driving or using public transportation • Using the telephone • Meal preparation • Housework • Home repair • Laundry • Taking medications • Handling finances **OR** **Continued on Next Page**	**CPT® II:** 1170F **HCPCS:** G0438,G0439 **CPT®:** 99483	**Members in Hospice**

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Functional Status Assessment (cont.)	A **Standardized Functional Status Assessment Tool** including but not limited to: • SF-36® • ALSAR (Assessment of Living Skills and Resources) • Barthel ADL Index Physical Self-Maintenance (ADLS) Scale • Bayer ADL (B-ADL) Scale • Barthel Index • EADL (Extended ADL Scale) • ILS (Independent Living Scale) • Katz Index of Independence in ADL • Kenny Self-Care Evaluation • Klein-Bell ADL Scale • KELS (Kohlman Evaluation of Living Skills) • Lawton & Brody's IADL Scales • PROMIS (Patient Reported Outcome Measurement Information System) Global of Physical Function Scales **OR** Notation that **at least 3 of the following** 4 components were assessed: • Cognitive status • Ambulation status • Hearing, vision and speech (must have all 3) • Other functional independence (exercise, ability to perform job) **NOTE:** The components of the functional status assessment may take place in separate visits in 2019. Functional status assessment related to a single condition, event or body system does not meet criteria for a comprehensive functional status assessment. Notation alone that cranial nerves were assessed does not meet criteria for the sensory component. Notation that the member spoke with the provider during a visit does not meet criteria for the speech component. Services provided in an acute inpatient setting are not counted.	**CPT® II:** 1170F **HCPCS:** G0438,G0439 **CPT®:** 99483	**Members in Hospice**

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Pain Assessment Percent of plan members age 66 years and older who had at least one pain assessment during 2019. **(This information about pain screening or pain management is collected for Medicare Special Needs Plans only.)**	Documentation in the medical record must include evidence of a **pain assessment** and the date it was performed in 2019. Either of the following will meet criteria for a pain assessment: Documentation in the medical record that the patient was **assessed for pain** (could be positive or negative findings) **--OR--** **Results of a Standardized Pain Assessment Tool** not limited to: • Numeric rating scales (verbal or written) • Face, Legs, Activity, Cry, Consolability (FLACC) Scale • Verbal descriptor scales (5-7 Word Scales, Present Pain Inventory) • Pain Thermometer • Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale) • Visual Analogue Scale • Brief Pain Inventory • Chronic Pain Grade • PROMIS Pain Intensity Scale • Pain Assessment in Advanced Dementia (PAIN AD) Scale **NOTE: The following do not meet criteria for a pain assessment:** • Notation of a pain management plan alone • Notation of pain treatment alone • Notation of screening for chest pain alone **Services provided in an acute inpatient setting are not counted.**	• **CPT®:** 1125F, 1126F	**Members in Hospice**

Helpful Tip: Assess patient's pain at every visit utilizing either a standard pain assessment tool or document positive or negative findings of pain. When documenting positive findings of pain provide a detailed assessment including: location, intensity and severity.

HEDIS codes can change from year to year. The codes in this document are from the 2019 specifications.

QUALITY+ PARTNERSHIPS

Program Resources

In-Home Screening Partners

The relationship between the PCP and the patient is instrumental in ensuring that patients get important exams and preventive screenings. We understand that sometimes it may be difficult to get patients in the office or to receive follow-up testing. That's why we offer our in-home vendor partners as a complimentary/additional way for patients to receive services they otherwise might not. Please refer to the list of vendor partners in the table below.

Vendor	Measure Addressed	Service Provided	Service Site	Communication to Provider
HealPros®	• Diabetes Care – Retinal Eye Exam	**Diabetic Retinal Eye Exams**	In-Home or BlueCross-Sponsored Event	Letter by mail
MedXM®	• Osteoporosis Management in Women with a Fracture	**Bone Mineral Density Testing**	In-Home	Letter by fax
Home Access Health Corporation®	• Diabetes Care – A1C Testing • Diabetes Care – Nephropathy Screening • Colorectal Cancer Screening	**Kits for in-home testing/ screening:** • A1C testing • Urine nephropathy screening • iFOBT/FIT colorectal cancer screening	In-Home or kits provided for in-home use at BlueCross-Sponsored Event	Letter by mail
Signify Health™	• Annual BMI Assessment • Annual Wellness Visit • Diabetes Care – A1C Testing • Diabetes Care – Retinal Eye Exam • Diabetes Care – Nephropathy Screening • Colorectal Cancer Screening • Controlling Blood Pressure • Osteoporosis Management in Women with a Fracture	**In-home comprehensive history and physical by a Physician, Physician Assistant or Nurse Practitioner, as well as the following, as appropriate:** • iFOBT/FIT Test Kit • HgbA1c Test Kit • Diabetic Retinal Eye Exam • Bone Density Screening • Urine Microalbumin Test Kit	In-Home	Letter by mail

In-Office Health Screening Event Partnerships

Preventive care helps your patients improve their ability to lead healthy lives. We would like to give you other options to get the recommended preventive screenings completed for your patients.

We're right here to help support you with flexible in-office screening events.

Services we provide can include:

- **Breast Cancer Screening***
- **Colorectal Cancer Screening****
- **Diabetic Retinal Eye Exam**
- **HbA1c Blood Test*****
- **Diabetic Kidney Disease Screening*****

Completed by BlueCross vendor partners and/or your office

We prefer to prioritize patients who have not yet received these screening tests during this calendar year for these in-office events. If your patient completes a test that is included in the Medicare Advantage Quality+ Partnerships program, you will get credit from us and your patient may earn wellness points if they are enrolled in the My HealthPath® rewards program.

*Block-scheduling availability or mobile van as available
**In-Office, In-Home or block-scheduling availability
***In-Office or In-Home Kit

Onsite Support and Education

The Medicare Advantage Quality Outreach Team will be onsite at your event to assist our vendor partners, answer your questions and provide additional support or education as needed.

Benefits of In-Office Events

- Assistance with educating your patients on the importance of prevention and screening tests
- Increase in early detection or prevention of serious diseases
- Opportunity to conduct other services during the same visit, i.e. Annual Wellness Visit, BP checks, BMI assessment
- Improved performance in the Medicare Advantage Quality+ Partnerships program

For more information about on-site wellness events or to schedule an event, contact one of our Medicare Advantage Member Experience or Provider Quality Outreach contacts listed at the front of this guide.

Supplemental Data Collection

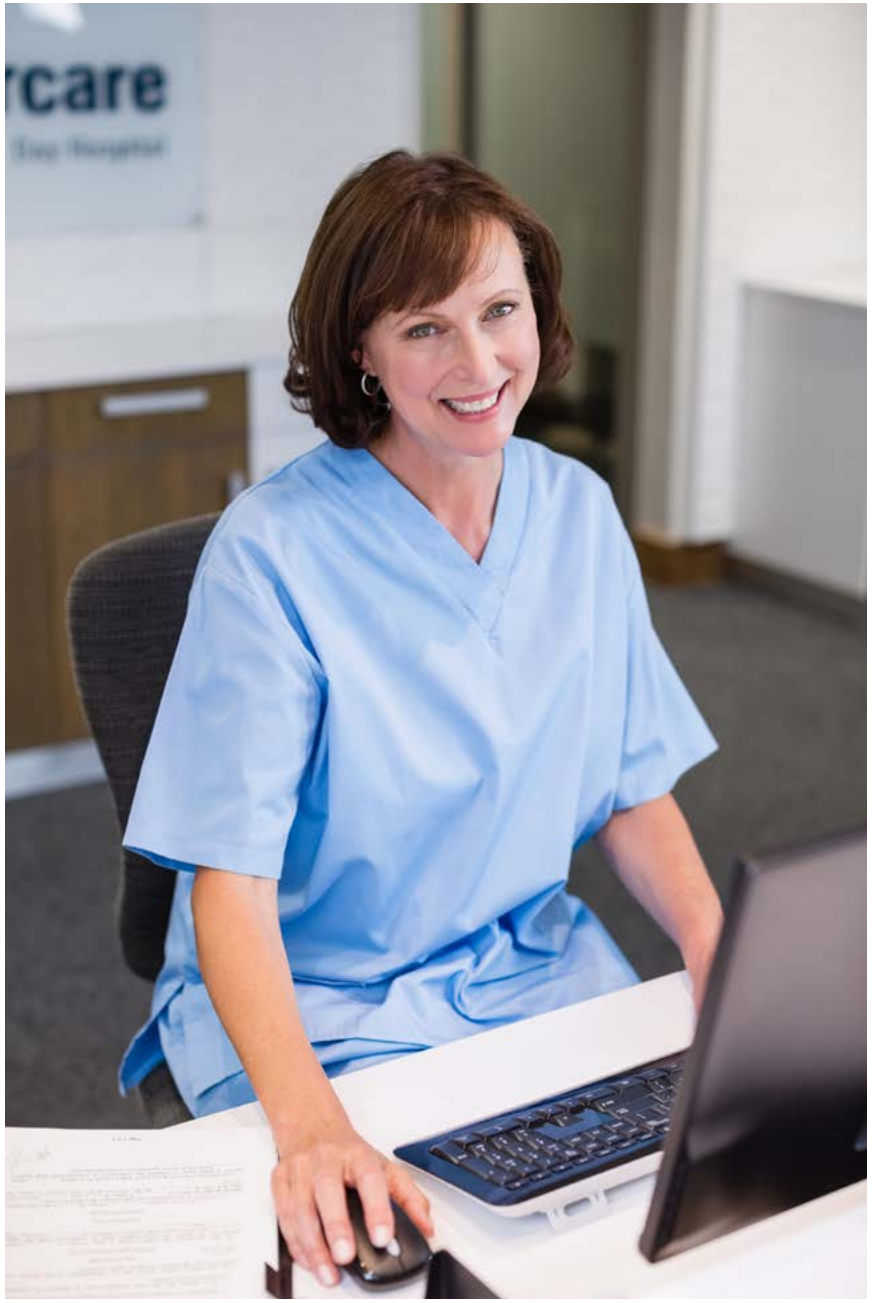
You're already providing quality care to your patients, but sometimes we don't get the data needed to document that. Our annual Supplemental Data Collection initiative helps to capture that information.

