2020 Quality Program Information

BlueAdvantage (PPO)™
BlueEssential (HMO SNP)™
BlueCare Plus (HMO SNP)™
BlueCare Plus Choice (HMO SNP)™
We’re Right Here

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BlueAdvantage (PPO)℠ and BlueEssential (HMO SNP)℠ 2020 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 and BlueEssential HMO SNP products – 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

Members are also rewarded
2020 My HealthPath® Wellness and 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 gift card incentive for the member to encourage completion of this visit. Members may also be eligible to earn additional gift cards for preventive screenings listed in the member incentive section of this guide.

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

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

This information applies to BlueAdvantage (PPO)℠ and BlueEssential (HMO SNP)℠ Only
# 2020 Calendar Year

## Medicare Advantage Quality Amendment Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>Member Incentive Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (CDC) – HbA1c Control (≤8.9%)</td>
<td>Outcome</td>
<td>3</td>
<td>$25</td>
</tr>
<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Medication Adherence for Hypertension (RASA)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Medication Adherence for Diabetes Medications (OAD)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Plan All-Cause Readmissions (PCR)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>Procedure</td>
<td>1</td>
<td>$50</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>Procedure</td>
<td>1</td>
<td>$20 - $75</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Retinal Eye Exam Performed</td>
<td>Procedure</td>
<td>1</td>
<td>$50</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy</td>
<td>Procedure</td>
<td>1</td>
<td>$15</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td>Outcome</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Medication Reconciliation Post-Discharge (MRP)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Osteoporosis Management in Women who had a Fracture (OMW)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease (SPC)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes (SUPD)</td>
<td>Outcome</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Measures for Display/Monitoring Status Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Outcomes Survey: Improving Bladder Control</td>
<td>HOS Survey</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Health Outcomes Survey: Monitoring Physical Activity</td>
<td>HOS Survey</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Health Outcomes Survey: Reducing the Risk of Falling</td>
<td>HOS Survey</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>Procedure</td>
<td>0</td>
<td>$30</td>
</tr>
<tr>
<td>Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)</td>
<td>Outcome</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)</td>
<td>Outcome</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Care for Older Adults (COA) - Medication Review</td>
<td>Procedure</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Care for Older Adults (COA) - Functional Status Assessment</td>
<td>Procedure</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Care for Older Adults (COA) - Pain Assessment</td>
<td>Procedure</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Medicare Diabetes Prevention Program Participation for 6 Months</td>
<td></td>
<td>0</td>
<td>—</td>
</tr>
</tbody>
</table>

*Please see MA Member Incentive table on page 52 for more information.

This information applies to BlueAdvantage (PPO)* and BlueEssential (HMO SNP)* Only
# BlueCross BlueShield of Tennessee Provider Quality Program

The Centers for Medicare & Medicaid Services (CMS) measures BlueCross utilizing Healthcare Effectiveness Data and Information Set (HEDIS®) measures for their 5-Star quality program. 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. Also included are pharmacy measures developed by the Pharmacy Quality Alliance that are incorporated into the 5-Star quality program.

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Cancer Screening (BCS)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of women 50-74 years old who had a mammogram</td>
<td><strong>Mammogram</strong></td>
<td><strong>Encounter/Claim with Codes:</strong></td>
<td>Any time during member’s history through 12/31/2020:</td>
</tr>
<tr>
<td></td>
<td>between 10/1/2018 - 12/31/2020 for all women 52-74 years</td>
<td><strong>CPT</strong>: 77055, 77056, 77057, 77061-77063, 77065-77067</td>
<td><strong>Bilateral mastectomy</strong></td>
</tr>
<tr>
<td></td>
<td><strong>NOTE</strong>: All of the following types and methods of mammogram qualify:</td>
<td><strong>HCPCS</strong>: G0202, G0204, G0206,</td>
<td><strong>ICD-10-CM</strong>: 0HTV0ZZ, Z90.13</td>
</tr>
<tr>
<td></td>
<td>• screening</td>
<td></td>
<td><strong>OR Unilateral mastectomy:</strong></td>
</tr>
<tr>
<td></td>
<td>• diagnostic</td>
<td><strong>CPT</strong>: 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307</td>
<td><strong>ICD-10-CM</strong>: 0HTU0ZZ, 0HTT0ZZ</td>
</tr>
<tr>
<td></td>
<td>• film</td>
<td></td>
<td>With bilateral modifier: 50, codes must be on the same claim</td>
</tr>
<tr>
<td></td>
<td>• digital</td>
<td></td>
<td>Any combination of codes from above that indicate a mastectomy on both the left and right side on the same or different dates of service.</td>
</tr>
<tr>
<td></td>
<td>• digital breast tomosynthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not count biopsies, breast ultrasounds or MRIs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). See www.ncqa.org.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **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 2020  
  - gFOBT requires 3 returned samples  
  - iFOBT/FIT requires 1 returned sample  
  **AND/OR**  
  - **Flexible sigmoidoscopy** during 2020 or last 4 years  
  **AND/OR**  
  - **Colonoscopy** during 2020 or last 9 years  
  - **CT Colonography** during 2020 or during the last 4 years  
  - **FIT-DNA Test** during 2020 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 1/1/2020 - 12/31/2020  
    - **CPT:** 82270, 82274  
    - **HCPCS:** G0328  
  - **Flexible sigmoidoscopy**  
    - between 1/1/2016 - 12/31/2020  
    - **CPT:** 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45346, 45347, 45349, 45350  
    - **HCPCS:** G0104  
  - **Colonoscopy**  
    - between 1/1/2011 - 12/31/2020  
    - **CPT:** 44388-44394, 44397, 45355, 45378-45393, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45398  
    - **HCPCS:** G0105, G0121  
  - **CT Colonography**  
    - between 1/1/2016 and 12/31/2020  
    - **CPT:** 74261-74263  
  - **FIT-DNA Test**  
    - between 1/1/2018 and 12/31/2020  
    - **CPT:** 81528  
    - **HCPCS:** G0464  
    - **LOINC:** 77353-1, 77354-9  

This measure applies to all BlueCross Medicare plans.  
**HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.**
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Osteoporosis Management in Women who had a Fracture (OMW)** | • Perform bone mineral density testing within six months on members 67-85 years old who experience a fracture | **Encounter/Claim with Codes:** Bone Mineral Density Testing  
**CPT**: 76977, 77078, 77080, 77081, 77082, 77085, 77086  
**ICD-10-PCS**: BP48Z1, BP49Z1, BP4GZ1-BP4PZ1,  
BQ00Z1, BQ01Z1, BQ03Z1, BQ04Z1, BR00Z1,  
BR07Z1, BR09Z1, BR0GZ1 | **Bone mineral density testing**  
during 24 months prior to fracture:  
**CPT**: 76977, 77077, 77080-77082  
**ICD-10-PCS**: BP48Z1, BP49Z1,  
BP4GZ1-BP4PZ1, BQ00Z1, BQ01Z1, BQ03Z1,  
BQ04Z1, BR00Z1, BR07Z1, BR09Z1, BR0GZ1 |
|  | **AND/OR**  
• Prescribe a medication to treat osteoporosis within six months of a fracture | **Pharmacy Claim for Osteoporosis Drug Therapy:**  
**HCPCS**: J0897, J1740, J3110, J3489 | **Osteoporosis therapy**  
during 12 months prior to fracture:  
**Injectables**  
**HCPCS**: J0897, J1740, J3110, J3489 |
|  | **NOTE**: Calcium alone does not meet criteria to close the gap in care | **Sample Codes to Identify Fractures:**  
**CPT**: 21811-21813, 21820, 21825, 22310, 23500, 23505,  
23515, 23570, 23575, 23585,  
23600, 23605, 23615, 23616,  
23620, 23625, 23630, 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, 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, 27506-27508,  
27510-27511, 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 | **Dispensed or active oral prescription to treat osteoporosis**  
during 12 months prior to fracture:  
• Listing of Approved therapies (next page) |

**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 67 and over enrolled in an institutional SNP or living long-term in an institution
- Members age 67 to 80 with frailty and advanced illness
- Members age 81 and older with frailty

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis Management in Women who had a Fracture (OMW) Continued</td>
<td></td>
<td>HCPCS: S2360</td>
<td></td>
</tr>
</tbody>
</table>

**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.
- Recognized osteoporosis therapies include:
  - **Biphosphonates**: alendronate, alendronate-cholecalciferol, ibandronate, risedronate, zoledronic acid
  - **Other agents**: albandronate, denosumab, raloxifene, teriparatide

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Controlling High Blood Pressure (CBP)** | The most recent BP in 2020 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 12/31/2020:  
CPT: 90935, 90937, 90945, 90947, 90997, 90999, 99512, 50360, 50365, 50380  
HCPCS: G0257, S9339; S2065  
**ICD-10-CM (kidney transplant):** 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2  
**AND/OR**  
Female members with pregnancy anytime during 2020:  
**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 2020 |

This measure applies to all BlueCross Medicare plans.  
HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
**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 2020

**NOTE:** DMARDs include:
- Aminoquinolines: Hydroxychloroquine
- 5-Aminosalicylates: Sulfasalazine
- Alkylating agents: Cyclophosphamide
- Anti-rheumatics: Auranofin, leflunomide, methotrexate, penicillamine
- Immunomodulators: Abatacept, adalimumab, anakinra, certolizumab, cyclophosphamide, 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

**Measure**

Assess all members with diagnosis of rheumatoid arthritis for DMARD treatment in 2020

**What To Report (Sample Of Codes)**

Encounter/Claim with Codes:
- Rheumatoid Arthritis
  - ICD-10-CM: M05.00-M06.89, M06.9
- Pharmacy Claim for DMARD in 2020:
  - HCPCS: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, Q5102, Q5103, Q5104

**Exclusions**

- HIV anytime on or before 12/31/2020:
  - ICD-10-CM: B20, Z21, B97.35, 079.53
- Female members with Pregnancy anytime during 2020:
  - 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

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
Comprehensive Diabetes Care (CDC)

