Blue Medicare Advantage 2023 Provider Workshop

November 2023

Agenda

Section One	Introductions
Two	2024 Plan Preview
Three	Provider Policies & Procedures
Four	STARS Overview
Five	Risk adjustment and Remote CDI
Six	Credentialing and Contracting
Seven	2024 CMS Updates & What's Ahead for MA
Eight	Who to Contact and Q&A

Section One

Introductions

Section Two

2024 MA Plans and Benefits Preview

Cheyenne
Rawlins
Decatur
Norton
Phillips
Smith
Jewell
Republic
Washington
Marshall
Nemaha
Brown
Doniphan
Sherman
Thomas
Sheridan
Graham
Rooks
Osborne
Mitchell
Cloud
Clay
Riley
Pottawatomie
Jackson
Atchison
Jefferson
Leavenworth
Wyandotte
Wallace
Logan
Gove
Trego
Ellis
Russell
Lincoln
Ottawa
Dickinson
Geary
Wabaunsee
Shawnee
Douglas
Johnson
Greeley
Wichita
Scott
Lane
Ness
Rush
Barton
Ellsworth
Saline
Morris
Osage
Franklin
Miami
Pawnee
Rice
McPherson
Marion
Chase
Lyon
Coffey
Anderson
Linn
Hamilton
Kearny
Finney
Hodgeman
Stafford
Reno
Harvey
Butler
Greenwood
Woodson
Allen
Bourbon
Edwards
Gray
Ford
Sedgwick
Stanton
Grant
Haskell
Kiowa
Pratt
Kingman
Elk
Wilson
Neosho
Crawford
Morton
Stevens
Seward
Meade
Clark
Comanche
Barber
Harper
Sumner
Cowley
Chautauqua
Montgomery
Labette
Cherokee

New counties
Old counties

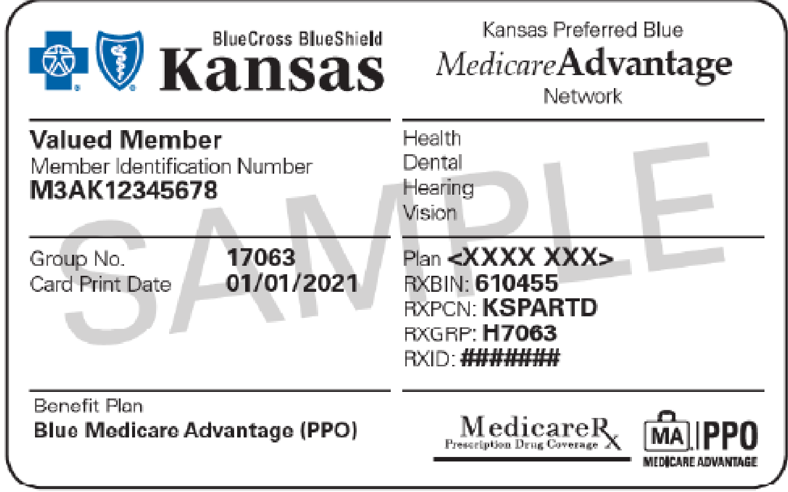
Adding Leavenworth County for 2024

Blue Medicare Advantage Plan Overview

The Power of PPO

- All plans offer both In and Out-of-Network Benefits
- Low or $0 Monthly Premium
- No Annual Deductible
- Added Benefits

ID Card & MA PPO Logo



Blue MA Plan Regions

Cheyenne Rawlins Decatur Norton Phillips Smith Jewell Republic Washington Marshall Nemaha Brown Doniphan
Sherman Thomas Sheridan Graham Rooks Osborne Mitchell Cloud Clay Riley Pottawatomie Jackson Atchison Jefferson Leavenworth Wyandotte
Wallace Logan Gove Trego Ellis Russell Lincoln Ottawa Dickinson Geary Wabaunsee Shawnee Douglas Johnson
Greeley Wichita Scott Lane Ness Rush Barton Ellsworth Saline Morris Osage Franklin Miami
Rice McPherson Marion Chase Lyon Coffey Anderson Linn
Hamilton Kearny Finney Hodgeman Pawnee Stafford Reno Harvey
Gray Edwards Butler Greenwood Woodson Allen Bourbon
Stanton Grant Haskell Ford Kiowa Pratt Kingman Sedgwick Elk Wilson Neosho Crawford
Morton Stevens Seward Meade Clark Comanche Barber Harper Sumner Cowley Chautauqua Montgomery Labette Cherokee

Northeast region
South Central region

2024 MA Product Offerings

Blue Medicare Advantage (PPO)

- Northeast and South Central region variations
- Base plan option
- Includes Prescription, Dental, Vision, Hearing, Fitness

Blue Medicare Advantage Comprehensive (PPO)

- All region plan for 2024
- Buy-up option
- Includes Prescription, Dental, Vision, Hearing, Fitness

Blue Medicare Advantage Choice (PPO)