How It Works

- This initiative begins in **June** and ends the first week of **January** each year
- We provide nurses who review your medical records to abstract data for HEDIS and STARS measures that we don't otherwise receive through claims or clinical data exchange (CDE)
- Reviews can be done through remote access or onsite visits
- Your practice receives the credit for all information our team locates in your records to close gaps in care
- Gap closures can assist in increasing your STARS score, which favorably impacts your fee schedule the following April

How To Participate

For more information about the Supplemental Data Collection project and how to participate, please contact a member of our Provider Outreach Team listed in the front of this guide. Remember, participation is voluntary. This is not an audit, but it does help document the quality services you're already providing to your patients.



Availity® Provider Portal

Availity®, our provider portal, gives you the answers you need 24 hours a day, seven days a week. Through one convenient **single sign-on**, you can request claim status, view remittance advices and check benefits and eligibility status online. You can also interact with other managed care plans who use Availity.

In addition, the **Quality Care Rewards** tool located within Availity allows you to access the **Quality+ Partnerships** programs that apply to your practice. There you can identify gaps in care for your patients, attest to completed screenings, fill out annual provider assessment forms, review your practice's overall progress on quality measures and STARS score and much more.

For FAQs and more information about using Availity, visit Availity.com/bcbst. You'll also be able to sign up for a helpful webinar hosted by the Availity team.

For assistance or more information about Availity and the Quality Care Rewards tool, please contact your eBusiness Regional Marketing Consultant or our eBusiness Technical Support Team listed below:

eBusiness Technical Support

Monday through Thursday,
8 a.m. to 6 p.m., ET and
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Quality Care Rewards Tool Tips

- The tool refreshes at the end of the month each month to reflect information received from claims, direct data feeds and attestations through the end of the prior month.
- Please allow up to 60 days for information to be processed and updated within the tool after submission.
- All attestations and Provider Assessment Forms completed within the tool must be submitted by Jan, 21, 2020 in order to be processed for the 2019 measurement year.

Pharmacy

Our pharmacy strategy is focused on giving members access to the most appropriate, affordable, and effective medications for their needs. We have a team of pharmacists who work with our Pharmacy and Therapeutics (P&T) Committee to create a broad Part D formulary for our Medicare Advantage and DSNP plans. The P&T Committee includes membership from community-based physicians representing a variety of specialties throughout Tennessee, who provide direct input in the formulary development. Additionally, we include innovative benefit designs such as co-pays as low as $1, a formulary focused on helping patients with adherence, and continued coverage through the gap for certain diabetes medications.

2019 Medicare Formulary

The 2019 BlueCross BlueShield of Tennessee formulary is a list of covered drugs selected by a team of pharmacists, physicians, nurses and other health care providers. This formulary, or list of covered medications, represents the prescription therapies believed to be a necessary part of a comprehensive quality treatment program. This formulary is approved by the BlueCross Pharmacy & Therapeutics Committee and CMS.

For more information on covered medications, drug tier locations, and utilization review requirements, please visit our website to find the link to the 2019 Formulary: bcbst-medicare.com/medicare-plans/are-my-drugs-covered.page

Medication Therapy Management Program (MTM)

Members that qualify for the CMS Medication Therapy Management Program to help manage their drugs receive an offer to have a discussion with a pharmacist to assess all their medications.

What's Included:

- Members receive:
  - Written summary of discussion with pharmacist
  - Action plan that recommends what they can do to better understand and use his or her medications
- Providers receive a recommendation if there are any opportunities identified during this discussion that could enhance:
  - Safety
  - Quality of care
  - Therapeutic outcomes
- Safety concerns are communicated to the provider, including:
  - Drug-to-drug interactions
  - Duplications in therapy
  - Side effects

For more information on the Medication Therapy Management Program, including who is eligible for this extra benefit, please visit bcbst-medicare.com/manage-my-plan/pharmacy/medication-therapy-management.page

Coverage Enhancement for Non-Insulin Diabetes Medications

Medication adherence is one of the most important ways people with diabetes can control their Hemoglobin A1c and prevent disease progression or complications from uncontrolled blood glucose. Keeping medications affordable and accessible can help patients continue taking their medications as prescribed.

BlueCross BlueShield of Tennessee covers non-insulin diabetes medications prescribed for members who are in their annual Part D coverage gap. This means your patients will not experience an increase in their costs during this time. The benefit occurs automatically at the pharmacy, so members do not have to enroll or sign up to get this benefit.

Below is a list of medications commonly used to treat diabetes that will allow a copay in the coverage gap:

	Medication Class and Drug Name					
	Alpha-glucosidase inhibitor	Biguanides	Meglitinides	Sulfonylureas	Thiazolidinediones	Combination Products
Tier 1 Medications	Acarbose	Metformin Metformin XR	Neteglinide	Glimipiridi	Pioglitazone	Glipzide-Metform
			Repaglinide	Glipizide Glipizide XR		Pioglitazone Metaformin
Tier 1 copay: $1-$6 for 30-day supply and as little as $1.00 for 90-day supply depending on pharmacy and plan type.						

	Medication Class and Drug Name					
	Biguanide	DPP-4 Inhibitors	GLP-1 incretin mimetics	SGLT2 Inhibitors	Combination Products	
Tier 3 Medications	Riomet™	Januvia™	Bydureon™	Farxiga™	Invokamet™ Inokamet XR™	Glyxambi™
		Tradjenta™	Byetta™	Invokana™	Janumet™ JanumetXR™	Synjardy™ Synjardy XR™
			Trulicity™	Jardiance™	Jentadueto™ Jentadueto XR™	
					XigduoXR™	
Tier 3 copay: $28-$47 for 30-day supply with 90-day supplies starting at $70 depending on pharmacy and plan type.						

$1 Co-pay for 90-day Supply

Preferred Pharmacy Home Delivery (via mail-order)

Enhanced pharmacy benefits for 2019 include $1 co-pay for either 30-day or 90-day supply within the preferred pharmacy network and home delivery. **This is an excellent benefit for patients on a stable, chronic medication regimen**.

This information applies to BlueAdvantage (PPO)℠ Only

Managing Statin-Related Muscle Pain

The Centers for Medicare and Medicaid Services (CMS) has created two new STAR measures related to prescribing statin medications for patients with either of the following conditions:

- Diabetes
- Atherosclerotic cardiovascular disease (ASCVD)

Adding a statin medication to help lower ASCVD risk instead of targeting a specific low-density lipoprotein level is a leading recommendation of both the American Diabetes Association and the American College of Cardiology/American Heart Association.

Muscular Pain and Disease Side Effect Considerations

Statin-associated muscle symptoms are one of the most common reasons patients stop taking statins on their own. Screening patients at increased risk for muscle symptoms may help you decide which statin product and dose may be the most likely to prevent or lessen these side effects.

Managing patients on statin therapy with muscular pain and disease includes reviewing their medical history for comorbidities and potential drug-to-drug interactions that could contribute to muscle symptoms.

Hydrophilic statins, like **rosuvastatin** and **pravastatin**, have demonstrated reduced likelihood of muscle-related adverse effects when compared to lipophilic statins, like atorvastatin or simvastatin.

The strongest risk factors for statin-induced myopathy include:

Lifestyle Factors and Demographics

- Age >80
- Small body frame or frail build
- Consuming >1 quart per day of grape-fruit juice
- Excessive alcohol consumption
- Excessive physical activity

Comorbidities and Medical History

- Untreated hypothyroidism
- History of creatinine kinase elevation
- Multisystem disease (particularly diseases involving the liver and/or kidney)
- Personal history of unexplained cramps
- Personal or family history of myopathy while receiving another lipid-lowering therapy

Consider prescribing lower doses of hydrophilic statins for patients with statin-related myalgia, myopathy or mild rhabdomyolysis.

Statin Therapy STAR Measures

Below are criteria for the STAR measures requiring statin therapy:

Statin Use in People With Diabetes

Inclusion Criteria

People **40-75** years of age with at least **two claims** for **any medication** used to treat **diabetes**

Statin Intensity

Individualize based on risk and patient-specific factors.

Exclusion Criteria

- End-stage renal disease
- Patients in hospice

> All generic statins are included in the BlueCross Medicare Part D formulary. Atorvastatin, lovastatin, pravastatin, rosuvastatin and simvastatin are available at the lowest copay of $1.00 for a 90-day supply.

References: Cardiovascular Disease and Risk Management: Standards of Medical Care in Diabetes – 2018. Diabetes Care. 2018;41(Suppl.1):S86-S104 2013 ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.Circulation. 2013;129:S1-S45 Muscle- and skeletal-related side-effects of statins: tip of the iceberg? European Journal of Preventative Cardiology. 2016;23(1):88-110

Statin Therapy for Patients With Cardiovascular Disease

Inclusion Criteria

Males **21-75** years of age or females **40-75** years of age identified as having clinical **ASCVD**, including:

- Diagnosis of ischemic vascular disease
- Myocardial infarction, coronary artery bypass grafting or a revascularization event, such as percutaneous coronary intervention

Statin Intensity

At least moderate intensity based on risk and patient-specific factors:

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

Exclusion Criteria

- Patients in hospice
- Any of the following in the measurement year or the year prior:
  - Pregnancy
  - In vitro fertilization
  - Clomiphene therapy
  - ESRD
  - Cirrhosis
- Any of the following in the measurement year:
  - Myalgia
  - Myositis
  - Myopathy
  - Rhabdomyolysis

You Play an Important Role in Your Patients' Medication Adherence

Health care providers have a critical role in educating patients on the benefits and risks of prescribed medication regimens. We've included the following tips that can help your patients adhere to your prescribed medication instructions:

1. Write prescriptions the way you instruct your patients to take their medications.

   NOTE: CMS does not support pill-splitting for Medicare beneficiaries.