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (CDC) - Retinal Eye Exam Performed</td>
<td>A retinal or dilated eye exam by an optometrist or ophthalmologist in 2020 OR A retinal or dilated eye exam negative for retinopathy by an optometrist or ophthalmologist in 2019 OR Bilateral eye enucleation anytime during the member’s history through 12/31/2020</td>
<td>Encounter/Claim with Codes: Retinal or Dilated Eye Exams <strong>CPT</strong>: 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 <strong>CPT II</strong>: 2022F, 2024F, 2026F, 3072F <strong>HCPCS</strong>: S0620, S0621, S3000</td>
<td>Non–diabetic members during 2019 and 2020 and: Gestational or steroid-induced diabetes during 2019 or 2020: <strong>ICD-10-PCS</strong>: 024.410-024.439</td>
</tr>
<tr>
<td></td>
<td>Obtain and place copy of all 2019 or 2020 eye exams with results in the member’s medical record. In order to count 2019 exams, documentation in the medical record must clearly indicate results were negative for retinopathy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy** | Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy in 2020:  
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 2020. Documentation must show clear evidence that a prescription for an ACE inhibitor/ARB was written, filled or taken by the member during 2020. | **Laboratory Claim/Encounter with Codes:**  
CPT: 82042, 82043, 82044, 84156  
CPT*: 3060F, 3061F  
**AND/OR**  
Physician Encounter/Claim with Codes:  
CPT*:  
Urine macroalbumin test: 81000-81003, 81005  
ESRD: 90935, 90937, 90945, 90947, 90997, 90999, 99512  
Kidney transplant: 50360, 50365, 50380  
CPT*:  
Positive urine macroalbumin test: 3062F  
**Nephropathy treatment:** 3066F, 4010F  
HCPCS:  
ESRD: G0257, S9339  
Kidney transplant: S2065  
ICD-10-CM:  
CKD Stage 4: N18.4  
Kidney Transplant: 0TY020-0TY022, 0TY10Z-0TY10Z  
**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 2019 and 2020 and:  
Gestational or steroid-induced diabetes during 2019 and 2020:  
ICD-10-CM: 024.410-024.439 |

This measure applies to all BlueCross Medicare plans.  
HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
<table>
<thead>
<tr>
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<th>Exclusions</th>
</tr>
</thead>
</table>
| **Comprehensive Diabetes Care (CDC) - HbA1c Control** | **HbA1c testing** on all diabetic patients in 2020 AND Diabetes management so that all members have the most recent HbA1c in 2020 ≤8.9% | **Encounter/Claim with Codes:**  
CPT: 83036, 83037  
CPT® II: 3044F, 3051F, 3052F, 3046F  
NOTE: In order to meet criteria, HbA1c must be ≤8.9%  
A copy of all lab results should be kept in member’s medical record | **Non–diabetic members** during 2019 and 2020 and:  
**Gestational or steroid-induced diabetes** during 2019 and 2020:  
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 >8.9%.  
- Encourage lifestyle changes and adherence to treatment regimens that will help bring A1C under control.

This measure applies to all BlueCross Medicare plans.  
HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
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.

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication Adherence for Cholesterol (Statins)</strong></td>
<td>Assess all members with a prescription for a <strong>cholesterol medication</strong> for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage compliance.</td>
<td>The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.</td>
<td>ESRD Members in Hospice</td>
</tr>
<tr>
<td>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% or more of the time they are supposed to be taking the medication.</td>
<td></td>
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</tr>
<tr>
<td><strong>Medication Adherence for Hypertension (RASA)</strong></td>
<td>Assess all members with a prescription for a <strong>blood pressure medication</strong> for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage compliance.</td>
<td>The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.</td>
<td>ESRD sacubitril/valsartan (Entresto™) Members in Hospice</td>
</tr>
<tr>
<td>Percentage of members 18 years and older with a prescription for a blood pressure medication (ACE-I, 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.</td>
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<tr>
<td>Medications in the angiotensin system antagonist class:</td>
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<tr>
<td>• Angiotensin converting enzyme inhibitor (ACEI)</td>
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<tr>
<td>• Angiotensin receptor blocker (ARB)</td>
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<tr>
<td>• Direct renin inhibitor</td>
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</tr>
<tr>
<td><strong>Medication Adherence for Diabetes Medications (OAD)</strong></td>
<td>Assess all members with a prescription for a <strong>diabetes medication</strong> for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage compliance.</td>
<td>The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.</td>
<td>ESRD Insulin Members in Hospice</td>
</tr>
<tr>
<td>Percentage of members 18 years and older with a prescription for diabetes medication (biguanide drug, sulfonylurea drug, thiazolidinedione drug, DPP-4 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.</td>
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<tr>
<td>NOTE: Members taking insulin are not included in this measure.</td>
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<tr>
<td>This measure is applicable to the following classes of Diabetes Medications:</td>
<td></td>
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</tr>
<tr>
<td>• Biguanides</td>
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<tr>
<td>• Sulfonylureas</td>
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<tr>
<td>• Thiazolidinediones</td>
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<tr>
<td>• DPP-IV inhibitors</td>
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<tr>
<td>• Incretin mimetics</td>
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<tr>
<td>• Meglitinides</td>
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<td></td>
<td></td>
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<tr>
<td>• SGLT2 inhibitors</td>
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<tr>
<td><strong>Helpful Tips:</strong> 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 at no cost or $1 co-pay depending on the member’s plan type. Educate and encourage patients about the purpose and effectiveness of their medications.</td>
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</tr>
</tbody>
</table>

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
### 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

<table>
<thead>
<tr>
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<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **Statin Therapy for Patients with Cardiovascular Disease (SPC)** | One of the following moderate to high intensity statin medications must be **prescribed and dispensed** by a pharmacy:  
- Atorvastatin ≥10 mg daily  
- Fluvastatin ≥40 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 medical and pharmacy claims. | **Members in Hospice**  
Any of the following in 2019 or 2020:  
- Female members with a diagnosis of **pregnancy**  
- **In vitro fertilization**  
- Dispensed at least one prescription for **clomiphene**  
- **ESRD**  
- **Cirrhosis**  
Any of the following in the patient’s history through 12/31/2020 (must be documented each calendar year):  
- **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.

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
<table>
<thead>
<tr>
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<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statin Use in Persons with Diabetes (SUPD)</strong></td>
<td>One of the following medications must be <strong>prescribed and dispensed</strong> by a pharmacy: - atorvastatin - atorvastatin/amlodipine - fluvastatin - Livalo® - lovastatin - pravastatin - rosuvastatin - simvastatin - simvastatin/ezetemibe</td>
<td>The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.</td>
<td>Members in Hospice ESRD</td>
</tr>
</tbody>
</table>

**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.

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)

The percentage of members 65 years and older with concurrent use of two (2) or more unique anticholinergic medications.

Notes:
A lower rate indicates better performance.

Concurrent use is identified using the dates of service and days’ supply of a member’s prescription claims.
The days of concurrent use is the count of days during the measurement year with overlapping days’ supply for two (2) or more unique anticholinergic medications.

The data for this measure comes from prescription claims.

Members in Hospice

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poly-A</td>
<td>Use of multiple anticholinergics in older adults is associated with an increased risk of cognitive decline. Screening patient’s medication lists for multiple anticholinergics promotes safe medication use and better outcomes for patients.</td>
<td>The data for this measure comes from prescription claims.</td>
<td>Members in Hospice</td>
</tr>
</tbody>
</table>

**POLY-A: Anticholinergic Medications**

<table>
<thead>
<tr>
<th>Antihistamines</th>
<th>Antiparkinsonian Agents</th>
<th>Skeletal Muscle Relaxants</th>
<th>Antidepressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>brompheniramine</td>
<td>benztropine trihexyphenidyl</td>
<td>cyclobenzaprine orphenadrine</td>
<td>amitriptyline</td>
</tr>
<tr>
<td>carbinoxamine</td>
<td>chlorpheniramine</td>
<td></td>
<td>amoxapine</td>
</tr>
<tr>
<td>clemastine</td>
<td>dexamethasone</td>
<td></td>
<td>clomipramine</td>
</tr>
<tr>
<td>cyproheptadine</td>
<td>dextromethorphan</td>
<td>desipramine</td>
<td>desipramine</td>
</tr>
<tr>
<td>dextromethorphan</td>
<td></td>
<td>doxepin (&gt;6 mg/day)</td>
<td>doxepin (&gt;6 mg/day)</td>
</tr>
<tr>
<td>diphenhydramine</td>
<td></td>
<td>imipramine</td>
<td>imipramine</td>
</tr>
<tr>
<td>doxylamine</td>
<td></td>
<td>nortriptyline</td>
<td>nortriptyline</td>
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<tr>
<td>hydroxyzine</td>
<td></td>
<td>paroxetine</td>
<td>paroxetine</td>
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<tr>
<td>meclizine</td>
<td></td>
<td>protriptyline</td>
<td>protriptyline</td>
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<tr>
<td>tripolidine</td>
<td></td>
<td>trimipramine</td>
<td>trimipramine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Antipsychotics</th>
<th>Antiarrhythmic</th>
<th>Antimuscarinics (urinary incontinence)</th>
<th>Antispasmodics</th>
</tr>
</thead>
<tbody>
<tr>
<td>chlorpromazine</td>
<td>disopyramide</td>
<td>darifenacin fesoterodine flavoxate oxybutynin solifenacin tolterodine trospium</td>
<td>atropine (excludes ophthalmic and injectable) belladonna alkaloids clidinium-chlordiazepoxide dicyclomine homatropine (excludes ophthalmic) hyoscine propantheline scopoline (excludes ophthalmic)</td>
</tr>
<tr>
<td>clozapine</td>
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<tr>
<td>loxapine</td>
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<tr>
<td>olanzapine</td>
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<tr>
<td>perphenazine</td>
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<tr>
<td>thioridazine</td>
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<tr>
<td>trifluoperazine</td>
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<table>
<thead>
<tr>
<th>Antiemetics</th>
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</thead>
<tbody>
<tr>
<td>prochlorperazine</td>
<td></td>
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<tr>
<td>promethazine</td>
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</tbody>
</table>