- All region plan
- Base plan option
- Includes Prescription, Dental, Vision, Hearing

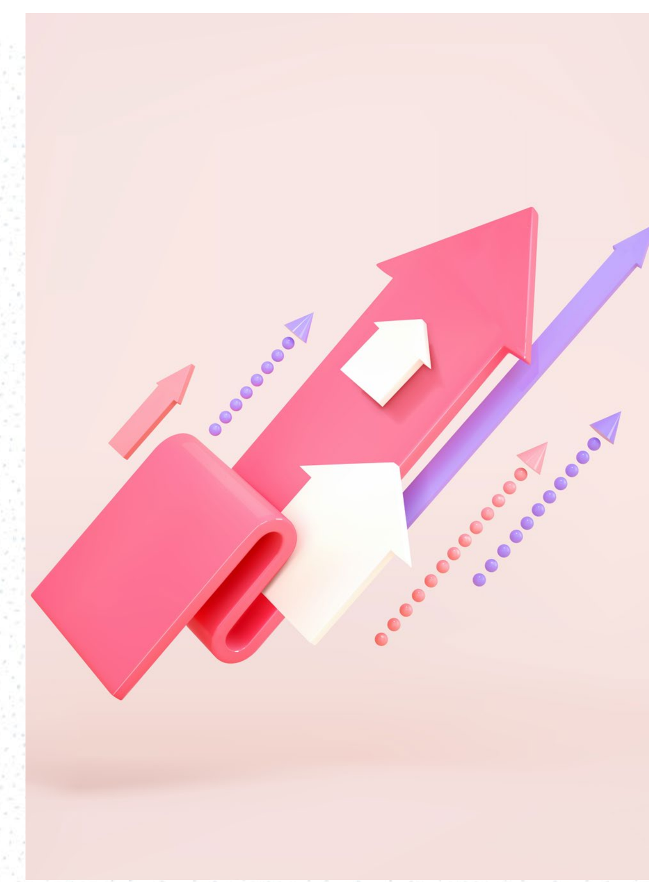
Blue Medicare Advantage Freedom (PPO)

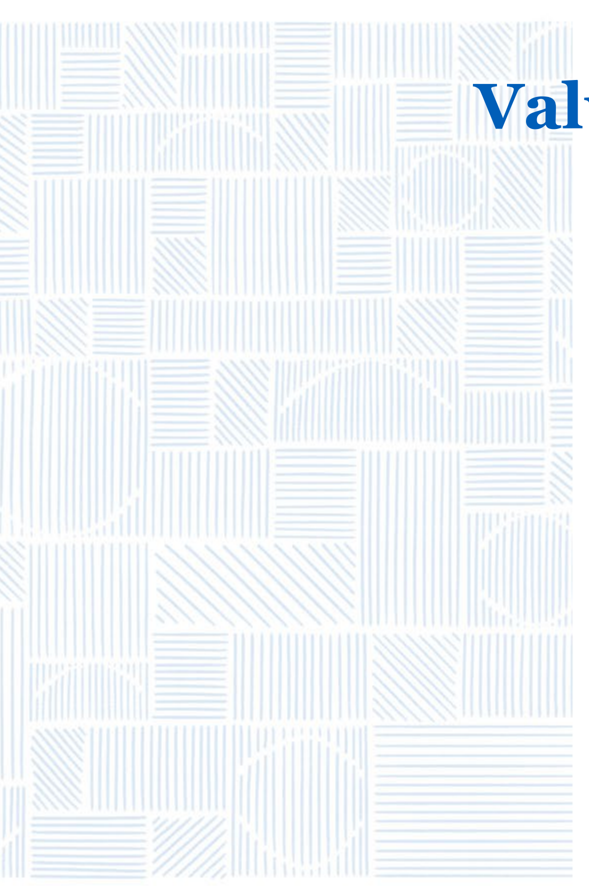
- NEW for 2024 – Medical (Part C) only plan
- Part B Premium Credit
- Includes Dental, Vision, Hearing, Fitness

2024 Plan Changes

Highlights of 2024 Benefit Enhancements

- Increased Dental allowances (maximum benefit limits) on all plans
- 3 of 5 plans have $0 PCP Copays
- Increased Vision allowances on Choice and Comprehensive plan
- OTC spend on all plans





Value Added Benefits

Dental
Vision
Hearing
OTC
Fitness
Meals

Dental

Embedded Preventive + Minor Comprehensive Services on all plans

Blue Medicare Advantage plans include the following embedded routine dental coverage:

- **Preventive Dental Services**
  - Routine cleanings (up to 2 every year)
  - Bitewing x-rays (up to 2 every year)
  - Oral Exams (up to 2 every year)
- **Comprehensive Dental Services**
  - Restorative
  - Endodontics
  - Periodontics
  - Extractions
  - Prosthodontics and Oral / Maxillofacial Services