2. Encourage patients on an established maintenance medication regimen to use mail-order and 90-day supply options.

3. Educate your patients about the purpose of their medications and how they may make them feel.

4. Coordinate all prescription refills for the same time in order to prevent gaps in therapy.

5. Suggest patients use pill boxes and set reminders for refills.

6. Schedule office visits and follow-up appointments prior to prescriptions running out.

7. Refer patients to our Care Management program, at **1-800-611-3489**, for assistance with other barriers to medication adherence. We have nurse case managers, social workers, and a dietitian available to help.

For questions about covered alternative medications, medication adherence measures, the coverage gap or sample usage, please contact our Medicare Advantage Quality Pharmacist or a member of our Provider Engagement and Outreach team listed in the front of this guide.

Our mission

Peace of Mind through Better Health℠

for our members

for our customers

for our partners

for our communities

Our mission is the motivating force behind the decisions we make each day. It's centered on our members, but extends to our business partners and to Tennessee as a whole.

Member Selection and Attribution

Members are attributed to you based on the following process:

Member Selection

Enrollment - Members select a PCP to whom attribution will be made. BlueCross calls members to welcome them and helps them select a PCP if they don't have one yet. If members don't select a PCP, the next part of the attribution process points to Medical Claims.

If member wants to update their PCP, please see the next page for instructions.

→

Medical Claims

If the member sees several providers, the one with the most number of claims is attributed.

→

Pharmacy Claims

The prescriber who has the most number of claims for a member receives attribution for that patient.

→

Vendor Interaction

If a member visits a mobile clinic or is visited by a home-care vendor, the member can tell them which PCP they selected.

Notes:

- Attribution logic searches back two years.
- Provider selected/attributed must be from an approved provider type (e.g., internal medicine, family practice, general practice) and be on the inclusion list with contract type of primary care.
- If a member has an equal number of claims between multiple providers/prescribers, the provider/prescriber with the most recent claim is used.
- Member attribution is refreshed monthly.

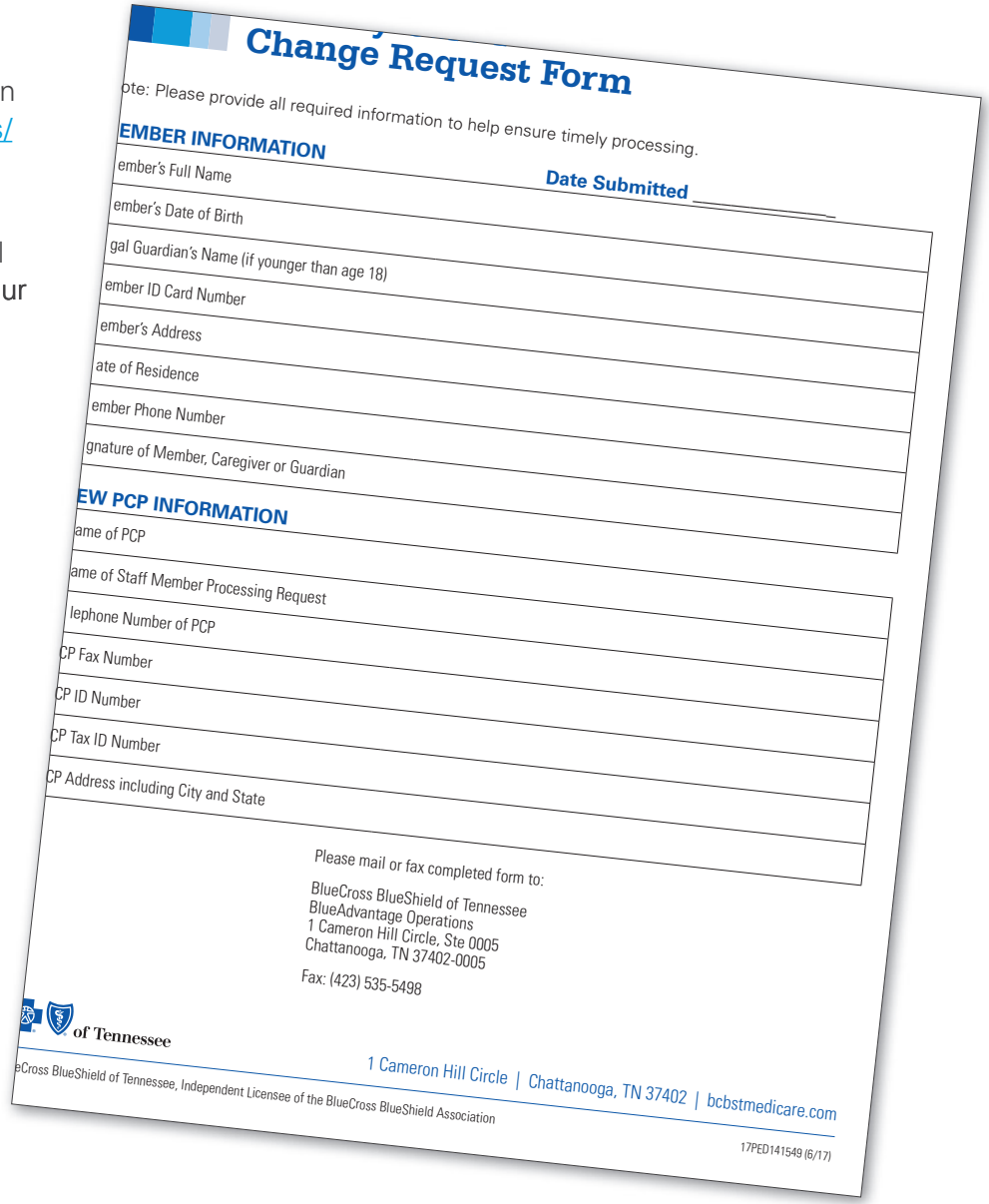
This information applies to BlueAdvantage (PPO)℠ Only

Primary Care Provider Change Request

In the event your patient would like to update their selected Primary Care Provider information with us, we have a form to help you with this process right from your office. The form can be found online at bcbst.com/docs/providers/quality-initiatives/Medicare-Advantage-PCP-Change-Form.pdf.

Please fax the form with the patient's signature to **423-535-5498**. Once we receive the completed form, we will update the patient's PCP information. While it will update in our system quickly, it may take a month to update in the Quality Care Rewards application within Availity®.

> Patient signature is required for the form to be processed.



Change Request Form

ote: Please provide all required information to help ensure timely processing.

EMBER INFORMATION

Date Submitted _____

ember's Full Name

ember's Date of Birth

gal Guardian's Name (if younger than age 18)

ember ID Card Number

ember's Address

ate of Residence

ember Phone Number

gnature of Member, Caregiver or Guardian

EW PCP INFORMATION

ame of PCP

ame of Staff Member Processing Request

lephone Number of PCP

CP Fax Number

CP ID Number

CP Tax ID Number

CP Address including City and State

Please mail or fax completed form to:

BlueCross BlueShield of Tennessee
BlueAdvantage Operations
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Fax: (423) 535-5498

of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbstmedicare.com

eCross BlueShield of Tennessee, Independent Licensee of the BlueCross BlueShield Association

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This information applies to BlueAdvantage (PPO)℠ Only

Annual Wellness Visit Facts

Medicare Advantage members are eligible for different wellness exams annually. These can vary based on their date of Medicare enrollment and gender.

This page outlines which codes to use and how best to document these important examinations.

Welcome to Medicare Exams

Frequency: Once per **lifetime** within first 12 months of Medicare enrollment

Service	Codes	Coverage Notes
Initial Preventive Physical Examination (IPPE)	G0402	Members are covered for comprehensive preventive medicine evaluation and management, including: - Appropriate history, age and gender - Examination - Counseling and anticipatory guidance - Risk factor reduction interventions Note that any out of office lab or diagnostic procedures that are ordered during this visit aren't covered under this benefit and the member may have a separate copayment for those services.
Initial Preventive Physical Examination (IPPE) w/EKG	G0402 with G0403, G0404 or G0405	

Annual Preventive Exams

Frequency: Once per **calendar year**, after the first 12 months of Medicare enrollment

Service	Codes	Coverage Notes
Annual Wellness Visit (AWV)	G0438 (Initial), G0439 (Subsequent)	Members are covered for comprehensive preventive medicine evaluation and management, including: - Appropriate history, age and gender - Examination - Counseling and anticipatory guidance - Risk factor reduction interventions Note that any out of office lab or diagnostic procedures that are ordered during this visit aren't covered under this benefit and the member may have a separate copayment for those services.
Annual Preventive Physical Exam	99385-99387 (New Patient), 99395-99397 (Established Patient)	This is a BlueCross Medicare Advantage benefit and isn't covered by Original Medicare. This service should be submitted with the correct Initial or Periodic Comprehensive Preventive Medicine code if all elements of these services are performed.
Well Woman Exam	Q0091 and/or G0101	BlueCross Medicare Advantage covers a pelvic examination screening – including a clinical breast examination – for all female members. When a complete Annual Preventive Physical Exam has been performed, **don't use** Well Woman Exam service codes.

This information applies to BlueAdvantage (PPO)℠ Only

Annual Provider Assessment Form

Frequency: Once per **calendar year**

Service	Codes	Coverage Notes
Provider Assessment Form (PAF)	96160	This is a BlueCross Medicare Advantage benefit and isn't covered by Original Medicare. A PAF may be submitted once per member, per calendar year. **Providers don't need to wait 365 calendar days from the last PAF submission or wellness exam**. A PAF may be completed in conjunction with the Welcome to Medicare Annual Preventive Exam or Annual Wellness Visit.