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<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)</strong></td>
<td>Use of multiple CNS-active medications in older adults is associated with an increased risk of falls. Screening patient’s medication lists for multiple CNS-active medications promotes safe medication use and better outcomes for patients.</td>
<td>The data for this measure comes from prescription claims.</td>
<td>Members in Hospice</td>
</tr>
<tr>
<td><strong>Notes:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lower rate indicates better performance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concurrent use is identified using the dates of service and days’ supply of an individual’s prescription claims.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The days of concurrent use is the count of days during the measurement year with overlapping days’ supply for three (3) or more unique CNS-active medications.</td>
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<tr>
<td><strong>POLY-CNS-A: CNS-Active Medications</strong></td>
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<tr>
<td><strong>Antipsychotics</strong></td>
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<td>asenapine</td>
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<td>aripiprazole</td>
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<td>brexpiprazole</td>
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<td>cariprazine</td>
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<td>chlorpromazine</td>
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<td>clozapine</td>
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<td>fluphenazine</td>
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<td>haloperidol</td>
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<td>iloperidone</td>
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<td>trifluoperazine</td>
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<td>ziprasidone</td>
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<tr>
<td><strong>Benzodiazepines and Nonbenzodiazepine Sedative/Hypnotics</strong></td>
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<td>alprazolam</td>
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<td>chlordiazepoxide</td>
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<td>clorazepate</td>
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<td>diazepam</td>
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<td>estazolam</td>
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<td>flurazepam</td>
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<td>lorazepam</td>
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<td>midazolam</td>
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<td>oxazepam</td>
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<td>triazolam</td>
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<td>zaleplon</td>
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<td>zolpidem</td>
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<td><strong>Opioids</strong></td>
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<tr>
<td>benzhydrocodone</td>
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<td>buprenorphine c</td>
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<tr>
<td>butorphanol (includes nasal spray)</td>
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<td>codeine</td>
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<td>dihydromorphone</td>
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<td>fentanyl (includes nasal spray)</td>
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<td>hydrocodone</td>
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<td>hydromorphone</td>
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<td>levorphanol</td>
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<td>meperidine</td>
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<td>oxycodone</td>
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<td>oxymorphone</td>
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<td>pentazocine</td>
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<td>tapentadol</td>
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<td>tramadol</td>
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<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors and Tricyclic Antidepressants</strong></td>
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<tr>
<td>amitriptyline</td>
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<td>amoxapine</td>
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<td>citalopram</td>
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<td>clomipramine</td>
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<td>desipramine</td>
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<td>doxepin</td>
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<td>escitalopram</td>
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<td>fluoxetine</td>
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<td>fluvoxamine</td>
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<td>imipramine</td>
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<td>nortriptyline</td>
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<td>paroxetine</td>
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<td>protriptyline</td>
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<td>sertraline</td>
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<tr>
<td>trimipramine</td>
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</tbody>
</table>

This measure applies to all BlueCross Medicare plans.

HEDIS codes can change from year to year. The codes in this document are from the 2020 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 or observation stay who were readmitted (acute, unplanned) to a hospital within 30 days, either for the same condition as their recent hospital stay 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.

This measure applies to all BlueCross Medicare plans.
HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
The following measures apply to Medicare Special Needs Plans Only (DSNP and CSNP)

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care for Older Adults (COA) - Medication Review</strong></td>
<td>- Medication Review in 2020 includes any of the following:</td>
<td></td>
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<tr>
<td></td>
<td>- Medication list in the record AND notation in the medical record of medication review in 2020 by the prescribing practitioner or clinical pharmacist AND the date the medication review was performed</td>
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<td></td>
<td>- Medication list signed and dated in 2020 by practitioner or pharmacist in the medical record</td>
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<td></td>
<td>- Notation in the medical record in 2020 that the member is not taking any medication AND the date it was noted</td>
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<td></td>
<td><strong>NOTE:</strong> Services provided in an acute inpatient setting are not counted.</td>
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<tr>
<td><strong>CPT</strong>:</td>
<td>Medication Review:</td>
<td></td>
<td>Members in Hospice</td>
</tr>
<tr>
<td></td>
<td>- 90863, 99605, 99606, 99483</td>
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<tr>
<td><strong>CPT II</strong>:</td>
<td>1159F, 1160F</td>
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<tr>
<td><strong>Transitional Care Management</strong>:</td>
<td>99495, 99496</td>
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<tr>
<td><strong>HCPCS</strong>:</td>
<td>G8427</td>
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</tbody>
</table>

**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 2020 specifications.
<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| Care for Older Adults (COA) - Functional Status Assessment | Documentation of a Functional Status Assessment must include **evidence of a complete functional status assessment performed** in 2020 **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 |

HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
# Care for Older Adults (COA) - Functional Status Assessment (cont.)

<table>
<thead>
<tr>
<th>Measure</th>
<th>What Service Is Needed</th>
<th>What To Report (Sample Of Codes)</th>
<th>Exclusions</th>
</tr>
</thead>
</table>
| **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 (Kohlbman 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 2020.  
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. | Members in Hospice |

**CPT® II:** 1170F  
**HCPCS:** G0438, G0439  
**CPT®:** 99483

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HEDIS codes can change from year to year. The codes in this document are from the 2020 specifications.
**Measure** | **What Service Is Needed** | **What To Report (Sample Of Codes)** | **Exclusions**  
--- | --- | --- | ---  
**Care for Older Adults (COA) - Pain Assessment**  
Percentage of plan members age 66 years and older who had at least one pain assessment during 2020.  
(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 2020.  
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 2020 specifications.
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.

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Measure Addressed</th>
<th>Service Provided</th>
<th>Service Site</th>
<th>Communication to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retina Labs</td>
<td>• Diabetes Care – Retinal Eye Exam</td>
<td>Diabetic Retinal Eye Exams&lt;br&gt;Kits for in-home testing/screening:&lt;br&gt;• HbA1c&lt;br&gt;• Urine microalbumin&lt;br&gt;• iFOBT/FIT</td>
<td>In-Home or BlueCross-Sponsored Event</td>
<td>Letter and results by mail</td>
</tr>
<tr>
<td>MedXM—a Quest Diagnostics Company</td>
<td>• Osteoporosis Management in Women who had a Fracture</td>
<td>Bone Mineral Density Testing&lt;br&gt;Kits for in-home testing/screening:&lt;br&gt;• HbA1c&lt;br&gt;• Urine Microalbumin&lt;br&gt;• iFOBT/FIT</td>
<td>In-Home</td>
<td>Letter and results by fax</td>
</tr>
<tr>
<td>Home Access Health Corporation®</td>
<td>• Diabetes Care – A1c Testing&lt;br&gt;• Diabetes Care – Nephropathy Screening&lt;br&gt;• Colorectal Cancer Screening</td>
<td>Kits for in-home testing/screening:&lt;br&gt;• HbA1c&lt;br&gt;• Urine Microalbumin&lt;br&gt;• iFOBT/FIT</td>
<td>In-Home or kits provided for in-home use at BlueCross-Sponsored Event</td>
<td>Letter and results by mail</td>
</tr>
<tr>
<td>Signify Health™</td>
<td>• Adult BMI Assessment&lt;br&gt;• Annual Wellness Visit&lt;br&gt;• Diabetes Care – A1c Testing&lt;br&gt;• Diabetes Care – Retinal Eye Exam&lt;br&gt;• Diabetes Care – Nephropathy Screening&lt;br&gt;• Colorectal Cancer Screening&lt;br&gt;• Controlling Blood Pressure&lt;br&gt;• Osteoporosis Management in Women who had a Fracture</td>
<td>In-home comprehensive history and physical by a Physician, Physician Assistant or Nurse Practitioner, as well as the following, as appropriate:&lt;br&gt;• iFOBT/FIT Test Kit&lt;br&gt;• HbA1c Test Kit&lt;br&gt;• Diabetic Retinal Eye Exam&lt;br&gt;• Bone Mineral Density Testing&lt;br&gt;• Urine Microalbumin Test Kit&lt;br&gt;• Peripheral Artery Disease Testing</td>
<td>In-Home</td>
<td>Letter and results by mail</td>
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</tbody>
</table>

This information applies to all BlueCross Medicare plans.
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 gift cards 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 and/or BlueCare Plus 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; or one of our D-SNP Member Experience or Provider Performance contacts listed at the back of this guide.**

This information applies to all BlueCross Medicare plans.
Supplemental Data Collection

You’re already providing quality care to your patients, but sometimes we don’t get the needed documentation to give you credit for the work you do. Our annual Supplemental Data Collection initiative helps to capture information needed to show Medicare the quality outcomes of our providers.

How It Works

- This focused initiative begins in **June** and ends the first week of **January** each year, however we work to gather quality information throughout the year.
- We provide quality 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.
- Practices who grant the quality team remote access to their BlueCross patient records enable our nurses to update quality gaps more timely throughout the year.

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.

**Note:** If your practice does not have dedicated staff to attest to gap closure in the Quality Care Rewards (QCR) tool, our remote access nurses can help.

This information applies to all BlueCross Medicare plans.
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.

For FAQs and more information about using Availity, visit Availity.com/bcbst.

For assistance or more information about Availity, please contact your eBusiness Regional Marketing Consultant or our eBusiness Technical Support Team listed below:

**eBusiness Technical Support**

**East Tennessee**
Faith Daniel  
(423) 535-6796  
Faith_Daniel@bcbst.com

**Middle Tennessee**
Faye Mangold  
(423) 535-2750  
Faye_Mangold@bcbst.com

**West Tennessee**
Debbie Angner  
(423) 535-2285  
Debbie_Angner@bcbst.com

This information applies to all BlueCross Medicare plans.
**Quality Care Rewards Tool**

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 progress on quality measures and STARS score and much more. You can also access medical and pharmacy-related clinical history as well as risk adjustment information for your patients.