	Blue Medicare Advantage (PPO) – Topeka Region	Blue Medicare Advantage (PPO) – Wichita Region	Blue Medicare Advantage Comprehensive (PPO)	Blue Medicare Advantage Choice (PPO)	Blue Medicare Advantage Freedom (PPO)
Embedded Preventive + Minor Comprehensive	$1,750 Annual Allowance	$2,500 Annual Allowance	$3,000 Annual Allowance	$1,750 Annual Allowance	$1,000 Annual Allowance
Dental Buy - up	$1,000 Annual Allowance for Minor Comprehensive Services	*Not Offered*	$1,000 Annual Allowance for Minor Comprehensive Services	*Not Offered*	*Not Offered*

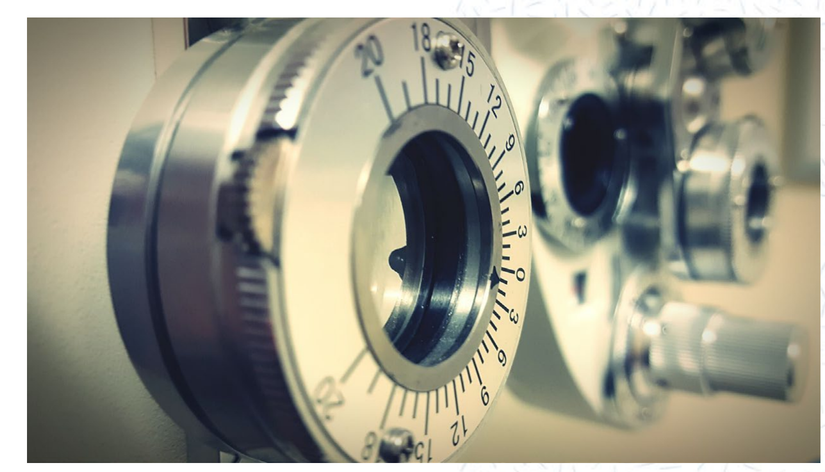
Reference Evidence of Coverage, Availity, or contact customer service for additional detail on covered comprehensive services / limitations.

Vision

Eye Care Made Crystal Clear

New for 2024 – Increased eyewear allowance on Choice & Comprehensive plans

- Medicare-covered diabetic eye exams and glaucoma screenings – $0 co-pay
- All other Medicare-covered eye exams & Medicare-covered eyewear– specialist co-pay
- Refractions – covered when billed with a medical exam
- Routine Eye Exam – one routine eye exam covered per year (EyeMed - $85 allowance)
- Frames, Lenses, and Contact Lenses - $150 or $200 annual eyewear allowance (EyeMed)



Claims for services covered under original Medicare should be filed to BCBSKS. Vision services (hardware) file to EyeMed.

Hearing

1 Routine hearing exam + discount on hearing aids on all plans

OTC

Quarterly retail and mail-order allowance at nationwide and local drug stores, grocery stores, and retailers. Available on all plans.

Fitness

SilverSneakers Fitness Membership via Tivity Health

*Not offered on Choice plan

Meals

14 home delivered meals over 7-day period after hospital discharge. Available on all plans.

Section Three

Provider Policies & Procedures

Provider Manual

1

Step 1: Select "Providers"

Providers News About Us Contact Us Search BlueAccess® Login/Pay Bill

Kansas Find Insurance Customer Service Health and Wellness Prescription Drugs Mental Health Find a Doctor/Hospital

Enroll in BlueCare today

INDIVIDUAL AND FAMILY PLANS

Institutional Professional Medical Policies Precert/Prior-auth Medicare Advantage COVID-19 Log In To BlueAccess®

Institutional Provider
UB04 Billing
ACCESS INSTITUTIONAL PROVIDER RESOURCES

Professional Provider
ACCESS PROFESSIONAL PROVIDER RESOURCES

2

Medicare Advantage Provider
ACCESS MEDICARE ADVANTAGE RESOURCES

COVID-19 Provider Information
ACCESS COVID-19 RESOURCES

Step 2: Select "Access Medicare Advantage Resources"

Providers News About Us Contact Us Search

Kansas Institutional Professional Medical Policies Precert/Pri

Medicare Advantage Provider

POLICY AND PROCEDURES

- Medicare Advantage Provider Manual
  - Specific Billing Guidelines
    - Medicare Advantage Home Health Billing
- Annual Physical Exam Policy
- Benefits Summary-Topeka Region
- Benefits Summary-Wichita Region

3

Step 3: Select "Medicare Advantage Provider Manual"