Member Incentives

Members who opt-in to the My Healthpath® program are eligible to earn wellness points when claims are received for one of the following exams annually:

- **Initial Preventive Physical Examination**
- **Annual Wellness Visit**
- **Annual Preventive Physical Exam**

Billing Tips

We allow separate reimbursement for these exams when they're rendered on the same day by the same provider and supported by the clinical documentation:

- **IPPE** and **Annual Preventive Physical Exam**
- **AWV** and **Annual Preventive Physical Exam**
- **PAF** with the **IPPE, Annual Preventive Physical Exam** or **AWV**

Documentation Tips

- When performing an **AWV** and a problem-oriented evaluation-and-management service (E/M) during the same visit, the information on the claim and in the medical record must support that the E/M service is significant and separately identifiable. If these conditions are met, modifier -25 should be appended to the E/M.
  - This also applies when you perform the **Annual Preventive Physical Exam** or **Well Woman Exam** with an E/M service during the same visit.
  - Problem-oriented E/M codes are 99201-99215.
- If the **Annual Preventive Physical Exam** and **Well Woman Exam** services are performed during the same visit, please submit the appropriate Annual Preventive Physical Exam code on the claim.
- If only the **Well Woman Exam** is performed, use these codes: Q0091 and/or G0101.
- A **PAF** must be completed during a patient's face-to-face visit and submitted within 30 days of completion.
- A **PAF** must provide a complete picture of the patient's current health status and be completed with acceptable provider authentication. All PAFs should be printed and retained in the patient's permanent medical record.

Provider Assessment Form (PAF) Information Guide

The Provider Assessment Form (PAF) is an important tool for collecting comprehensive information on each patient's current health status annually. It shows how all active chronic and acute conditions are documented and managed.

The PAF data may also close some quality measure gaps, impacting your STARS score and future annual fee schedule for providers in a quality amendment or care management agreement.

Immediate and Future Benefits to You

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

- Submit **CPT**™ code **96160** once per calendar year in addition to your visit E/M code. No modifier is needed.
- Reimbursement for completion of a PAF is based on date of the face-to-face encounter supporting PAF completion:
  - **$225** for dates of service between January 1 and June 30
  - **$175** for dates of service between July 1 and December 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 out of office lab or diagnostic procedures, such as X-rays or an EKG, that are ordered during this visit are not covered under this benefit, and the member may have a separate copayment for those services.

This information applies to BlueAdvantage (PPO)℠ Only

Important PAF Details

- Must be completed during a patient's **face-to-face visit**. Must be submitted via online or fax **within 30 days** of face-to-face visit or a new encounter must be completed.
- Must submit claim with appropriate CPT code within **six months** of face-to-face visit to receive incentive payment.
- Incentive payment is based on date of service of the face-to-face visit. Date of service for PAF must match the date of service for the face-to-face visit.
- If we are **not** in receipt of a complete PAF after receiving a PAF incentive claim, a member of our provider outreach team will contact you and request a complete PAF to be submitted within the next 30 days. PAFs remaining incomplete or missing after that time will be subject to PAF incentive recovery.
- 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.
- 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:
  - Patient demographics (auto-filled in electronic version)
  - Conditions list
  - Assessment and management of each active condition
  - Plan and follow-up
  - Practitioner Attestation/Signature
- If completed using a BlueCross paper form or online through Availity®, print and retain as part of the patient's permanent medical record.

PAF Completion Options

You have three options for completing and submitting PAFs:

- Online via secure Availity® portal: availity.com
- Submit your BlueCross approved non-standard PAF from your medical records by fax to **1-877-922-2963**
- Or access the writable PDF at the Quality Care Rewards website: bcbst.com/providers/quality-initiatives.page. Fax the completed form to 1-877-922-2963.

Training and Assistance

For training and assistance with the BlueCross PAF and quality measure gaps please contact a member of our Provider Outreach team listed in the front of this guide.

For Availity® 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**.

This information applies to BlueAdvantage (PPO)℠ Only

Q&A Additional Information / Frequently Asked Questions

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

A. No. 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.

Q. How often will I need to complete the PAF for each member?

A. 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, Medicare Annual Wellness Visit or any other face-to-face encounter. You do not have to wait 365 days between PAF completions or Annual Wellness visits.

Q. What steps must I take to ensure payment for completion of the PAF?

A. Complete the PAF during the patient's visit.

- Submit the appropriate E/M code for the reason for the visit.
- Submit CPT code 96160 (administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument).
- If an Annual Wellness Visit is performed at the same time as the PAF, submit preventive medicine service codes 99387 or 99397 in addition to 96160 for reimbursement.

Submit the PAF via fax or online within 30 days of the face-to-face visit. Submit the claim for the incentive payment within six months of the face-to-face visit.

If we are **not** in receipt of a complete PAF after receiving a PAF incentive claim, we will request a complete PAF to be submitted within the next 30 days. PAFs remaining incomplete or missing after that time will be subject to PAF incentive recovery.

Q. If I have my own form, can I submit it for the PAF?

A. You may contact a member of our Provider Quality team to submit your form for review as an acceptable PAF. Once your form has been approved, you may submit it as a non-standard PAF.

Q. What is needed in addition to the completed PAF?

A. Nothing, but the completed PAF should have:

- **Problem list** that outlines all of the patient's problems including any unresolved conditions/diagnoses.
- **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"
- **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."
- **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 BlueCross 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.

Q. What if the visit was preventive only?

A. 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.

Q. If I want to submit the form only for preventive screenings or gaps in care, can I just complete part of the PAF?

A. No. 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 recovery. Incomplete PAFs may also not be reviewed for gaps in care information.

Q. How should we code chronic conditions?

A. 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.

Q. What is considered acceptable provider authentication?

A. 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.

Q. What do I do with the PAF after completion?

A. 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.

Q. How should we code Medicare Advantage claims?

A. 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 ICD-10 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.

Q. Why should I perform this coding?

A. 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.

Q. How does the PAF close gaps in care?

A. The PAF often provides current and historical data that can be used to close gaps in care. 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 at the time of review, our staff will submit an attestation to close those gaps in the Provider Quality Care Rewards module on behalf of the provider.

Q. How long does it take for BlueCross to review a faxed PAF and the gaps in care to close?

A. 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 a minimum of four weeks to update in the system once submitted.

Q. How can I find out how many PAFs I've submitted and how many gaps in care my PAFs have closed?

A. 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 Availity®.

This information applies to BlueAdvantage (PPO)℠ Only

Helpful Tip: You may perform additional services, as needed, in conjunction with the Annual Wellness Visit such as Advance Care Planning, Counseling to Prevent Tobacco Use and Influenza and Pneumococcal vaccinations. For a complete list of Medicare preventive services, please visit: cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

Risk Adjustment

Risk Adjustment is a mechanism used by CMS to set premium levels paid to Medicare Advantage plans for managing Medicare beneficiaries' health care costs. Each member is assigned a risk score based on their age and gender demographics and diagnoses. ICD-10 codes for significant conditions map to Hierarchical Condition Categories (HCCs). The HCCs are actually what CMS uses to determine the individual risk score. CMS requires that all active acute and chronic diagnoses be documented **every calendar year**.

Risk scores are derived from five primary sources:

- Claims processed by the health plan
- Member demographics
- Medical record review
- In-home assessments
- Physician Assessment Forms (PAFs)

Appropriate documentation results in premium levels that:

- Cover medical expenses
- Maintain benefit levels
- Minimize monthly member premiums
- Provide the health plan with reasonable margins

Tips to Improve Risk Scores

- **Code all diagnoses on claims**
  - All conditions evaluated during the office visit (must be a face-to-face encounter)
  - Any conditions taken into consideration during active treatment of other conditions
  - Use CPT 99080 to transmit additional ICD-10 codes beyond 12, if necessary
  - All active conditions should be documented in the medical record using M.E.A.T.
    - **M**onitor
    - **E**valuate
    - **A**ssess
    - **T**reat
- **Return all requested medical records**
- **Submit PAFs annually on as many patients as possible**

How to Submit Medical Records for Risk Adjustment

Documentation Adequacy Begins with You

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Plans to meet standards for data submission and coding accuracy. To meet this requirement, BlueCross BlueShield of Tennessee performs annual medical record reviews to help ensure they properly reflect the clinical conditions of our members. We may ask your office to assist us in documentation, so that we remain compliant with Medicare's risk adjustment payment system. This helps us maintain and expand member benefits by ensuring appropriate reimbursement by CMS for the Medicare beneficiaries covered under our plan.

To help us with this effort, BlueCross has partnered with Ciox Health and its affiliate ArroHealth™ Inc. to gather medical records on our behalf. This relationship means that Ciox Health must follow the terms of our business associate agreement, which protects the privacy of medical records in accordance with HIPAA requirements.

When medical records are requested for a patient, please provide a complete copy (including: dates of service, patient name, treatment plan and provider's signature with credentials) for each patient and dates of service requested.

Guidelines on Patient Authorization

Our medical records request is conducted according to the CMS guidelines and based on the terms and conditions of your Medicare Advantage Provider Agreement (Section C.7) and/or the Model Terms and Conditions of Payment (Section 6). Also, according to Section 164.506(c) (4) of the Privacy Rule, medical providers are permitted, when appropriate, to disclose patient medical information without patient authorization.