### Scorecard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Num. Elig.</th>
<th>Num. Comp.</th>
<th>Year Rate</th>
<th>Region Rate</th>
<th>Quality Score</th>
<th>To 1 Star</th>
<th>To 2 Stars</th>
<th>To 3 Stars</th>
<th>To 4 Stars</th>
<th>To 5 Stars</th>
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<tbody>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>285</td>
<td>222</td>
<td>78%</td>
<td>77%</td>
<td>★★★★</td>
<td>-80</td>
<td>-70</td>
<td>0</td>
<td>4</td>
<td>21</td>
<td>1</td>
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<tr>
<td>CDC HbA1c Control &lt; 9%</td>
<td>194</td>
<td>190</td>
<td>98%</td>
<td>83%</td>
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<td>-111</td>
<td>-101</td>
<td>-35</td>
<td>-18</td>
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<tr>
<td>Colorectal Cancer Screening (COS)*</td>
<td>666</td>
<td>539</td>
<td>80%</td>
<td>72%</td>
<td>★★★★★</td>
<td>-130</td>
<td>-120</td>
<td>-38</td>
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<tr>
<td>Comprehensive Diabetes Care (CDC - Eye Exam)*</td>
<td>194</td>
<td>121</td>
<td>68%</td>
<td>64%</td>
<td>★★★★</td>
<td>-19</td>
<td>-14</td>
<td>0</td>
<td>15</td>
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<tr>
<td>Comprehensive Diabetes Care (CDC - Hemoglobin A1c Testing)*</td>
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<td>117</td>
<td>91%</td>
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<td>★★★★★</td>
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<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis Management (ART)</td>
<td>42</td>
<td>9</td>
<td>78%</td>
<td>68%</td>
<td>★★★</td>
<td>-1</td>
<td>0</td>
<td>1</td>
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<td>3</td>
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<td>Medication Adherence for Cholesterol (Statins)</td>
<td>608</td>
<td>538</td>
<td>89%</td>
<td>87%</td>
<td>★★★★★</td>
<td>83</td>
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<td>15</td>
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<td>Medication Adherence for Hypertension (RAS Antagonists)</td>
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<td>90%</td>
<td>88%</td>
<td>★★★★★</td>
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<td>Medication Adherence for Non-Insulin Diabetes Medications</td>
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<td>90%</td>
<td>87%</td>
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<td>46%</td>
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<td>Osteoporosis Management in Women Who Have a Fracture</td>
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<td>25%</td>
<td>41%</td>
<td>★</td>
<td>6</td>
<td>1</td>
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<td>Plan All Cause Readmissions (PCR)</td>
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<td>0%</td>
<td>4%</td>
<td>★★★★★</td>
<td>12</td>
<td>10</td>
<td>9</td>
<td>5</td>
<td>0</td>
<td>3</td>
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<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy</td>
<td>80</td>
<td>63</td>
<td>79%</td>
<td>79%</td>
<td>★★★★★</td>
<td>-6</td>
<td>-1</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>1</td>
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<tr>
<td>Statin Use in Persons with Diabetes</td>
<td>171</td>
<td>132</td>
<td>77%</td>
<td>76%</td>
<td>★★★★</td>
<td>-6</td>
<td>0</td>
<td>2</td>
<td>9</td>
<td>14</td>
<td>1</td>
</tr>
</tbody>
</table>

### Attestations

#### Breast Cancer Screening (BCS)

- **Remove from Measure**
  - Excluded due to low utilization: May not be applicable for all BCBS plans.
  - Excluded due to high utilization: May not be applicable for all BCBS plans.
  - Excluded due to data availability: May not be applicable for all BCBS plans.

- **Met Goal for Measure**
  - Screened and treated for breast cancer within the past two years.

- **Provider**
  - Search for provider name and select from the dropdown.

- **Attestation Details**
  - Select the type of documentation from the dropdown.

- **Have read and agree to the terms of the attestation agreement.**

#### Provider Assessment Form

For assistance or more information about the Quality Care Rewards tool, please contact your eBusiness Regional Marketing Consultant or our eBusiness Technical Support Team listed on the previous page.

This information applies to all BlueCross Medicare plans.
Quality Care Rewards Tool Tips

- The tool refreshes at the end of each week to reflect information received from claims, direct data feeds and attestations completed from approximately two weeks prior.
- Please allow up to 30 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. 31, 2021 in order to be processed for the 2020 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, CSNP and DSNP plans. The P&T Committee includes membership from community-based physicians representing a variety of specialties throughout Tennessee, who provide direct input into developing the formulary. The 2020 formulary is focused on helping patients with adherence by strategic tier placement, low or no co-pays depending on their plan type, and by covering many commonly used generic medications through the donut hole.

2020 Medicare Formulary

The 2020 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 2020 Formulary: bcbst-medicare.com/medicare-plans/are-my-drugs-covered.page

For the 2020 DSNP formulary, please visit bluecareplus.bcbst.com/docs/2020_bluecare_plus_formulary.pdf

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 their 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, please visit bcbst-medicare.com/manage-my-plan/pharmacy/medication-therapy-management.page

This information applies to all BlueCross Medicare plans.
### 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. Copays range from $0-$1 for a 90-day supply depending on the member’s plan type.**

### 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
- Any of the following in the measurement year:
  - Myalgia
  - Myositis


This information applies to all BlueCross Medicare plans.
Managing Statin-Related Muscle Pain

Statin therapy is commonly prescribed to reduce the risk of developing atherosclerotic cardiovascular disease (ASCVD). While most people tolerate statins well, one of the primary reasons for statin non-adherence or discontinuation is the association with statin-associated muscle symptoms, or SAMS. It’s important to note that there are chemical and pharmacokinetic differences between the statins. These medication-specific properties could be an important factor when discussing initiation or continuation of statin therapy with a patient when there is concern for SAMS.

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.

This information applies to all BlueCross Medicare plans.
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.

This information applies to all BlueCross Medicare plans.
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 a 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)™ and BlueEssential (HMO SNP)™ Only
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 . 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.
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

<table>
<thead>
<tr>
<th>Service</th>
<th>Codes</th>
<th>Coverage Notes</th>
</tr>
</thead>
</table>
| 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                                       |                                                                                                                                                                                                             |

Welcome to Medicare Exams

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Codes</th>
<th>Coverage Notes</th>
</tr>
</thead>
</table>
| 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                              | G0091 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)** and BlueEssential (HMO SNP)** Only
Annual Wellness Visit Facts, Continued

Provider Assessment Form
Frequency: Once per calendar year

<table>
<thead>
<tr>
<th>Service</th>
<th>Codes</th>
<th>Coverage Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Assessment Form (PAF)</td>
<td>96160</td>
<td>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.</td>
</tr>
</tbody>
</table>

Member Incentives
Members who opt-in to the My Healthpath® program are eligible to earn gift cards 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. Information in the medical record must support the diagnosis documented on the PAF. All PAFs should be printed and retained in the patient’s permanent medical record.

This information applies to BlueAdvantage (PPO)® and BlueEssential (HMO SNP)® Only
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 the date of 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)™ and BlueEssential (HMO SNP)™ 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 by **uploading to the Quality Care Rewards tool** located in Availity.
- 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** or by **uploading to the Quality Care Rewards tool** located in Availity.

**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)™ and BlueEssential (HMO SNP)™ Only.
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 reimbursement.

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, online completion or upload to the Quality Care Rewards tool 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 12/13/20”
   - **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.

This information applies to BlueAdvantage (PPO)™ and BlueEssential (HMO SNP)™ Only
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 tool located within Availity 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 tool 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 weekly 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)™ and BlueEssential (HMO SNP)™ 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](http://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 what CMS uses to determine the diagnosis component of the individual risk score. CMS requires that all active acute and chronic diagnoses be documented *every calendar year*.

<table>
<thead>
<tr>
<th>Risk scores are derived from five primary sources:</th>
<th>Appropriate documentation results in premium levels that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Claims processed by the health plan</td>
<td>• Cover medical expenses</td>
</tr>
<tr>
<td>• Member demographics</td>
<td>• Maintain benefit levels</td>
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<tr>
<td>• Medical record review</td>
<td>• Minimize monthly member premiums</td>
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<tr>
<td>• In-home assessments</td>
<td>• Provide the health plan with reasonable margins</td>
</tr>
<tr>
<td>• Physician Assessment Forms (PAFs)</td>
<td></td>
</tr>
</tbody>
</table>

## 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.
    -Monitor
    -Evaluate
    -Assess
    -Treat

- **Return all requested medical records**
- **Submit PAFs annually on as many patients as possible**

This information applies to all BlueCross Medicare plans.
Guide to Risk Adjustment Documentation

The following tips can help ensure accurate medical coding and billing compliance for Medicare risk adjustment. These are based on the Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage plans and American Hospital Association (AHA) Coding Clinic™ guidelines.

**State the diagnosis**

Under International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) guidelines, a diagnosis can only be coded on a claim if it is stated in the documentation for the face-to-face visit.

Chronic conditions must be restated each time they are monitored, evaluated, assessed or treated. Medications and the corresponding diagnosis should be clearly linked in the clinical documentation.

Documentation must be explicit. Assessing the signs, symptoms or findings related to a disease is not enough (e.g., “Fasting Blood Sugar 300” cannot be coded as uncontrolled diabetes).

**Create a clear relationship to the diagnosis**

Causal relationships should be stated, not inferred. Use phrases such as “due to,” “because of” or “related to” to establish a clear relationship. “With” does not always establish cause, except in the case of diabetes with neuropathy.

**Include conditions and health status**

Under ICD-10-CM guidelines, a condition exists only when it is stated. Frequently overlooked, but significant conditions include:

- Angina Pectoris
- Drug/Alcohol Abuse
- CHF
- Heart Arrhythmias
- COPD
- Morbid Obesity
- Depression
- Rheumatoid Arthritis
- Diabetes
- Vascular Disease

Certain health status codes are very important to assess, document and code at least annually, using the highest level of specificity:

- Patients undergoing dialysis (Z99.2)
- Lower limb amputation status (Z89.4X – Z89.9)
- Asymptomatic HIV status (Z21)
- Ostomy (specify SITE) (V93.X)

Remember to document permanent diagnoses as often as they are assessed or treated, or when they are a consideration in the patient’s care, otherwise they must be documented at least once annually.