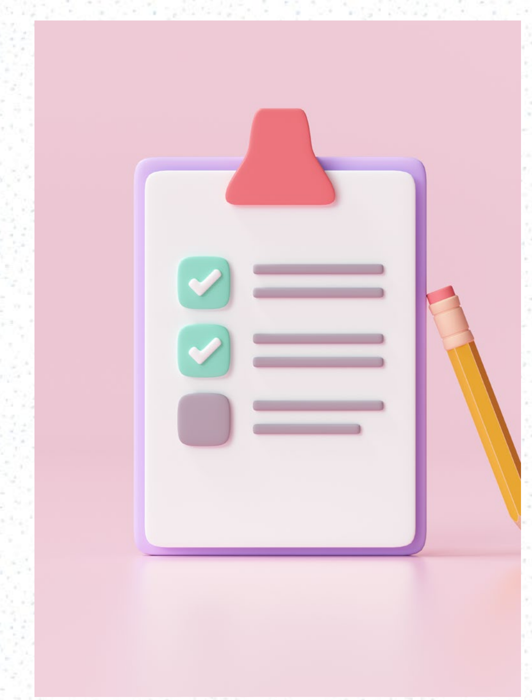
Claim Filing

- Submit electronic claims to BCBSKS, Payer ID 47163
- Submit paper claims to:

  Kansas Preferred Blue Medicare Advantage

  P.O. Box 239

  Topeka, KS 66629
- Non-Kansas providers, file with the local Blue plan
- Timely filing



Unlisted/NOC Procedure Codes

Guides for Prompt Claim Processing

Submit supporting documentation, records, reports for medical and surgical procedures.

- Include narrative/description on claim form where appropriate
- For unlisted DMEPOS items, include UPN in box 19, and manufacturer's invoice

Unclassified/Unlisted Drug Codes

- NDC Qualifier (N4)
- NDC Billing Number (11 digits, no spaces or characters)
- Product package size unit of measure
- NDC Units
- One unit of service (Box 24G / Field 46)

RHC & FQHC Billing

Providers must bill Blue MA in the same manner they bill Original Medicare.

Services performed at an RHC payable as a RHC, or performed at an FQHC payable as an FQHC, are billed to Blue MA on a UB-04 claim form.

- RHC & FQHC services outside of the CMS all inclusive rate should be billed on a CMS 1500 claim form.
- Reimbursement will be the same as original Medicare.
- A copy of the current rate letter is necessary to be provided at initial contracting and each following year when CMS provides updated interim rate letters for RHC and CAH.
- Reference Medicare Claims Processing Manual, Chapter 9, and Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13.

DME Provider Records

Ensure you're ready to bill DME HCPCS Codes

If it's billed to the DMERC, Complete DME Credentialing

- DME Supplier record is needed for HCPCS codes that are normally filed to the DME Medicare Contractor (Noridian)
- If you have a separate DME NPI, utilize for Blue MA
- Differs form commercial business
- Special Instructions for claims filing

Chiropractic Billing

Coding & Coverage

Blue MA follows Medicare/Part B coverage and billing guidelines

- Spinal Chiropractic Manipulative Treatment (CMT) only (CPT Codes 98940-98942)
- Active Treatment / AT Modifier
- Segmental and somatic diagnosis (precise level of subluxation) primary, symptom/condition codes secondary (neuromusculoskeletal condition necessitating treatment)
- Date of initiation of treatment course
- Documentation requirements

Additional Information & Resources:

WPS GHA Local Coverage Article A56273 “Billing and Coding: Chiropractic Services)

Publication 100-02 Medicare Benefit Policy Manual Chapter 15 Covered Medical and Other Health Services: §30.5, 40.4, 220, 240

Publication 100-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, §220

Kansas Preferred Blue Medicare Advantage Provider Manual

Member Evidence of Coverage

Health Equity and Social Determinants of Health

BCBSKS is committed to addressing disparities in care by recognizing and improving environmental and societal conditions and advancing health equity and inclusion.

SDoH codes in ICD-10-CM Chapter 21:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

Medical Policy & Reimbursement

CMS Resources

Claims are processed in accordance with Original Medicare:

- National Coverage Determinations
- Local Coverage Determinations
  - WPS GHA (J5 MAC Part B) or Noridian (JD DEMRC)
- Billing Articles

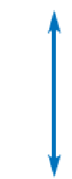
Providers should follow all applicable Original Medicare guidelines, including:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, you must supply all applicable digits.
- Follow National coding guidelines (NCCI).
- Medicare Part B supplier number, national provider identifier and federal tax identification number.

Medical Policy Hierarchy

In terms of the sequence of prior authorization review, BCBSKS will first reference existing National Coverage Determinations (NCD) or Local Coverage Determinations (LCD). If neither of these exist, BCBSKS will reference InterQual criteria (Acute Adult, Subacute/SNF, Long-Term Acute Care Rehabilitation).