Medical Records Return Instructions - Time Sensitive

Please return a copy of the full medical record(s) for the requested members, including dates of service, by either:

- Uploading to the Ciox Health provider portal at cioxlink.com (contact Ciox Health at 1-855-651-1885 for user ID and password assistance)
- Calling **1-855-651-1885** to arrange for remote EMR retrieval
- Faxing to **1-972-957-2184** (HIPAA compliant fax)
- Mailing the records directly to Ciox Health (mark the envelope "Confidential"):

  Ciox Health
  15458 N. 28th Ave., Suite E
  Phoenix, AZ 85053

- Calling **1-855-651-1885** to have a scanner technician visit your office

Thank you for your assistance in helping us document active clinical diagnoses to CMS. If you have any questions about our request, please contact Ciox Health by calling **1-855-651-1885**. If they are unable to answer your questions or resolve your concerns, please contact your BlueCross Quality Outreach Contact listed in the front of this guide.

Helpful Tips: Document each active chronic and acute condition every year. Up to 12 diagnoses can be submitted on claims which can help minimize the volume of medical records requested. A second zero dollar claim using CPT® code 99080 can be submitted if there are more than 12 active diagnoses.

Signify Health™ In-Home Health Assessments

Sometimes it can be difficult to get your patients in your office for necessary testing and screenings. To help, we've partnered with Signify Health™, formerly CenseoHealth®. They can send licensed providers (physicians, nurse practitioners and physician assistants) to patients' homes to perform in home health risk assessments and selected preventive testing at no additional cost to our members.

The In-Home Assessment Can:

- Encourage members to remain engaged with their PCP
- Perform certain preventive screening tests in the home for patients who otherwise would not be able or willing to come to the office
- Assess current health conditions
- Ensure the patient is following your prescribed treatment plan

Because we believe the relationship with the primary care provider is important, we always encourage your patients to see you to get their annual wellness visit.

You can still bill for an annual wellness visit and completion of a provider assessment form (PAF), even if an in-home health assessment was already performed by Signify Health. Additionally, you can also receive a payment from BlueCross for completing and submitting the Provider Assessment Form (PAF).

For more information about Signify Health and its in-home health assessments, you may call our Provider Service Team at **1-800-924-7141**, Monday through Friday from 8 a.m. to 6 p.m. (ET). We're right here if you a question about this or any of our Medicare Advantage quality programs. Please contact your Provider Outreach Consultant listed in the front of this guide.

Identification of Patients

Patients are identified based on a variety of qualifications, such as

- No listed PCP or provider visits within the past year
- Gaps in chronic condition documentation
- Potential undocumented co-morbidities
- Use of medication indicating the presence of a condition without a documented diagnosis

If the member does not want to participate in an in-home health assessment, he or she may decline. Signify Health will encourage the patient to follow-up with their PCP for evaluation and follow-up.

Assessment Components

The provider performs a comprehensive history and physical, as well as the following, as appropriate:

- iFOBT/FIT Test Kit
- HgbA1c Test Kit
- Diabetic Retinal Eye Exam
- Bone Density Screening
- Urine Microalbumin Test Kit

Signify Health sends results of the assessments to members and their attributed PCP (the member identifies his or her PCP during the visit).

Our values

We value our relationships with:

our customers

our business partners

our employees

In those relationships, we value:

exceptional service

innovation and agility

collaboration

All of these are underscored by a constant foundation of integrity and trust.

My Healthpath®

Your patients can earn points toward gift cards for following healthy behaviors and completing the screenings they need.

Q. Why is BlueCross BlueShield of Tennessee offering incentives for members to complete various health screenings?

A. BlueCross' member wellness and reward program, My Healthpath®, will continue to focus on better health outcomes in 2019 with the added push to help ensure each BlueAdvantage member receives an annual wellness visit. BlueAdvantage members can continue to earn wellness points for completing the annual wellness visit as well as additional points for completing other preventive screenings.

Q. How do members sign up to participate?

A. Members can join the program by logging in at bcbstmyhealthpath.com, downloading our mobile app "AlwaysOn® Wellness" or returning the business reply card attached to the 2019 My Healthpath introduction that is mailed to the member at the beginning of the year or when they become eligible for coverage in a BlueAdvantage plan. Once a member joins the program, they do not need to join again in subsequent years.

Q. How can members get started earning wellness points to redeem for rewards?

A. Members will receive a letter asking them to opt in to the incentive program. Once they opt in, they opt in for life and are eligible to earn wellness points for preventive services that you are ordering.

Q. What are points worth?

A. Each point is valued at $1 and can be used after a single screening or accumulated. For example, a member who completes their Annual Wellness Visit by June 30 can redeem points for a $50 gift card once the claim has been processed or let points add up to redeem at a higher value.

Annual Wellness Visit Tips: Use GO402, GO438, GO439 plus E/M codes appropriate for the annual wellness visit. Or use 99387, 99397, 99385, 99395, 99386, 99396, 96160 (Provider Assessment Form).

NOTE: In the Annual Wellness Visit (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 out of office 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.

This information applies to BlueAdvantage (PPO)℠ Only

Available Member Incentives for 2019

my healthpath®

Measure/Activity	Wellness Points	Incentive Criteria
Annual Wellness Visit (AWV)	**50**	Available for all members annually who complete an Annual Wellness Visit anytime in January through June
	30	Available for all members annually who complete an Annual Wellness Visit anytime in July through December
Breast Cancer Screening (BCS)	**75**	Available for Women ages 52-74 every other year who complete a mammogram at a provider facility
Colorectal Cancer Screening (COL)	**20**	Available for members ages 51-75 annually who complete a gFOBT/iFOBT. Incentive only available in absence of FIT-DNA in the previous three years, sigmoidoscopy or CT Colonography within the previous 5 years or colonoscopy within the previous 10 years
	30	Available for members ages 51-75 every three years for members that complete a FIT-DNA (Cologuard®)
	60	Available for members ages 51-75 every 5 years who complete a CT Colonography or Sigmoidoscopy at a provider facility
	80	Available for members ages 51-75 every 10 years who complete a Colonoscopy at a provider facility
Comprehensive Diabetes Care (CDC) - A1C Control (≤8.9%)	**25**	Available for diabetic members ages 18-75 annually who complete an A1C test in home, in the provider office or at a BCBST community outreach event
Comprehensive Diabetes Care (CDC) – Retinal Eye Exam	**50**	Available for diabetic members ages 18-75 annually who complete a Retinal Eye Exam at an ophthalmologist or optometrist provider office, in-home, in the provider office or at a BCBST community outreach event
Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy	**15**	Available for diabetic members ages 18-75 annually who complete a Urine Nephropathy Screening test in home or in the provider office
Osteoporosis Management in Women with a Fracture (OMW)	**50**	Available for all women ages 65-85 who complete a Bone Density Screening in home or in the provider office within six months of a fracture of a long bone or the spine
Statin Therapy for Patients with Cardiovascular Disease (SPC)	**25**	Available for male members ages 21-75 and female members ages 40-75 with atherosclerotic cardiovascular disease (ASCVD) who filled at least one prescription for a statin.
Health Needs Assessment (HNA)	**25**	Available for all members who complete a health needs assessment online, by phone or mail
Digital My HealthPath® Enrollment	**20**	Available for all members who enroll in the member incentive program through the mobile app or online portal
Medicare Diabetes Prevention Program Participation	**100**	Available for all members who qualify for the Medicare Diabetes Prevention Program and participate for at least 6 months.

This information applies to BlueAdvantage (PPO)℠ Only

You Make a Big Difference in Your Patient's Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Medicare Health Outcomes Survey (HOS) annual surveys are used by CMS to evaluate care and services provided to your patients. Your patients are asked to respond to survey questions in several categories. We've included a few of those below with tips on how you can help improve patient satisfaction.

Your interaction with members has a direct impact on your patients' response to CAHPS and HOS surveys. Incorporating these simple techniques into your daily interactions with patients will provide them with a better experience, help them achieve better health outcomes, and can lead to better patient retention.

Survey	Measure	Survey Question(s)	Tips
HOS	**Reducing the Risk of Falling**	• A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking? • Did you fall in the past 12 months? • In the past 12 months, have you had a problem with balance or walking? • Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?	• Discuss balance problems, falls, difficulty walking and other risk factors for falls • Recommend the use of a walker or cane, if appropriate • Check standing, sitting and reclining blood pressures • Recommend a physical therapy or exercise program, if appropriate • Recommend vision and hearing tests, if appropriate • Perform bone density screenings, especially for patients at risk • Consider home health performing a home safety assessment to look for risks for tripping
HOS	**Improving or Maintaining Physical Health**	• In general, would you say your health is: Excellent, Very Good, Good, Fair, Poor • The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? - Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf - Climbing several flights of stairs • During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? - Accomplished less than you would like as a result of your physical health? - Were limited in the kind of work or other activities as result of your physical health? • During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	• Assess patients' physical health, functional status and activity • Talk to your patients about their level of physical activity and encourage them to start, maintain or increase activity, if appropriate • Assess pain and intervene, if appropriate • Encourage members to use their free SilverSneakers® gym membership benefit

Continued

Survey	Measure	Survey Question(s)	Tips
CAHPS	**Getting Needed Prescription Drugs**	• In the last 6 months, how often was it easy to use your prescription drug plan to get the medicines your doctor prescribed? • How often was it easy in the last 6 months, to use your prescription drug plan to fill a prescription at your local pharmacy? • How often was it easy in the last 6 months, to use your prescription drug plan to fill a prescription by mail?	• Consider use of generic medications • Encourage use of mail-order – in 2019, members will pay the reduced 30-day copay for a 90-day supply by mail • Discuss barriers to getting needed medication

Did you know? BlueAdvantage (PPO)℠ and BlueCare Plus (HMO SNP)℠ members have a **free** SilverSneakers® benefit. This free fitness program for seniors includes access to over 15,000 participating gym and fitness centers. The program also offers fitness classes for all abilities led by SilverSneakers trained instructors at gyms and other locations as well as on-demand workout videos and health and nutrition tips.