This information applies to all BlueCross Medicare plans.
**Signing off**

Stamped signatures are not accepted.

- A typed signature alone does not meet the CMS signature requirement. Examples:
  - “Dictated by: John Doctor, MD”
  - “Dictated but not read” records also must be properly authenticated by the provider.

- Transcribed records must be either electronically or hand signed including date.
- Electronic signatures must be stated as “authenticated by,” “signed by” or “approved by” and include the date, name and credentials of the authoring/authenticating provider.

**Use “History of” only when appropriate**

Under ICD-10-CM guidelines, the term “history of” means the patient no longer has the condition. Do not use this term to describe a disease or condition that the patient is managing or you are monitoring. Frequently seen examples:

- History of congestive heart failure to indicate compensated congestive heart failure
- History of atrial fibrillation to indicate atrial fibrillation controlled by medication

**Note:** As an exception, always document when the patient has a history of a myocardial infarction (I25.2), and the approximate date of the myocardial infarction.

**Oncology: malignancy reminders**

Malignancies should be documented only when the patient has evidence of current disease. If the disease has been eradicated through surgical intervention, radiation therapies or chemotherapy, then include a “history of” code.

- Patients who do not receive definitive treatment for their malignancy should continue to be coded with the malignancy diagnosis.
- Breast and prostate cancer patients on adjuvant therapy should be coded as if they have an active disease.

**Stroke reminders**

Because a cerebrovascular accident (CVA) is an acute event, it should not be documented as an active diagnosis for prolonged periods of time. Once the patient has been discharged from the hospital following a stroke, it should be documented and coded as a “history of” CVA without residual deficits, if none are present. The sequelae should be documented and coded every time they are assessed.

**Other tips**

- Use only standard medical abbreviations.
- Members with conditions that typically require medications (i.e. Major Depressive Disorder, Embolism, Vascular Claudication) should not be coded if the member is not receiving medications to treat the condition (i.e. anti-depressants, anti-coagulants or neurogenic claudication medications).
- Ensure the medical record is complete and legible.
- Record the patient’s name, date of birth and date of service on each page of his or her chart.
- Use subjective, objective, assessment and plan (SOAP) note format when applicable.

**Additional Resources:** For more information related to risk adjustment, visit the Centers for Medicare & Medicaid Services website at [http://csscooperations.com](http://csscooperations.com). For more information related to Medicare Advantage, see the BlueCross BlueShield of Tennessee Provider Administration Manual at [http://www.bcbst.com/providers/manuals/bcbstPAM.pdf](http://www.bcbst.com/providers/manuals/bcbstPAM.pdf). This information is not intended to be and should not be relied upon as legal, financial or compliance advice. Consult your own attorney or other appropriate professional for such advice.

This information applies to all BlueCross Medicare plans.
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 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.

You may receive a request for medical records directly from us or from our partner Ciox Health. Please follow the instructions on your request packet for returning the requested records.

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.

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.

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 following the directions on your request packet. Options for record return include:

- Uploading to the provider portal
- Remote EMR retrieval
- Faxing to a HIPAA compliant fax
- Mailing
- Onsite visit by a technician

Thank you for your assistance in helping us document active clinical diagnoses to CMS. If you have any questions about our request, please contact us at 1-855-413-8776, or if your request comes from Ciox Health, please contact them by calling 1-877-445-9293.

This information applies to all BlueCross Medicare plans.
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™. 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.

Identification of Patients

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

- No listed PCP or claims evidence of 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, they 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
- HbA1c Test Kit
- Diabetic Retinal Eye Exam
- Bone Mineral Density Testing
- Urine Microalbumin Test Kit
- Peripheral Artery Disease Testing

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

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.

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 have 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.

This information applies to all BlueCross Medicare plans.
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.
Your patients can earn 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 2020 with the added push to help ensure each BlueAdvantage member receives an annual wellness visit. Members can continue to earn gift cards for completing the annual wellness visit and other preventive screenings.

**Q. How do members sign up to participate?**

**A.** Members can join the program by logging in at bcbstmyhealthpath.com, downloading the mobile app “AlwaysOn” Wellness” or returning the business reply card attached to the 2020 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 don’t need to join again in subsequent years.

**Q. How can members get started earning rewards?**

**A.** Members will receive a letter encouraging them to join the program and highlighting ways to enroll. Once they opt in, they are eligible to earn gift cards for preventive services that you are ordering. These incentives are aligned with the HEDIS guidelines and members are only eligible for gift cards when they have an open gap in care and need the service.

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**Annual Wellness Visit Tips:** Use GO402, GO438, GO439 plus E/M codes appropriate for the annual wellness visit. Or use 99387, 99397, 99385, 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.

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This information applies to BlueAdvantage (PPO)** and BlueEssential (HMO SNP)** Only
## Available Member Incentives for 2020

<table>
<thead>
<tr>
<th>Measure/Activity</th>
<th>Gift Card Amount</th>
<th>Incentive Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>$30</td>
<td>Available for all members annually who complete an Annual Wellness Visit</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>$50</td>
<td>Available for Women ages 52-74 every other year who complete a mammogram at a provider facility</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td></td>
<td><strong>$20</strong> 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</td>
</tr>
<tr>
<td></td>
<td>$30</td>
<td>Available for members ages 51-75 every three years for members that complete a FIT-DNA (Cologuard®)</td>
</tr>
<tr>
<td></td>
<td>$50</td>
<td>Available for members ages 51-75 every 5 years who complete a CT Colonography or Sigmoidoscopy at a provider facility</td>
</tr>
<tr>
<td></td>
<td>$75</td>
<td>Available for members ages 51-75 every 10 years who complete a Colonoscopy at a provider facility</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – A1C Control (≤8.9%)</td>
<td>$25</td>
<td>Available for diabetic members ages 18-75 annually who complete an A1C test in home, in the provider office or at a BlueCross community outreach event</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Retinal Eye Exam</td>
<td>$50</td>
<td>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 BlueCross community outreach event</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy</td>
<td>$15</td>
<td>Available for diabetic members ages 18-75 annually who complete a Urine Nephropathy Screening test in home or in the provider office</td>
</tr>
<tr>
<td>Health Needs Assessment (HNA)</td>
<td>$20</td>
<td>Available for all members who complete a health needs assessment online, by phone or mail</td>
</tr>
</tbody>
</table>

This information applies to BlueAdvantage (PPO)™ and BlueEssential (HMO SNP)™ 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

<table>
<thead>
<tr>
<th>Survey</th>
<th>Measure</th>
<th>Question(s)</th>
<th>Tips</th>
</tr>
</thead>
</table>
| **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.  
• 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 four 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 Silver&Fit gym membership benefit. |
| **HOS** | Improving Bladder Control | • Have you ever talked with a doctor, nurse, or other health care provider about leaking of urine?  
• There are many ways to control or manage the leaking of urine, including bladder training exercises, medication, and surgery. Have you ever talked with a doctor, nurse, or other health care provider about any of these approaches? | • Screen all patients for urinary incontinence and discuss treatment options if positive.  
• Recommend treatment options no matter the frequency or severity of the bladder control problem. |

This information applies to all BlueCross Medicare plans.
Did you know? BlueAdvantage (PPO)℠, BlueEssential (HMO SNP)℠, BlueCare Plus (HMO SNP)℠ and BlueCare Plus Choice (HMO SNP)℠ members have a free Silver&Fit® benefit. This free fitness program for seniors includes access to more than 14,000 participating fitness centers and YMCAs. The program also offers fitness classes for all abilities at many fitness centers and YMCAs as well as on-demand workout videos and health and nutrition tips.
The Silver&Fit® Healthy Aging & Exercise Program offers a personalized approach to healthy aging with flexibility, support and the following features tailored to meet your patients’ unique needs:

**National Network of 14,000+ Fitness Centers**
- No-cost membership at participating fitness centers and select YMCAs
- Many fitness centers and YMCAs also offer:*  
  - Group fitness classes tailored to older adults  
  - Dance or yoga studios and/or swimming pools (where available)

**Home Fitness Kits**
- Members who prefer to work out at home receive two kits per calendar year.
- Thirty-four unique options are available.

**Member Resources**
- Forty-eight Healthy Aging classes
- The Silver Slate® quarterly newsletter

**Silver&Fit’s ASHConnect™ Mobile App**
- Enhanced fitness center search with photos and location details to help members find fitness centers and YMCAs with their favorite features
- Activity tracking supported on more than 250 wearable fitness devices, including Apple Watch®, apps, and exercise equipment**
- Virtual streaming group exercise videos so members can work out on their schedule

BlueCross BlueShield of Tennessee includes Silver&Fit for free for members of these Medicare Plans:
- BlueAdvantage (PPO)™
- BlueCare Plus (HMO SNP)™
- BlueElite™ Medicare Supplement
- BlueEssential (HMO SNP)™
- BlueCare Plus Choice (HMO SNP)™

Your patients should visit SilverandFit.com or call the health plan to verify Silver&Fit eligibility.

Members’ use of ASHConnect serves as their consent for American Specialty Health Fitness, Inc. (ASH Fitness) to receive information about their tracked activity. The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas. Members should talk to a doctor before starting or changing an exercise routine. The people in this piece are not Silver&Fit members. Something for Everyone, Silver&Fit, ASHConnect, the Silver&Fit logo, and The Silver Slate are trademarks of ASH. Other names or logos may be trademarks of their respective owners. Home kits are subject to change. Not all YMCAs participate in the network. Members are advised to check the searchable directory on the Silver&Fit website to see if their location participates in the program.

* Services that call for an added fee are not part of the Silver&Fit program.
** Purchase of a wearable fitness device or application may be required and is not reimbursed by the Silver&Fit program.