National Coverage Determinations (NCD) or Local Coverage Determinations (LCD)



InterQual Criteria
(Acute Adult, Subacute/SNF, Long-Term Acute Care Rehabilitation)

Prior Authorization

For medical, only required for the following inpatient services:

- Acute Inpatient Hospital Admissions
- 14 Day Bundling for Readmissions
- Long Term Acute Care Hospital Admission
- Skilled Nursing Facility Admissions
- Inpatient Rehabilitation Admissions
- Mental Health and SUD Inpatient Admissions

Inpatient Prior Authorization Submission

Phone:

- Prior Auth/Utilization Management team – 800-325-6201
- MA Provider Services (eligibility/benefits) – 800-240-0577

Online:

- Symphony
  - Login and resources through the BlueMA Medical Provider Portal
  - Availity > Payer Spaces > BCBSKS > Blue MA Medical > Authorizations

Fax:

- 877-218-9089

CLEAR FORM

Prior Authorization Request Form

☐ **Please Expedite***

Justification for Expedited Request:

If no justification given, request will be processed as standard

Submit requests to:
Fax: 877-218-9089
Phone 800-325-6201

*Please ONLY check this option if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

1. Member Information & Background

Patient Name:	Previous auth # (if applicable):
Member/Patient ID Number:	Contact Name:
Patient DOB: Pt. phone:	Contact Phone: Fax:
Patient Address:	Requesting Provider:
	Requesting Provider NPI#:
ICD-10Code(s):	Treating Provider:
CPT/HCPCS Code(s):	Treating Provider NPI#:
Date of Admission/Procedure: ☐ TBD	Admitting Provider:
Type: ☐ IP Hospital	Admitting Provider NPI#:
# Visits/Units/Days:	Servicing Facility:
Authorization Date Span: -	Svc Facility NPI#:

For inpatient services: If overnight admission is planned, please provide justification (e.g. procedure on CMS inpatient only list). ***Note:*** *Must specify IP admission with appropriate code in CPT Code field above or services are assumed & reviewed as OP setting.*

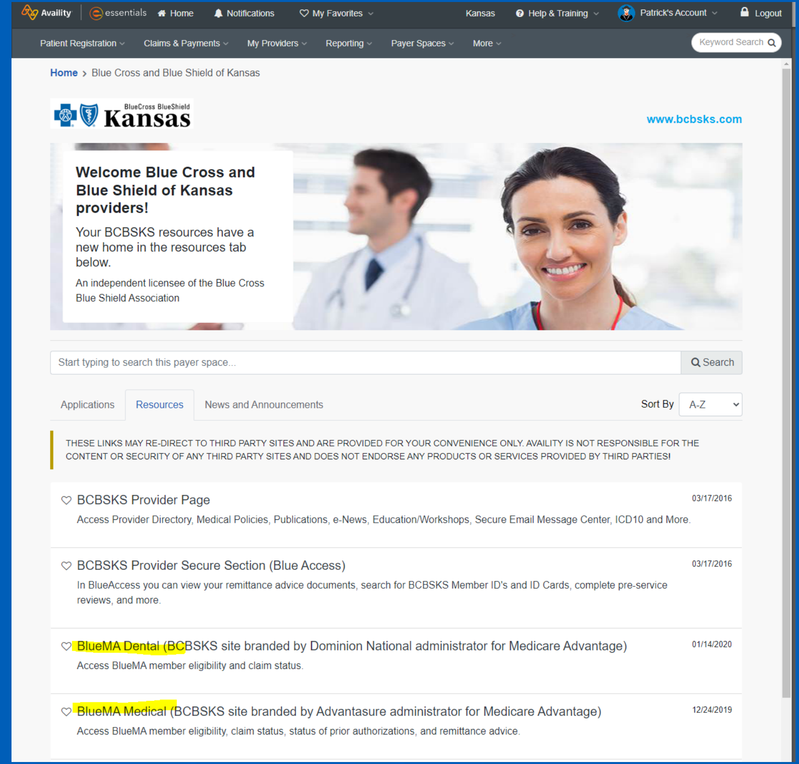
Comments:

This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.

This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Feb 2022 H7063_PriorAuthRqstFrm

Provider Self Service


Availity
essentials
Home
Notifications
My Favorites
Kansas
Help & Training
Patrick's Account
Logout
Patient Registration
Claims & Payments
My Providers
Reporting
Payer Spaces
More
Keyword Search
Home > Blue Cross and Blue Shield of Kansas
BlueCross BlueShield Kansas
www.bcbsks.com
Welcome Blue Cross and Blue Shield of Kansas providers!
Your BCBSKS resources have a new home in the resources tab below.
An independent licensee of the Blue Cross Blue Shield Association
Start typing to search this payer space...
Search
Applications
Resources
News and Announcements
Sort By A-Z
THESE LINKS MAY RE-DIRECT TO THIRD PARTY SITES AND ARE PROVIDED FOR YOUR CONVENIENCE ONLY. AVAILITY IS NOT RESPONSIBLE FOR THE CONTENT OR SECURITY OF ANY THIRD PARTY SITES AND DOES NOT ENDORSE ANY PRODUCTS OR SERVICES PROVIDED BY THIRD PARTIES!
BCBSKS Provider Page
03/17/2016
Access Provider Directory, Medical Policies, Publications, e-News, Education/Workshops, Secure Email Message Center, ICD10 and More.
BCBSKS Provider Secure Section (Blue Access)
03/17/2016
In BlueAccess you can view your remittance advice documents, search for BCBSKS Member ID's and ID Cards, complete pre-service reviews, and more.
BlueMA Dental (BCBSKS site branded by Dominion National administrator for Medicare Advantage)
01/14/2020
Access BlueMA member eligibility and claim status.
BlueMA Medical (BCBSKS site branded by Advantasure administrator for Medicare Advantage)
12/24/2019
Access BlueMA member eligibility, claim status, status of prior authorizations, and remittance advice.