SilverSneakers by Tivity Health

SilverSneakers®

5 Reasons patients may not be exercising and how SilverSneakers® addresses them.

I don't have time OR It's too far.

With 14,000+ SilverSneakers participating locations, it's likely they have one close by. (They can find locations by ZIP code at SilverSneakers.com/Locations.) They can attend class or work out on their own and be on their way, or socialize over coffee with friends afterward.

I've never been to a gym OR I wouldn't know what to do there.

They're not alone: Helpful staff and other members welcome and guide new members. Nearly half of SilverSneakers members never had a fitness membership prior to joining the program, so they relate well with newcomers. SilverSneakers FLEX® community fitness classes can help ease the transition to a fitness location setting.

I don't know how to use fitness equipment.

Staff members at SilverSneakers locations provide fitness equipment orientations. They show new members how to use each machine, emphasizing technique and safety.

It will be too difficult OR I'm not in good enough shape.

SilverSneakers group fitness classes are designed for individual participants' fitness levels and abilities. Class members' comfort and safety are of primary concern; the certified instructors are specially trained in older-adult fitness.

I'd rather work out on my own than be in a class or group.

SilverSneakers members have access to all basic amenities – not just classes. They can use cardio equipment, weights, pools, walking tracks and any other amenities included in a basic membership. Classes and group work are never mandatory but can be very enjoyable.

Talk to your patients about starting, increasing or maintaining their level of exercise and refer them to SilverSneakers at their next visit.

BlueCross BlueShield of Tennessee includes SilverSneakers for free for members of these Medicare Plans:

BlueAdvantage (PPO)℠
BlueCare Plus (HMO SNP)℠
BlueElite℠ Medicare Supplement

Your patients should visit silversneakers.com or call the health plan to verify SilverSneakers eligibility.

Population Health

The Medicare Advantage Population Health program is a fully integrated medical and behavioral health care management team which includes registered nurses, licensed social workers and registered dietitians who specialize in helping the senior population. Our programs are available to all members at no additional cost. They provide additional education and support to your patients, as well as promote quality and cost effective coordination of care.

Care Management Programs

- Complex/Catastrophic Care Management
- Transition of Care Assistance
- Chronic Condition Health Coaching
- Behavioral Health Care Management
- Specialized Support Services through Licensed Clinical Social Workers and Registered Dietitians
- Transplant Care Management

Targeted Interventions

- Coordinate access to services for members with complex illnesses
- Support and reinforce the provider's plan of care
- Educate members and their caregivers on any diagnosis made by their provider
- Motivational Interviewing/Readiness to Change Coaching

To make a referral or contact our Population Health Department, call **1-800-611-3489**.
For assistance with escalated or urgent issues, please contact a member of our Population Health Management Team:

Wendy Pitts, MSN, MBA, RN, CCM
Director, Health Services,
Medicare Advantage
Phone: (423) 535-3636
Email: Wendy_Pitts@bcbst.com

Lee Warren, RN, BSN, CCM
Manager, MA Population Health
Phone: (423) 535-7414
Email: Lee_Warren@bcbst.com

Brian Jones, MS, RDN, LDN, CDE, CCM
Supervisor, MA Population Health, West/Middle TN
Phone: (423) 535-5447
Email: Brian_Jones@bcbst.com

Ashley Morgan, RN, CCM
Supervisor, MA Population Health, East TN
Phone: (423) 535-5198
Email: Ashley_Morgan@bcbst.com

This information applies to BlueAdvantage (PPO)℠ Only

Medicare Diabetes Prevention Program

SOLERA

We have a preventive benefit that can help your patients lower their risk of developing type 2 diabetes. This once in a lifetime benefit, per CMS, is available at no cost to the patient.

Our partner, Solera Health, has a diabetes prevention program that teaches your patients how to make better diet choices and change activity levels that can positively impact their health. They will also get support from a small support group and a personalized health coach.

Under CMS program requirements, patients are eligible for this program if:

- BMI greater than or equal to 25 (greater than or equal to 23 if self-identified as Asian)
- At least one of the following blood tests:
  - fasting glucose of 110-125 mg.dL
  - a two-hour plasma glucose of 140-199 mg/dL (oral glucose test)
  - hemoglobin A1C test with a value between 5.7 - 6.4 within the previous 12 months

Patients with previous history of diabetes (excluding gestational) or end stage renal disease, aren't eligible for the program.

If we've identified any of your patients who qualify for the program based on the above eligibility criteria, we will notify you by letter and contact them to offer this program.

You May Also Refer Your Patients

Call or fax the referral form. Visit our website to find the referral form: bcbst.com/providers/quality-initiatives/Supportive-Programs.

BlueAdvantage (PPO)[SM]
Phone: 1-800-611-3489
Fax: 1-800-727-0841

BlueCare Plus (HMO SNP)[SM]
Phone: 1-877-715-9503
Fax: 1-866-325-6694

For more information, please see the Frequently Asked Questions on the following page.

If you have any questions about this benefit, please call our Provider Service line at 1-800-924-7141, Monday through Friday from 8 a.m. to 6 p.m. (ET).

Helpful Tip: Qualifying BlueAdvantage patients can earn 100 wellness points for participation in the Medicare Diabetes Prevention Program for at least six months if they are enrolled in the My Healthpath® member incentive program.

Frequently Asked Questions

Q. What is the Medicare Diabetes Prevention Program (MDPP)?

A. The MDPP helps your patients develop lifestyle strategies to lose weight, adopt healthy habits and decrease their risk of developing type 2 diabetes. The program meets weekly for 16 weeks, and then monthly for the rest of the year.

Q. How effective is the MDPP in reducing the risk of type 2 diabetes?

A. The program has been proven by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to decrease the risk of developing type 2 diabetes by 58 percent for those who lose 5 – 7 percent of their body weight, via changes in diet and exercise.

Q. What's included in the no-cost program?

A. There are many versions of the lifestyle change program, but most include these components:

- 16 weekly lessons, followed by monthly sessions
- A second year of maintenance sessions for those who meet the 5 percent weight-loss goal
- Lifestyle health coach to help set goals and keep participants on track
- Small group for support and encouragement

Q. Who is eligible for the program?

A. This once in a lifetime preventive benefit (per CMS) is available to all our eligible Medicare Advantage members. Patients are eligible for the program if they have a BMI greater than or equal to 25 (greater than or equal to 23 if self-identified as Asian), at least one of the following blood tests – fasting plasma glucose of 110-125 mg/dL, a two-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test) or a hemoglobin or A1C test with a value between 5.7-6.4 – within the previous 12 months. Patients with previous history of diabetes (excluding gestational) or end stage renal disease aren't eligible for the program.

Q. How do your patients find out if they qualify?

A. If you discover your patients have prediabetes or score high risk for developing type 2 diabetes after their annual wellness visit, you have several easy ways to reach us:

BlueAdvantage (PPO)℠
Phone: 1-800-611-3489
Fax: 1-800-727-0841

BlueCare Plus (HMO SNP)℠
Phone: 1-877-715-9503
Fax: 1-866-325-6694

Q. Is there a cost to members for participating?

A. This program is available at no cost to members. Once a member enrolls in the program on Solera4Me.com, BlueCross will receive a claim from Solera to cover the program services for this preventive benefit. Members may receive an Explanation of Benefits (EOB) from BlueCross BlueShield of Tennessee for this benefit showing no member liability. MDPP is a covered Medicare Advantage preventive benefit.

MDLIVE® (PhysicianNow®) FAQ

MDLIVE Telehealth (PhysicianNow) is a convenient way for Medicare Advantage and DSNP members to get care during off hours for minor illnesses. They can talk to a doctor from home or on the go – 24 hours a day, seven days a week – even on holidays.

PhysicianNow doctors are board-certified and consult with members by phone or secure video to help treat several non-emergency medical conditions like allergies, cold/flu, fevers, sinus infections, respiratory issues, rashes or insect bites, sore throats or urinary tract infections. If members need a prescription, the PhysicianNow provider will send it electronically to the member's nearest pharmacy. The PCP of record provided during patient registration will also receive a visit summary.

PhysicianNow providers do not write prescriptions for controlled substances or refills for chronic medical conditions.

It's easy for members get started using PhysicianNow

Members can use PhysicianNow immediately after signing up and activating their account.

After they have an account, they can browse doctor profiles, view available appointment times and schedule appointments.

Setting up an account is free, but members will have to pay the equivalent of their PCP copayment for the consultation. Customer Service can help anyone with questions about PhysicianNow benefits or cost-share.

Members can download the PhysicianNow app

The mobile app is available at the Apple® App Store® or Google Play™ (search PhysicianNow as one word).

PhysicianNow is safe and private

PhysicianNow is compliant with the Health Insurance Portability and Accountability Act (HIPAA). Member information will only be shared with their selected PCP and pharmacy. If you have questions, please call Customer Service at **1-800-924-7141**, Monday through Friday, 8 a.m. to 6 p.m. (ET).

PhysicianNow is not intended to replace the member's Primary Care Physician (PCP). However, a virtual doctor's consultation can be an acceptable alternative for visiting the urgent care center or emergency room for non-emergency situations.

Member Home Meal Benefit After Discharge

Mom's Meals NourishCare

Effective **Jan. 1, 2019**, BlueAdvantage (PPO)[SM] and BlueCare Plus (HMO SNP)[SM] members will have a new supplemental benefit to receive prepared, refrigerated meals after they have been discharged to home from an inpatient stay at an acute hospital or skilled nursing facility. BlueCross has partnered with Mom's Meals NourishCare to provide this service at no cost to our members.