This information applies to all BlueCross Medicare plans.
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:

**Rebecca Williams, RN, BSN**  
Director, Healthcare Services, Medicare Advantage  
Phone: (423) 535-6706  
Email: Rebecca_Williams@bcbst.com

**Tracy L Curtis, MHA, BSN, RN, CCM, MMA**  
Manager, MA Population Health  
Phone: (423) 535-8345  
Email: Tracy_Curtis@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)™ and BlueEssential (HMO SNP)™ Only
Medicare Diabetes Prevention Program

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 they have:

- 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)™
Phone: 1-800-611-3489
Fax: 1-800-727-0841

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

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).

This information does not apply to BlueEssential (HMO SNP)™.
MDLIVE® (PhysicianNow®) FAQ

MDLIVE Telehealth (PhysicianNow) is a convenient way for Medicare Advantage and all special needs plans 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 don’t 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.

This information applies to all BlueCross Medicare plans.
# Member Home Meal Benefit After Discharge

BlueAdvantage (PPO)™, BlueEssential (HMO SNP)™, BlueCare Plus (HMO SNP)™, and BlueCare Plus Choice (HMO SNP)™ members have a 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.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</table>
| **What is Mom’s Meals?** | - Mom’s Meals is a vendor partner who will supply members with the meals after discharge to home.  
- **BlueAdvantage** and **BlueEssential** members will receive **two meals per day for five days** following discharge from an acute inpatient hospital or skilled nursing facility.  
- **BlueCare Plus** and **BlueCare Plus Choice** 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 qualify 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. |
## Transportation Benefit for Health-Related Treatments

BlueEssential (HMO SNP)℠, BlueCare Plus (HMO SNP)℠ and BlueCare Plus Choice (HMO SNP)℠ members have access to a supplemental benefit for non-emergency transportation for medical or health-related visits.* BlueCross has partnered with Southeastrans, Inc. to provide this service at no cost to our members.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</table>
| What is the transportation benefit?                  | • BlueEssential members are eligible for up to **twenty-four (24) one-way trips per calendar year** for non-emergent medical or health-related treatments. Trip distance is allowed up to **twenty-five (25) miles per one-way trip**.  
  • BlueCare Plus and BlueCare Plus Choice members are eligible for up to **one hundred (100) one-way trips per calendar year** for non-emergent medical or health-related treatments. Trip distance is allowed up to **fifty (50) miles from pick-up location per one-way trip**. |
| How do members qualify for the transportation benefit?| • BlueEssential, BlueCare Plus and BlueCare Plus Choice members that are in need of transportation for non-emergent medical or health-related treatments are eligible for this benefit. |
| What are the costs and limitations?                  | • There is **no cost-share** for the member with the transportation benefit through Southeastrans.  
  • Emergency transportation is **not allowed**.  
  • Prior authorization is **not required**.  
  • BlueEssential members are limited to **twenty-four (24) one-way trips per calendar year** with **twenty-five (25) miles per-one way trip distance**.  
  • BlueCare Plus and BlueCare Plus Choice members are limited to **one hundred (100) one-way trips per calendar year** with **fifty (50) miles per-one way trip distance**. |
| What are the hours that transportation is available?  | • Transportation assistance is available **24 hours a day, 7 days a week, 365 days a year**.  
  • Routine/Non-Urgent visits for follow-up or long-term care require **three (3) business days** prior notification.  
  • Urgent visits (needed within 24 hours) require **four (4) hours prior notification**. |
| What types of transportation are available?          | • Ambulatory sedan, van or taxi.  
  • Lift equipped wheelchair vehicle.  
  • Stretcher van, if available. |
| Are additional passengers allowed?                   | • Member and one (1) additional passenger are allowed. |
| Is durable medical equipment allowed?                | • Yes, the member is required to provide all necessary DME, i.e. wheelchair, walker, cane. |
| How does a member access the transportation benefit? | • Reservations are required:  
  • Three (3) business days prior for routine/non-urgent visits  
  • Four (4) hours prior for urgent visits  
  • BlueEssential members, plan case managers or other plan representatives may request transportation for the member by calling the trip reservation line at **1-855-735-4660** Monday through Friday 8:00am to 6:00pm ET.  
  • BlueCare Plus and BlueCare Plus Choice members, plan case managers or other plan representatives may request transportation for the member by calling the trip reservation line at **1-855-681-5032** Monday through Friday 8:00 a.m. to 5:00 p.m. ET. |

*This benefit is different than the non-emergency medical transportation benefit.

**Note:** This supplemental benefit is only available for our Special Needs Plan members and does not apply to BlueAdvantage PPO℠.
Over-the-Counter (OTC) Catalog Benefit

BlueEssential (HMO SNP)™, BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ members have access to quarterly supplemental benefit credits that allow them to purchase from a catalog of covered over-the-counter health and wellness products. BlueCross has partnered with DrugSource, Inc. to provide this service at no cost to our members.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</table>
| **What is the Over-the-Counter (OTC) benefit?** | • BlueEssential members are eligible for **four quarterly benefit credits of $25 each** that can be used to purchase items from a catalog of covered over-the-counter health and wellness products, i.e. ointments, vitamins, cold and allergy medications. Items are shipped directly to the member.  
• BlueCare Plus and BlueCare Plus Choice members are eligible for **four quarterly benefit credits of $300 each** that can be used to purchase items from a catalog of covered over-the-counter health and wellness products, i.e. ointments, vitamins, cold and allergy medications. Items are shipped directly to the member. |
| **What are the costs and limitations?** | • There is **no cost-share** for the member with the OTC benefit through DrugSource.  
• Quarterly benefit credits may **only** be used to purchase items from the **OTC catalog**.  
• BlueEssential members are allowed **one order per month with a total of three orders**, not to exceed **$25 per quarter** (product price + applicable sales tax).  
• BlueCare Plus and BlueCare Plus Choice members are allowed **one order per month with a total of three orders**, not to exceed **$300 per quarter** (product price + applicable sales tax). |
| **Will benefit credits carry-over from quarter to quarter?** | • Benefit credits **do not carry over** from quarter to quarter. |
| **Will returns be accepted?** | • Due to the personal nature of these products, **returns will not be accepted** and no refund or credit will be given once items are ordered and mailed. |
| **How does a member access the OTC benefit?** | • BlueEssential members have two ways to order OTC catalog items:  
  • Order by phone 1-833-332-8305 (TTY: 711) Monday through Friday 8:30 am to 10 pm CT or 9:30 am to 11 pm ET.  
  • Order online at [shopping.drugsourceinc.com/blueessential](http://shopping.drugsourceinc.com/blueessential).  
• BlueCare Plus and BlueCare Plus Choice members have two ways to order OTC catalog items:  
  • Order by phone 1-800-400-6864 (TTY: 711) Monday through Friday 8:30 am to 10 pm CT or 9:30 am to 11 pm ET.  
  • Order online at [shopping.drugsourceinc.com/bluecareplus](http://shopping.drugsourceinc.com/bluecareplus). |

**Note:** This supplemental benefit is only available for our Special Needs Plan members and **does not apply** to BlueAdvantage PPO™
AbleTo Behavioral Health Program

BlueAdvantage (PPO)℠, BlueEssential (HMO SNP)℠, BlueCare Plus (HMO SNP)℠ and BlueCare Plus Choice (HMO SNP)℠ members have access to a behavioral health program that is designed to engage and treat members overcoming the challenges of managing a chronic condition, recovering from a medical event, or navigating through a difficult life change. BlueCross has partnered with AbleTo, a behavioral health care provider, to provide this service at no cost to our members.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>What is the goal of the behavioral health program?</td>
<td>• This program aims to help members improve their emotional health by learning techniques for managing stress, set and reach personal goals and improve their mood and overall outlook on life.</td>
</tr>
<tr>
<td>What does the behavioral health program offer?</td>
<td>• 8-week behavioral health program providing customized, structured support and coaching.</td>
</tr>
<tr>
<td></td>
<td>• Sessions are conducted in the comfort of the member’s home confidentially over the phone or by video.</td>
</tr>
<tr>
<td>Who will the members work with?</td>
<td>• The member’s personal team includes a licensed therapist and a behavioral coach.</td>
</tr>
<tr>
<td></td>
<td>• All AbleTo therapists are licensed clinical social workers who, on average, have more than ten years of experience working with individuals to address a variety of life events and challenges.</td>
</tr>
<tr>
<td></td>
<td>• All behavioral coaches have master’s-level education in a health-related field and experience in counseling.</td>
</tr>
<tr>
<td>What are the costs and limitations?</td>
<td>• There is no cost-share for the member with the behavioral health program through AbleTo.</td>
</tr>
<tr>
<td></td>
<td>• Prior authorization is not required.</td>
</tr>
<tr>
<td></td>
<td>• If AbleTo determines that a member is more appropriate for community-based treatment, the member will be assessed, supported and linked to the appropriate resources.</td>
</tr>
<tr>
<td></td>
<td>• Currently, AbleTo does not provide any psychiatric services and cannot prescribe any medications.</td>
</tr>
<tr>
<td>What are the hours that the behavioral health program is available?</td>
<td>• Sessions are available 24 hours a day, seven (7) days a week.</td>
</tr>
<tr>
<td></td>
<td>• Members can participate from the comfort and privacy of their home at times that best fit their schedule.</td>
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<tr>
<td></td>
<td>• Appointments are available as soon as the very next day.</td>
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<tr>
<td>How does a member begin participation in the program?</td>
<td>• AbleTo will contact members that are referred by BlueCross.</td>
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<td></td>
<td>• Members may also be referred by their providers for this program by contacting BlueCross Population Health at 1-800-611-3489.</td>
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</table>
**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.
- If you do an Annual Wellness Visit with the PAF, members will qualify for a $30 gift card if they are enrolled in the member incentive program.

**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 $50 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.
- Consider special reminders to your patients around Mother’s Day and Breast Cancer Awareness Month.

**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.
- Remind patients that if they participate in the member incentive program, they will be eligible for a gift card for completing a colorectal cancer screening. Gift card amounts will vary depending on screening type.
**Best Practice Tips Continued**

**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/mailed to the provider so they can be incorporated in the patient’s chart.