Online Inpatient Prior Authorization

LOGOUT

HOME | ELIGIBILITY & BENEFITS | CLAIMS & REMITTANCE ADVICE | AUTHORIZATIONS | FORMS & RESOURCES

Welcome, Patrick

This website provides the ability to check your patient's eligibility, benefits, and allow the information to be exported. You may check status of claims and also status of authorizations phoned or faxed in. The website provides links to other important sites that involve Blue Medicare Advantage member benefits.

Provider Resources

Authorizations

Symphony

Starting June 5, 2023, Symphony, the tool used to enter authorization requests, will look a little different. To help you navigate the updates, please use the quick guides below.

- Inpatient Quick Reference Guide
- Outpatient Quick Reference Guide
- Part B Quick Reference Guide

Instructions

EOPs

An explanation of payment (EOP) accompanies reimbursement from Blue MA

The EOP provided line-by-line detail, and can be received via:

- Paper/Mailed EOP
- ERA
  - Look for “AD835V5*” file name
  - Not applicable for dental providers

EXPLANATION OF PAYMENTS

BlueCross Blue Shield of Kansas
Address Line 1
Address Line 2
City, State Zip

Tax ID: 123456789
Check Number: 40000017
Check Amount: $7.24
Check Date: 01/01/2019
NPI: 1234567890

Provider Name
Address Line 1
Address Line 2
City, State Zip

Patient Name:	First M Last	Provider/Prof:	Prov Name		
Insured No:	12345678900	Provider/Prof No:	1234567	Network:	Network
Patient No:	12345678900	Employer Name:	Name		
Pat Acct No:	999999999	Employer ID:	999999999	Claim No:	1234567890

Service Dates	Service Code	Quantity	Charged Amount	Allowed Amount	Discount	Coinsurance	Deductible	Copay	Sequestration	Withhold	Paid Amount
01/01/2017 - 01/01/2017	12345	1	$110.00	$3.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.62
EOP Codes: 123,456 Denial Code and Reason											
01/01/2017 - 01/01/2017	12345	1	$110.00	$3.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.62
EOP Codes: 123,456 Denial Code and Reason											
Totals this claim:			$220.00	$7.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.24
Interest paid this claim:											$0.00
Adjustment amount this claim:											$0.00
Total paid this claim:											$7.24
Paid by primary payer:											$0.00
Remark Code: 105											

Post-Service Appeals & Payment Disputes

Payment Disputes for Kansas Blue MA

- Call Provider Inquiry Services
- Submit written First-Level Appeal within 60 days of the initial determination
- Will be reviewed and responded to within 60 days of receipt

Appeal/Dispute Phone	Appeal/Dispute Fax	Appeal/Dispute Mail	Mail Effective 1/1/2024
800-240-0577	800-976-2794	BCBSKS MA Provider Correspondence PO Box 260875 Plano TX 75026	BCBSKS PO Box 211421 Eagan MN 55121

Post-Service Appeals & Payment Disputes

Second-Level

- Must be submitted within 60 days of the initial determination
- Submitted by fax or mail
- The decision rom the Second-Level Appeal will be final and binding.

Appeal/Dispute Phone	Appeal/Dispute Fax	Appeal/Dispute Mail	Mail Effective 1/1/2024
800-240-0577	800-976-2794	BCBSKS MA Provider Correspondence PO Box 260875 Plano TX 75026	BCBSKS PO Box 211421 Eagan MN 55121

Post-Service Appeals & Payment Disputes

Appropriate supporting documentation needed for First and Second Level Part C Appeals includes:

- Provider or supplier contact information including name and address.
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered and provider specialty.
- Reason for dispute, a description of the specific issue.
- Copy of the provider's submitted claim with disputed portion identified.
- Documentation and any correspondence that supports your position that the plan's denial was incorrect including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation, and interim letters when appropriate.
- Appointment of provider or supplier representative authorization statement, if applicable.
- Name and signature of the provider or provider's representative.
- Waiver of liability for non-participating Blue MA providers

BCBSKS Provider Portal Attestation

- Consolidated Appropriations Act (CAA)
- 90-day attestation requirement
- Separate from Availity portal
- Group and Individual provider attestation