Question	Answer
What is Mom's Meals?	• Mom's Meals is a vendor partner who will supply members with the meals after discharge to home. • **BlueAdvantage** members will receive **two meals per day for five days** following discharge from an acute inpatient hospital or skilled nursing facility. • **BlueCare Plus** members will receive **two meals per day for seven days** following discharge from an acute inpatient hospital or skilled nursing facility. • The 10 or 14 (depending on program) prepared meals will be delivered in a **single shipment** to the member's home by the vendor or by FedEx delivery.
How do members qualify for Mom's Meals?	• Members are eligible for Mom's Meals after being inpatient in an acute care setting or a Skilled Nursing Facility (SNF), and they are then discharged to home. - The inpatient acute care setting includes the following settings: • Inpatient in the hospital • Long-Term Care Facility • Acute Inpatient Rehabilitation • The meals should typically be requested within **two days** after the member is discharged from the inpatient setting.
What are the costs and limitations?	• There is **no cost share** for the member with the meal benefit through Mom's Meals. • There is **no limit** to how many times a member can qualify for the benefit in a year, as long as they meet the qualifications listed above.
Information about the meals	• The member will be sent freshly prepared meals that need to be refrigerated. • All 10 or 14 (depending on program) meals are delivered at one time. • Most meals only need to be microwaved to be ready to eat. - If a member does not have a microwave, Mom's Meals can suggest options that do not require a microwave. • Mom's Meals can accommodate most dietary restrictions or special diets.
How does a member know if they quality for the Mom's Meals benefit?	• The Inpatient Nurse or a Nurse Case Manager will advise the member and/or discharging facility if Mom's Meals is an option for them. - If the member wants to use the Mom's Meals benefit, a Nurse Case Manager will activate the benefit upon member discharge. • Members can call and request the benefit from Mom's Meals. - If the member calls to request the benefit, Mom's Meals will verify with the MA Population Health Team that the member meets the qualifications to start the benefit.
What happens after the member has used their Mom's Meals benefit?	• If the member likes Mom's Meals, they will have the option to purchase additional meals at their own cost, after the 10 or 14 meal benefit has ended. The meals will be about $7 per meal, if the member wishes to purchase additional meals directly.

Best Practice Tips

Provider Assessment Form (PAF) Completion

- Begin scheduling Annual Wellness Visits in late December for the following year or early January.
- Review your list of BlueAdvantage patients on at least a quarterly basis to identify those that still need a PAF.
- Review the Quality Care Rewards tool before each PAF to help identify any existing open quality measure gaps.
- Encourage office staff to see if a PAF has been completed when patients call to schedule return office visits. Discuss the importance of this assessment and schedule some additional time during the visit for the provider to complete.
- Consider shared medical office visits utilizing nurses or pharmacists before the actual provider visit to pre-populate PAF documentation or perform medication reconciliation.

Medication Reconciliation Post-Discharge/Transitions of Care

- Partner with local hospitals to make sure you're receiving discharge information for patients.
- Use on-hold messaging opportunities to remind your patients to schedule a follow-up visit within five (5) days of being discharged.
- Follow the guidelines for Transitional Care Management after a discharge to close the Medication Reconciliation Post-Discharge gap and also receive higher reimbursement than a traditional office visit.

Breast Cancer Screening

- Remind patients that if they participate in the member incentive program, they can receive a gift card for getting their mammogram. "Did you know you can receive a $75 gift card for having a mammogram?"
- Partner with the imaging center in your community and host a day or evening event for your patients. Let us know how we can help.
- Use lobby video streaming services to highlight the importance of mammography throughout the year.

Colorectal Cancer Screening

- Inform patients that screening can decrease or prevent colorectal cancer-related mortality.
- Discuss patients' fears and concerns about having a colorectal cancer screening.
- Offer patients different prep options and encourage a low-residue diet the week before the procedure.
- Educate patients on what to expect the day of the procedure and when to expect results.

Home Bound Patients

- Let your outreach consultant know if you have patients with transportation issues. We work with companies who specialize in many preventive screenings and can complete these for your patients in the comfort of their home. The results are always faxed to the provider so they can be incorporated in the patient's chart.

Osteoporosis Management in Women with Fracture

- Schedule bone density screening in conjunction with a mammogram every two years.
- Discuss balance problems, falls, difficulty walking and other risk factors for falls.
- Prescribe an osteoporosis therapy medication for patients at risk.

Dual Special Needs Plan (DSNP)

BlueCare Plus Tennessee

Our Model of Care is designed to serve the unique, individual needs of the dual eligible Medicare and Medicaid population. Our programs promote improved cost efficient health outcomes through coordination of care for patients with complex, chronic or catastrophic health care needs.

Our Multi-Disciplinary Team

- Physicians
- Registered Nurses
- Licensed Behavioral Health Clinicians
- Social Workers

Our Focus

- Member engagement and self-management
- Transition of care
- Medication reconciliation and adherence
- Preventive and health promotion services
- Integration and coordination of care among providers and health plans

Our Model of Care

- Initial and annual reassessments
- Individualized Care Plan (ICP)
- Documentation related to the ICP
- Appropriately credentialed members of Interdisciplinary Care Teams (ICT)
- Annual Model of Care training available for network providers, ICT members, and BlueCare Plus staff

This information applies to BlueCare Plus (HMO SNP)SM Only

Patient Assessment & Care Planning Form Interdisciplinary Care Team Guide

The Patient Assessment and Care Planning Form (PACF) is an important tool for collecting comprehensive information on each patient's current health status annually. It documents all active chronic and acute conditions and outlines how they're managed.

The PACF data may also close some quality measure gaps, impacting your STARS score and future annual fee schedule for providers in a quality amendment.

Immediate and Future Benefits to You

The **PACF** is the Health Risk Assessment Tool also used as a communication tool for the **Interdisciplinary Care Team (ICT)**, which includes members, their primary care physician (PCP) and BlueCare Plus Care Coordination team.

The ICT is designed to bring the plan and providers together in promoting better health outcomes for this most vulnerable population. The sharing of information constitutes your ability to bill for the ICT.

BlueCare Plus encourages our members to complete an Annual Wellness Visit (AWV). There is also a member incentive to complete an AWV. PCPs can include the PACF and ICT procedure code billing in conjunction with the completion of the AWV.

PACF submission should be billed on your encounter claim for reimbursement.

Code	Description	Amount
99366-99368	Interdisciplinary Care Team	$54.00
96160	Administration of PACF	$155.00

The completion of the PACF and ICT may be done in conjunction with the Welcome to Medicare or Medicare Annual Wellness Visit. Member incentives for closing gaps and getting necessary preventative screenings are triggered by the codes billed for the AWV.

Charges and reimbursement are based on date of service.

Code	Description	Amount
G0438	Annual Wellness Visit – First Visit	$163.03
G0439	Annual Wellness Visit – Subsequent	$109.98
99497	Advance Care Planning (ACP) first 30 minutes face-to-face	$78.78
99498	Advance Care Planning (ACP) each additional 30 minutes	$69.19

NOTE: Use G0438, G0402 or G0439 with your E/M codes or E/M Codes 99387 or 99397. No modifier is needed.

This information applies to BlueCare Plus (HMO SNP)SM Only

Important PACF Details

Submit annually, ideally during the patients AWV. CMS requires we conduct an annual assessment; our goal is to align the timing of the annual reassessment with the AWV. The PACF may only be submitted once per member per calendar year and you do not have to wait 365 calendar days from last PACF submission or AWV.

To be considered for reimbursement for both the PACF and ICT, the following data must be provided within the PACF, or equivalent medical record:

- **Review of current medications**
- **Vital Signs**
  - Includes BP, height, weight for BMI or BMI score
- **Physical Exam**
  - Condition specific information such as Circulatory, Cardiac, artificial openings, digestive system, endocrine, nutritional, mental, nervous system, respiratory, etc.
  - Any unlisted diagnosis
- **Gaps in care** (include completed service date in MM/DD/YYYY format)
  - Breast Cancer Screening (BCS)
  - Colorectal Screening (COL)
  - Osteoporosis Screening in women with a fracture (OMW)
  - Rheumatoid Arthritis Drug Therapy (ART)
  - Diabetes Nephropathy (CDC Neph)
  - Diabetes HbA1C (CDC A1C)
  - Diabetes Retinal Eye Exam (CDC EYE)
  - Cervical Cancer Screening (CCS)
  - Medication Adherence (RASA/Statins/OAD)

  NOTE: If not performed indicate referral and appointment date.

Care for Older Adults

- Functional Status Assessment (66 and older)
  - Notation of Activities of Daily Living (ADLs), at least 5; e.g. Bathing, Dressing, Eating, Transferring, Toileting, Walking, OR
  - Notation of Instrumental Activities of Daily Living (IADLs), at least 4; e.g. Shopping for groceries, Driving or using public transportation, Using the telephone, Meal preparation, Housework, Home repair, Laundry, Taking medications, Handling finances, OR
  - A Standardized Functional Status Assessment Tool, OR
  - Notation of at least 3 of the following: Cognitive status, Ambulation status, Hearing, Vision, and Speech (must have all 3), Other functional independence (exercise, ability to perform job)
- Pain Assessment
  - Evidence of a Pain Assessment and patient was assessed for pain (could be positive or negative findings) OR
  - Results of a Standardized Pain Assessment Tool (Pain Scale)

- **PCP Recommended Plan of Care/instruction**
  - Review the individualized plan of care developed for/with the member by the care coordination team and make any additions or recommendations necessary for the members treatment plan.
- **Advanced Directives**
  - By checking the box on the PACF, and/or including information in your medical record will allow you to bill for CPT 99497 or 99498 each time you have discussions regarding advance care planning.

    NOTE: While we encourage these discussions and you now can bill for them, this particular element is not required to be considered complete.
- **Practitioner Attestation/Signature/Date of Service**

  NOTE: if you are providing your medical record, the electronic signature of the doctor will suffice for attestation of service.