**Osteoporosis Management in Women who had a 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.

**Diabetic Eye Exams**

- Consider purchasing a mobile retinal scanner so you could complete eye exams on your patients who don’t routinely see an eye care professional.
- Encourage the importance of eye health through one of our posters.
- Remind patients that if they participate in the member incentive program, they can receive a gift card for getting a diabetic retinal eye exam. “Did you know you can receive a $50 gift card for having a diabetic retinal eye exam?”
BlueEssential (HMO SNP)℠ Chronic Special Needs Plan

The First Plan of its Kind in Tennessee

BlueEssential is a Chronic Special Needs Plan (C-SNP) plan that offers tailored benefits to Medicare Advantage members with diabetes and other co-morbidities. A Model of Care (MOC) is implemented to ensure the unique needs of each member are identified and addressed.

Eligibility

• The member must sign up specifically for this plan.
• The member’s provider must confirm the member has diabetes, which is a CMS condition of enrollment.
• Members may have other conditions in addition to diabetes except ESRD on dialysis.
• This plan is offered at the same time of the year and with the same restrictions as other Medicare Advantage plans.

HMO Product

• Members must select a primary care provider (PCP).
• **No** referrals are required.
• The same rules apply for authorization of services as with our MA PPO plan.
• There’s no out-of-network coverage except for urgent and emergent services.

Network

• There is a limited, narrow network built around key hospitals, and PCP and specialist groups in 30 counties covering the major metro areas of Tennessee.
• Providers will have the opportunity to identify members currently in traditional Medicare or other Medicare plans that may be appropriate for this plan design aimed at diabetics who have cost barriers limiting compliance.

Unique Enrollment Options

• People who age in to Medicare can enroll in this C-SNP if they have the qualifying diagnosis of diabetes.
• Medicare members already enrolled in Original Medicare or a traditional Medicare Advantage plan can enroll at any time of the year (i.e., even outside of AEP) if they develop or currently have diabetes.
• Members currently enrolled in a C-SNP can switch out of the C-SNP at any time of the year if they are cured of diabetes.
Benefits

We’re attempting to address many of the socio-economic barriers of non-adherent individuals with diabetes and here are a few examples how:

Lower Member Cost for Certain Medicines and Equipment

• Copay for endocrinologist is **reduced** to match a PCP.
• Limited over-the-counter drug coverage.
• External infusion insulin pumps and continuous glucose monitors with **reduced** member cost-share.

Improved Coverage for Diabetic Care Services

• **Increase** in covered podiatry visits over Medicare for routine foot care.
• Added $0 cost-share tier for select care drugs commonly used to treat diabetics as well as associated chronic conditions. Examples include:
  - Diabetes medications such as metformin, pioglitazone and glyburide.
  - Statin medications such as rosuvastatin and atorvastatin.
  - Blood pressure medications such as lisinopril and olmesartan.

• Lower co-pays for insulin through our preferred pharmacy network as compared to a standard network. Examples include:
  - Lantus®
  - NovoLog®
  - Tresiba®

Enhanced Supplemental Benefits

• Limited transportation benefit to help with getting to medical appointments:
  - 24 one-way trips per calendar year for non-emergent medical or health-related treatments. Trip distance is allowed up to twenty-five (25) miles per one-way trip.
  - Diabetic or other meals that support the dietary plan of care for **five days** after discharge from a hospital or skilled nursing facility at no member cost.
  - Comprehensive medication review by a pharmacist for eligible members to help optimize therapeutic outcomes, minimize risks and maximize cost-effectiveness.
  - Regionally-located field-based nurse case managers and regionally assigned telephonic case managers to encourage compliance with the provider’s ordered plan of care.
Model of Care

Our Model of Care is designed to serve the unique, individual needs of the Medicare population living with diabetes and other co-morbidities. Our programs promote improved cost-efficient health outcomes through coordination of care and member self-management.

**Our Multi-Disciplinary Team**
- Physicians
- Pharmacists
- Registered Nurses
- Dietitians
- Social Workers
- Behavioral Health Specialists

**Our Focus**
- Essential diabetic care services
- Member engagement and self-management
- Care coordination and coaching
- Preventive and health promotion services
- Transition of care
- Medication therapy management and adherence

**Our Model of Care**

- **Initial and Annual Reassessments**
  - Health-risk assessment
  - Focused diabetic health assessment
  - Provider assessment form

- **Annual Individualized Care Plan (ICP)**
  - Ensures the member’s healthcare, long-term services, support needs and preferences are met

- **Interdisciplinary Care Team (ICT)**
  - Shares information among team members to promote better health outcomes

- **Annual Model of Care (MOC) Training**
  - Available for network providers, ICT members and BlueEssential staff
Interdisciplinary Care Team

Interdisciplinary Care Team (ICT) activities are important communications between professionals seeking to coordinate care and supports for BlueCross SNP members. The ICT content is individualized according to the member’s medical behavioral health, psychosocial, cognitive and functional needs.

As a provider serving a BlueCross SNP member, you are considered part of the ICT in addition to:

- Member and/or appropriate family/caregiver
- Care Coordinator
- Other providers appropriate to the member’s healthcare needs (Primary Care Providers, Pharmacist, Dentist, long term services and supports, etc.)
- Others as needed, i.e. social worker, dietitian, behavioral health specialist

You will receive a copy of the member’s individualized plan of care developed between the member, care coordinator and PCP.

Compensation is provided for provider participation in ICT activities. The sharing of information through the return of the signed care plan or conversations with the plan’s care coordination team constitutes your ability to bill for the ICT.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Code</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Care Team</td>
<td>99366-99368</td>
<td>$54</td>
</tr>
</tbody>
</table>

For more information about the Chronic Special Needs Plan, please contact a member of our Provider Quality Outreach team listed in the front of this guide.
Advanced Illness and Frailty Exclusions

In 2018, the National Committee for Quality Assurance (NCQA) made changes to specifications that impact Centers for Medicare & Medicaid (CMS) Star measures for patients with advanced illness and frailty. Additional exclusions to these measures were made because the services recommended in the original definition may not benefit older adults with limited life expectancy or advanced illness.

Codes must be billed in the current (measurement) year or the prior year for Advanced Illness, and in the current year for Frailty, in order to exclude the patient from the Star measures in the table below.

### Patients age 66 and older can be excluded if they have both advanced illness and frailty

- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Comprehensive Diabetes Care (CDC)
- Controlling Blood Pressure (CBP)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Osteoporosis Management in Women Who Had a Fracture (OMW)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)

### Patients age 81 and older can be excluded with frailty alone

- Controlling Blood Pressure (CBP)
- Osteoporosis Management in Women Who Had a Fracture (OMW)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

**Helpful Tip**

To qualify for advanced illness, the patient must have at least one of the following:

- Two outpatient claims on different dates of service with an advanced illness code
- One inpatient claim with an advanced illness code
- One filled prescription for a dementia medication

To qualify for frailty, the patient must have at least one claim with a frailty diagnosis or treatment code.

For more information, including a list of Advanced Illness and Frailty codes, please contact a member of our Provider Outreach team listed in the front of this guide and/or reference our Guide to Advanced Illness and Frailty Exclusions.

This information applies to all BlueCross Medicare plans.
Medicare Advantage Inter-Plan Program

Effective Jan. 1, 2020, all BlueCross Medicare Advantage Plans (including BlueCross BlueShield of Tennessee) will be a part of the Inter-Plan Medicare Advantage Program created by the BlueCross BlueShield Association.

This new plan-to-plan arrangement is designed to enhance the way Blues Plans support Medicare Advantage Employer Group accounts and their members who live outside of their home plan service areas. This newly designed collaborative model is intended to lessen confusion when patients have out-of-state BlueCross BlueShield cards and provide a more seamless process for care among all BlueCross members. Additionally, this model can help improve Star scores, ensure appropriate risk adjustment, meet market expectations and increase the effectiveness of members’ care management.

The Inter-Plan program will help insurance carriers and providers coordinate between Blues plans across state lines to close gaps in care. For example, a member who resides in Tennessee but holds membership from an out-of-state Blues plan will become part of BlueCross BlueShield of Tennessee’s quality program for providers. This helps facilitate gap closure for physicians in Tennessee who treat patients with out-of-state Blues health care coverage, which in turn improves providers’ Stars scores.

What You Should Know

• Providers will be responsible for ensuring members from out-of-state Blues plans (Inter-Plan members) receive the same needed screenings, tests and services as in-state blues members.
• The same quality measures apply to Inter-Plan members as in-state Blues plan members.
• BlueCross BlueShield of Tennessee will provide you with a list of Inter-Plan members that are attributed to your practice beginning in January through March.
• Beginning in March 2020, Inter-Plan members will display in your provider roster in the Quality Care Rewards (QCR) tool along with your local attributed members. Inter-Plan members will be displayed with an indicator to designate their Inter-Plan status.
• Your practice will be able to complete Provider Assessment Forms (PAFs) and will receive the same reimbursement that you receive for a BlueCross BlueShield of Tennessee member. You will also be able to attest to completed screenings for Inter-Plan members in the QCR tool, however a copy of the documentation from the medical record to support the attestation will be required to be uploaded into the QCR at the time of the attestation.
• You may not see a change in the compliance status of an Inter-Plan member’s measure status for up to 90 days, as we work with the Inter-Plan member’s home plan to obtain measure compliance status after an attestation has been completed and/or a claim has been received.

For more information about the Inter-Plan Program, please contact a member of our Provider Quality Outreach team listed in the front of this guide.

This information applies to BlueAdvantage (PPO)™ Only
**Dual Special Needs Plan (DSNP)**

DSNP is a Medicare Advantage special needs plan serving people who are dual-eligible for Medicare and Medicaid. Our DSNP plan is called BlueCare Plus (HMO SNP). Our focus is to promote quality of care and cost-effectiveness through care coordination for this most vulnerable population who are at a higher risk of poor outcomes and increased service utilization related to both medical and social issues.