GETTING STARTED

1. Select **Provider Information**
2. Select **Provider Information Forms**

GROUP ATTESTATION

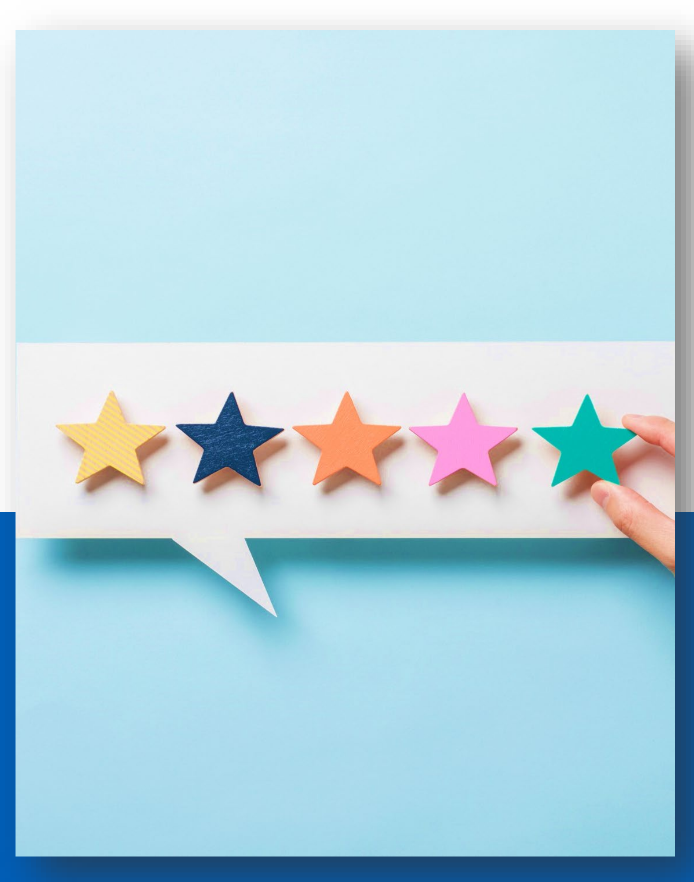
3. Group attestation form
4. Info message stating which requirements will be met with submission
5. Review all group information and update as needed
6. Enter **Contact Info** for person completing attestation
7. Select **Check Box → Submit**
8. Repeat steps 1 & 2 above
9. Uncheck **Box** to see all providers attached to the group
10. Repeat steps 5, 6 & 7 for ***EVERY*** provider attached to the group

SOLO ATTESTATION

11. Solo attestation form
12. Info message stating which requirements will be met with submission
13. Review all solo information and update as needed
14. Enter **Contact Info** for person completing attestation
15. Select **Check Box → Submit**

Section Four

STARS Overview



What is the Medicare star ratings program?

The Centers for Medicare & Medicaid Services (CMS) developed the Medicare star ratings program to help consumers compare Medicare Advantage (MA) health plans based on quality and performance

Ratings are determined using different data sets including, but not limited to:

- HEDIS® Data
- Prescription Drug Event
- CAHPS Survey
- HOS
- Operations Data

By providing high-quality care to patients in a timely manner, providers play a critical role in the star ratings program.

2023 HEDIS® Measures

Addressing Gaps in Care

HEDIS® measures performance in health care where improvements can make a meaningful difference in people's lives.

Measures collected for 2023CY:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Diabetes – Hemoglobin A1c Control for Patients with Diabetes
- Diabetes – Eye Exam for Patients with Diabetes
- Diabetes – Kidney Health Evaluation
- Statin Therapy Cardiovascular Disease
- Statin Use in Persons with Diabetes
- Transitions of Care – Medication Reconciliation
- Transitions of Care – Patient Engagement
- Follow Up after ED Visit with Multiple Chronic Conditions
- Plan All Cause Readmissions
- Medication Adherence – Cholesterol, Diabetes, Hypertension

Healthcare Effectiveness Data Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

2023 MA Provider Incentives

Incentive Payout	Measure(s)
New for 2023	
$50	Uncontrolled blood pressure
$300	Annual wellness visit
Returning for 2023	
$50	Medication Adherence – Cholesterol*, Medication Adherence – Diabetes*, Medication Adherence – Hypertension*
$100	Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patients with Diabetes, Hemoglobin A1c Control for Patients with Diabetes, Statin Therapy Cardiovascular Disease, Statin Use in Persons with Diabetes, Transitions of Care – Medication Reconciliation, Transitions of Care – Patient Engagement
$200	Controlling Blood Pressure

*Previously reported measures, newly incentivized for 2023

Incentive is a fixed dollar amount per star gap closed for the attributed members by the end of the measurement year