PACF Completion Options

You have three options for completing and submitting PACFs:

- Online via secure Availity® portal: availity.com
- Submit your BlueCarePlus approved non-standard PACF from your medical records by fax to **423-591-9504**
- Access the writable PACF at the BlueCarePlus website: bluecareplus.bcbst.com
  Fax the completed form to **423-591-9504**

NOTE: For Availity® 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**.

Training and Assistance

For training and assistance with PACF and quality measure gaps please contact:

- BlueCare Plus Care Coordination Line **1-877-715-9503**
- Visit our Provider Resources Page at bluecareplus.bcbst.com

This information applies to BlueCare Plus (HMO SNP)SM Only

Q&A Additional Information / Frequently Asked Questions

Q. What is considered acceptable provider authentication?

A. 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 PACF include the following: MD, DO, NP or PA.

Q. What is needed in addition to the completed PACF?

A. Nothing. But the completed PACF should include the items listed below. You may also fax medical records along with the PACF if you choose.

- **Problem list** that outlines all of the patient's problems including any unresolved conditions/diagnoses.
- **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".
- **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."
- **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 BlueCross 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.

Q. As a contracted BlueCross BlueShield of Tennessee provider, am I required to complete a PACF on all my patients?

A. No, however, we do encourage you to participate for the overall health and well-being of our BlueCare Plus members. You also have the opportunity to earn an incentive for each PACF you complete. Additionally, by identifying and closing members' gaps in care during the PACF completion, you are positively impacting your STARS score, which in turn, positively affects your fee schedule.

Q. How often will I need to complete the PACF for each member?

A. PACF must be completed once every calendar year ideally during their Welcome to Medicare, Annual Wellness, any other face-to-face visit, or when requested from the plan. You do not have to wait 365 days between PACF completions or Annual Wellness visits.

Q. What do I do with the PACF after completion?

A. CMS requires the original PACF 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. Also submit a copy of the PACF through the Quality Care Rewards tool or by fax to **423-591-9504**.

Q. How does the PACF close gaps in care?

A. Providers completing the PACF online have the opportunity to attest to gaps in care in the Provider Quality Care Rewards module as they complete the PACF. Faxed PACFs are reviewed by BlueCross clinical staff and information not typically closed by the submission of the claim. BMI, Blood Pressure, Diabetes care for Nephropathy and HbA1c screenings, and Care for Older Adult assessments should be included in the PACF to close gaps in care. Our staff will submit an attestation to close those gaps in the Provider Quality Care Rewards module on your behalf.

Q. How long does it take for BlueCare Plus to review a faxed PACF and the gaps in care to close?

A. BlueCare Plus strives to review a faxed PACF 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 PACF should be given at least four weeks to update in the system once submitted.

Q. How can I find out how many PACFs I've submitted and how many gaps in care my PACFs have closed?

A. Providers can view the number of PACFs completed online as well as gaps in care attestations/closures via the Provider Quality Care Rewards module in Availity®.

Q. What steps must I take to ensure payment for completion of the PACF?

A.
- Submit the appropriate E/M codes for the AWV
- Submit CPT code 96160 (administration of patient-focused health risk assessment)
- Fax the PACF, or your equivalent medical record, via fax to **423-591-9504** or online via the **Quality Care Rewards tool**

Q. If I have my own non-standard form, can I submit it in place of the PACF?

A. Yes as long as your record includes all the key components contained within the PACF. For questions about what is acceptable please contact the BlueCare Plus Care Coordination team at 1-877-715-9503.

Q. If I want to submit the form only for preventive screenings or gaps in care, can I just complete part of the PACF?

A. The PACF is used to capture data for various reasons, outside of closing gaps in care. A portion of the form notates the plan of care developed by the plan and a portion for you to indicate your plan of care. Sharing this information helps us show CMS we are meeting our DSNP Model of Care requirements. Due to the importance of receiving a complete PACF, incomplete PACF's will be returned with a request to complete and return to us within 30 days. PACF's remaining incomplete after that time could result in PACF incentive recoupments. You may submit your PACF through the Quality Care Rewards module to expedite the process.

Q. When is it appropriate to bill for an ICT?

A. You can bill for an ICT in conjunction with completing the PACF, or at any time we request medical records that would include the member's care plan or patient instruction.

BlueCare Plus Tennessee

We're Right Here

Provider Service

1-800-299-1407

Care Management

1-877-715-9503

Utilization Management

1-866-789-6314

PACF Fax

1-423-591-9504

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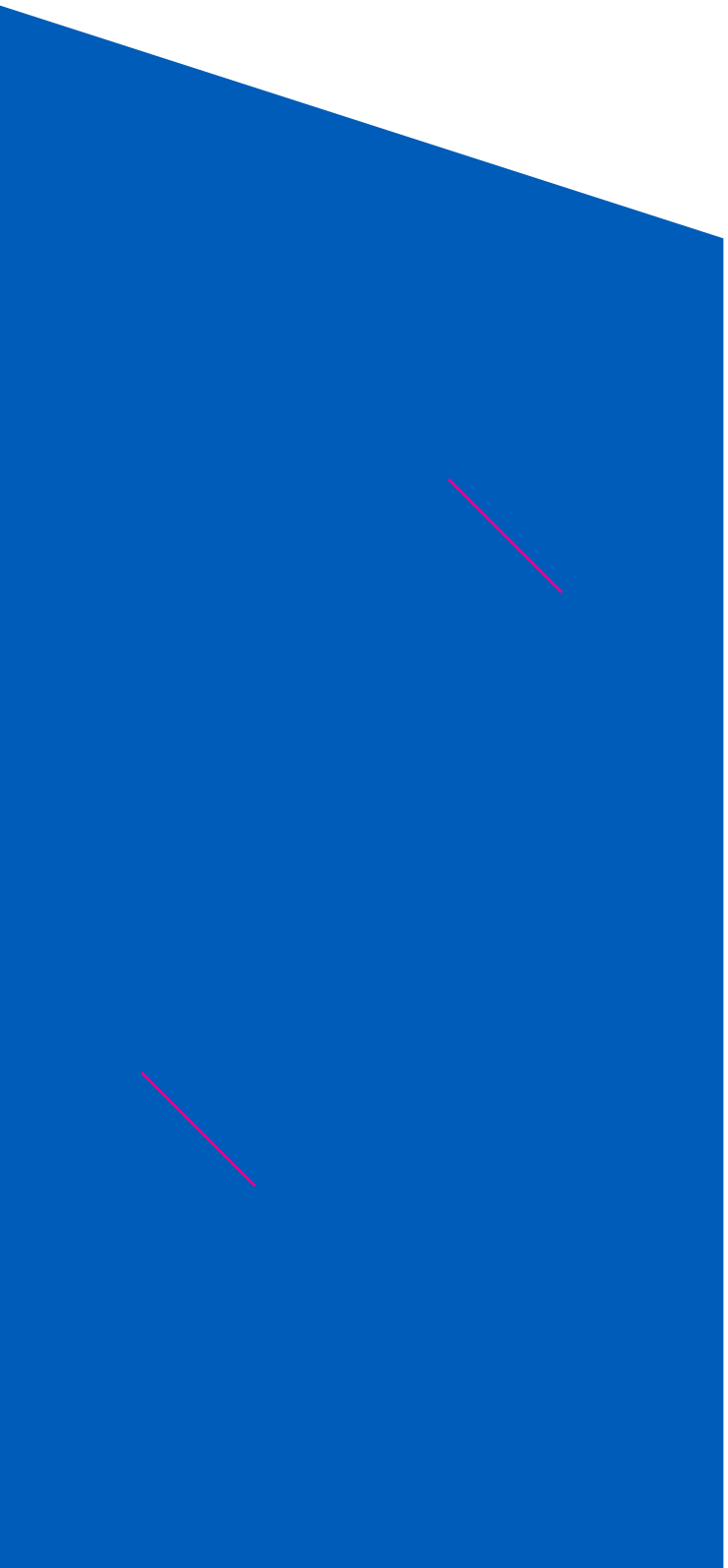
This information applies to BlueCare Plus (HMO SNP)SM Only

2019 Calendar Year

Medicare Advantage Quality Amendment Measures

Measure Name	Measure Type	Weight	Member Incentive Available*
Comprehensive Diabetes Care (CDC) – HbA1c Control (≤8.9%)	Outcome	3	**25 Wellness Points**
Medication Adherence for Cholesterol (Statins)	Outcome	3	—
Medication Adherence for Hypertension (RASA)	Outcome	3	—
Medication Adherence for Diabetes Medications (OAD)	Outcome	3	—
Plan All-Cause Readmissions (PCR)	Outcome	3	—
Statin Use in Persons with Diabetes (SUPD)	Outcome	3	—
Breast Cancer Screening (BCS)	Procedure	1	**75 Wellness Points**
Colorectal Cancer Screening (COL)	Procedure	1	**20, 30, 60 or 80 Wellness Points**
Comprehensive Diabetes Care (CDC) – Retinal Eye Exam	Procedure	1	**50 Wellness Points**
Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy	Procedure	1	**15 Wellness Points**
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	Procedure	1	—
Medication Reconciliation Post-Discharge (MRP)	Procedure	1	—
Osteoporosis Management in Women with a Fracture (OMW)	Procedure	1	**50 Wellness Points**
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Procedure	1	**25 Wellness Points**
Measures for Display/Monitoring Status Only			
Annual Wellness Visit (AWV)	Procedure	0	**50 or 30 Wellness Points**
Controlling Blood Pressure (CBP)	Outcome	0	—
High-Risk Medication (HRM)	Outcome	0	—
Use of Opioids from Multiple Providers (UOP)	Outcome	0	—
Use of Opioids at High Dosage (UOD)	Outcome	0	—
Medicare Diabetes Prevention Program Participation for 6 Months	—	0	**100 Wellness Points**

**Please see Member Incentive table for more information.*



We're Right Here

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