**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) and BlueCare Plus Choice (HMO SNP) Only.
BlueCare Plus (HMO SNP)℠ 2020 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 products – 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%.

Putting members first
Additional incentives are available when you complete Provider Assessment and Care Planning Forms (PACFs). These forms help identify opportunities for care and encourage treatment plan implementation throughout the year. You can earn a fixed reimbursement rate of $155 for dates of service between January 1 and December 31 for completing and submitting PACF forms on your patients.

Members are also rewarded
Our members are rewarded in the form of gift cards for getting certain health screenings as recommended by their PCP. There’s no opt-in needed by the member in order to receive rewards. Members simply receive a gift card in the appropriate amount after completing screenings that are applicable to them.

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Member Incentive Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Wellness Exam (AWE)</td>
<td>$50</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>$25</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>$50 (Colonoscopy or Flexible Sigmoidoscopy) $15 (FOBT in home kit or FIT DNA)</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) A1C</td>
<td>$25</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) Medical Attention for Nephropathy</td>
<td>$10</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) Retinal Eye Exam</td>
<td>$15 (BCBST Vendor Partner) $50 (Optometrist or Ophthalmologist)</td>
</tr>
<tr>
<td>Osteoporosis Management in Women who had a Fracture (OMW)</td>
<td>$25</td>
</tr>
</tbody>
</table>

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

This information applies to BlueCare Plus (HMO SNP)℠ Only
A FIDE SNP is a type of special needs plan that covers all of the core benefits under original Medicare and any optional or mandatory supplemental benefits included with BlueCare Plus. Any Medicaid-only benefits available under TennCare are also included. With the FIDE SNP plan, you’ll file one claim and we’ll process both Medicare and Medicaid benefits. You’ll only get one remittance advice showing how the claim processed, which means less paperwork for you.
Additional Information / Frequently Asked Questions

Q: Why are we adding a FIDE?
A: A FIDE promotes the full integration and coordination of Medicare and Medicaid benefits and Long-Term Support Services (LTSS) for dual eligible beneficiaries by a single managed care organization. This means these members will have a single entity coordinating care and services.

Q: Who’s eligible?
A: Eligibility requirements include individuals who:
- Live in our plan service area of Tennessee
- Are eligible for both Medicare part A and B
- Have BlueCare Tennessee Medicaid/TennCare with Choices 1, 2 or 3

Q: Will provider contracts change?
A: Provider contracts won’t change because they already serve this population.

Q: How many members will this impact?
A: About 700 BlueCare Plus members meet our FIDE eligibility requirements now and will transition to BlueCare Plus Choice starting Jan. 1, 2020. We’re forecasting about 1,000 members will enroll by the end of 2020.

Q: What are the benefits for BlueCare Plus Choice?
A: The Medicare benefit package includes the same benefits and services that our BCP members have with the addition of Medicaid and Long-Term Support Services.

Q: How will providers file claims?
A: They’ll file only one claim, and BlueCare Plus Choice will process both Medicare and Medicaid benefits. Providers will get one remittance advice showing how the claim processed, which means less paperwork for them.

Q: How will coordination of care work?
A: BlueCare Plus plans will continue providing member incentives to help encourage engagement in primary care, preventive and wellness screenings. BCP will also keep reimbursing for requirements outlined in the BCP Model of Care, such as the PACF completion, Interdisciplinary Care Team participation and Model of Care training.

This information applies to BlueCare Plus Choice (HMO SNP)™ Only
Member PCP Selection

Primary Care Providers (PCPs) are responsible for the overall health care of BlueCare Plus members assigned to them. Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care
- Providing or making arrangements for all medically necessary and covered services
- Initiating and/or authorizing referrals for specialty care
- Collaboration with the care coordinator and the Interdisciplinary Care Team (ICT)
- Monitoring the continuity of member care services
- Routine office visits for new and established members

Member Selection

Enrollment – Members select a PCP to whom attribution will be made. BlueCare Plus calls members to welcome them and helps them select a PCP if they don’t have one yet.

Automated Assignment

If a member doesn’t select a PCP within 30 days of enrollment, one will be assigned based on their address and provider type, e.g. internal medicine, family practice, general practice.

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:

- Members can change their PCP by calling Member Services or completing and returning a PCP change form at any time.
- Members remain with a PCP until they ask for a PCP change.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ 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 at https://bluecareplus.bcbst.com/. Member services can be reached at 1-800-332-5762 to change their PCP at any time via phone.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ Only
Annual Wellness Visit Facts

BlueCare Plus 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

<table>
<thead>
<tr>
<th>Service</th>
<th>Codes</th>
<th>Coverage Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Preventive Physical Examination (IPPE)</td>
<td>G0402</td>
<td>Members are covered for comprehensive preventive medicine evaluation and management, including:</td>
</tr>
<tr>
<td>Initial Preventive Physical Examination (IPPE) with EKG</td>
<td>G0402 with G0403, G0404 or G0405</td>
<td>- Appropriate history, age and gender</td>
</tr>
<tr>
<td>Annual Preventive Exam</td>
<td></td>
<td>- Examination</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>G0438 (Initial), G0439 (Subsequent)</td>
<td>- Counseling and anticipatory guidance</td>
</tr>
<tr>
<td>Annual Preventive Physical Exam</td>
<td>99385-99387 (New Patient), 99395-99397 (Established Patient)</td>
<td>- Risk factor reduction interventions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Members are covered for comprehensive preventive medicine evaluation and management, including:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Appropriate history, age and gender</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Examination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counseling and anticipatory guidance</td>
</tr>
</tbody>
</table>

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ Only
Patient Assessment & Care Planning Form (PACF) and Interdisciplinary Care Team (ICT)

Frequency: PACF may be billed once per **calendar year**. ICT has no frequency limitations.

<table>
<thead>
<tr>
<th>Service</th>
<th>Codes</th>
<th>Coverage Notes</th>
<th>Reimbursement Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Assessment &amp; Care Planning Form (PACF)</td>
<td>96160</td>
<td>This is a BlueCare Plus DSNP benefit and isn’t covered by Original Medicare. A PACF may be submitted once per member, per calendar year. Providers don’t need to wait 365 calendar days from the last PACF submission or wellness exam. A PACF may be completed in conjunction with the Welcome to Medicare Annual Preventive Exam or Annual Wellness Visit.</td>
<td>$155.00</td>
</tr>
<tr>
<td>Interdisciplinary Care Team (ICT)</td>
<td>99366-99368</td>
<td>This is a BlueCare Plus DSNP benefit and isn’t covered by Original Medicare. 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 through the return of the completed PACF, patient medical records, or conversations with the plan’s care coordination team constitutes your ability to bill for the ICT.</td>
<td>$54.00</td>
</tr>
</tbody>
</table>

**Billing Tips**

- No modifier is needed.
- Charges and reimbursement are based on date of service.
- Use G0438, G0402 or G0439 with your E/M codes or E/M codes 99387 or 99397

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ Only
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) and assists with appointment scheduling and transportation. 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.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>99366-99368</td>
<td>Interdisciplinary Care Team</td>
<td>$54.00</td>
</tr>
<tr>
<td>96160</td>
<td>Administration of PACF</td>
<td>$155.00</td>
</tr>
</tbody>
</table>

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 getting necessary preventive screenings are triggered by the codes billed for the annual wellness visit or comprehensive preventive medicine evaluation and management.

This information applies to BlueCare Plus (HMO SNP)SM and BlueCare Plus Choice (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) *(must indicate type of screening)*
  - 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.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO)™ Only
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

Note: It is important the information in the PACF or medical record is complete. If not all information is includeded you will receive a fax requesting additional information.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ 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.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ Only
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.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ Only
## 2020 Calendar Year

### Dual Special Needs (DSNP) Program Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>Member Incentive Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care (CDC) – HbA1c Control (≤8.9%)</td>
<td>Outcome</td>
<td>3</td>
<td>$25</td>
</tr>
<tr>
<td>Medication Adherence for Cholesterol (Statins)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Medication Adherence for Hypertension (RASA)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Medication Adherence for Diabetes Medications (OAD)</td>
<td>Outcome</td>
<td>3</td>
<td>—</td>
</tr>
<tr>
<td>Plan All-Cause Readmissions (PCR)</td>
<td>Outcome</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>Procedure</td>
<td>1</td>
<td>$25</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>Procedure</td>
<td>1</td>
<td>$15, $50</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Retinal Eye Exam Performed</td>
<td>Procedure</td>
<td>1</td>
<td>$15, $50</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC) – Medical Attention for Nephropathy</td>
<td>Procedure</td>
<td>1</td>
<td>$10</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (CBP)</td>
<td>Outcome</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Medication Reconciliation Post-Discharge (MRP)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Osteoporosis Management in Women who had a Fracture (OMW)</td>
<td>Procedure</td>
<td>1</td>
<td>$25</td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease (SPC)</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes (SUPD)</td>
<td>Outcome</td>
<td>1</td>
<td>—</td>
</tr>
</tbody>
</table>

### Measures for Display/Monitoring Status Only

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Type</th>
<th>Weight</th>
<th>Member Incentive Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Outcomes Survey: Improving Bladder Control</td>
<td>HOS Survey</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Health Outcomes Survey: Monitoring Physical Activity</td>
<td>HOS Survey</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Health Outcomes Survey: Reducing the Risk of Falling</td>
<td>HOS Survey</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>Procedure</td>
<td>0</td>
<td>$50</td>
</tr>
<tr>
<td>Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)</td>
<td>Outcome</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)</td>
<td>Outcome</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Care for Older Adults (COA) - Medication Review</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Care for Older Adults (COA) - Functional Status Assessment</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Care for Older Adults (COA) - Pain Assessment</td>
<td>Procedure</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Medicare Diabetes Prevention Program Participation for 6 Months</td>
<td>—</td>
<td>0</td>
<td>—</td>
</tr>
</tbody>
</table>

*Please see DSNP Member Incentive table on page 72 for more information.

This information applies to BlueCare Plus (HMO SNP)™ and BlueCare Plus Choice (HMO SNP)™ Only
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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