HEDIS® & Incentive Support

2022 Clinical Quality Performance - Member Level Detail Report
Blue Cross and Blue Shield of Kansas

BlueCross BlueShield Kansas

Provider Group

Data Through: xx/xx/xxxx - xx/xx/xxxx

Report Generated: xx/xx/xxxx

				Incentivized Measures														
NPI #	Provider Name	Member Name	DOB	Breast Cancer Screening	Colorectal Cancer Screening	Controlling Blood Pressure	Diabetes - Hemoglobin A1c Control for Patients with Diabetes	Diabetes - Eye Exam for Patients with Diabetes	Statin Therapy Cardiovascular	Statin Use in Persons with Diabetes	Transitions of Care - Medication Reconciliation[1]	Transitions of Care - Patient Engagement[1]	Diabetes - Kidney Health Evaluation for Patients with Diabetes	Follow Up after ED Visit with Mulitple Chronic Conditions[1]	Plan All Cause Readmissions[1]	Med Adherence - Cholesterol	Med Adherence - Diabetes	Med Adherence - Hypertension
123456789	WILLIAM SMITH	SUE SMITH	10/4/1952	OPEN	OPEN	OPEN	OPEN	OPEN	-	-	-	-	-	-	-	OPEN	-	OPEN
123456789	WILLIAM SMITH	SUE SMITH	2/24/1950	-	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	7/10/1947	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	12/1/1942	-	-	-	-	-	CLOSED	CLOSED	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	-
123456789	WILLIAM SMITH	SUE SMITH	7/11/1947	CLOSED	-	-	-	-	-	-	-	-	-	-	-	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	6/6/1985	CLOSED	-	-	CLOSED	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	12/10/1952	-	-	-	-	-	-	-	-	-	-	-	-	CLOSED	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	4/23/1955	OPEN	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	OPEN	CLOSED	CLOSED	CLOSED	OPEN	-	CLOSED	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	2/8/1967	CLOSED	CLOSED	CLOSED	OPEN	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	OPEN	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	9/7/1952	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	-	-	-	-	-	-	CLOSED	OPEN	CLOSED
123456789	WILLIAM SMITH	SUE SMITH	11/3/1937	-	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	7/17/1937	-	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-
123456789	WILLIAM SMITH	SUE SMITH	10/6/1954	-	-	-	-	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	CLOSED	-	OPEN	-
123456789	WILLIAM SMITH	SUE SMITH	3/23/1945	OPEN	CLOSED	CLOSED	CLOSED	CLOSED	OPEN	OPEN	OPEN	OPEN	OPEN	OPEN	OPEN	-	OPEN	CLOSED

[1] *This measure may have multiple occurrences based on the number of discharges that occurred during the measure year. Status is **OPEN** if at least one occurrence remains open.*

HEDIS® & Incentive Support

Addressing Gaps in Care

How to Close the Open Gaps

Claim Submission:

- Capturing the CPT or CPTII code supporting the HEDIS service
- Medicare Advantage Stars Tip Sheet / Stars Reference Manual
- 2023 HEDIS® Coding & Reference Guide
- Claims must be adjudicated by February 28, 2024

Record Submission:

- Submit the portion of the medical record that documents the service/test
- Include results and demographic information
- Must be submitted by December 15, 2023
- Fax: 833-505-2348, Attn: HEDIS Ops
- Email the patient's supporting documentation for the services(s) to KSOperations@advantasure.com
- Mail the patient's supporting documentation for the service(s) to:

Blue Cross and Blue Shield of Kansas
PO Box 260
Southfield, MI 48037-0260
Attn: HEDIS Ops, TC1402-E

Professional Relations

Understanding Star Ratings

Blue Cross and Blue Shield of Kansas
2023 Reference Guide

bcbsks.com

Healthcare Effectiveness Data Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Controlling Blood Pressure

Tips to Close Gaps in Care

Measure definition

Patients ages 18–85 in the measurement year who had a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90 mm Hg) as of December 31 of the measurement year.

Information that patient medical records should include

Include all blood pressure readings and the dates they were obtained. The last blood pressure reading of the year will be used for HEDIS compliance determination.

Information that patient claims should include

Blood pressure CPT® II codes can be billed alone on a $0.01 claim or with an office visit. This includes telehealth, telephone, e-visit or virtual visit.

CPT® II code	Most recent systolic blood pressure
3074F	< 130 mm Hg
3075F	130–139 mm Hg
3077F	≥ 140 mm Hg
CPT® II code	Most recent diastolic blood pressure
3078F	< 80 mm Hg
3079F	80–89 mm Hg
3080F	≥ 90 mm Hg

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HEDIS® measures for diabetic patient health

Capturing quality care and improving health outcomes

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Eye Exam for Patients with Diabetes (EED)
- Kidney Health Evaluation for Patients with Diabetes (KED)

HEDIS® measures for diabetic patient health

HBD: Patients ages 18−75 with a diagnosis of diabetes (Type 1 or Type 2) whose HbA1c was adequately controlled (≤9%) as of December 31 of the measurement year.

EED: Patients ages 18−75 with a diagnosis of diabetes (Type 1 or Type 2) who received screening or monitoring for diabetic retinal disease.

- Retinal eye exam by an eye care professional in the measurement year
- Negative retinal eye exam by an eye care professional in the year prior to the measurement year
- Bilateral eye enucleation any time during the patient's history

KED: Patients ages 18−85 with a diagnosis of diabetes (Type 1 or Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ration (uACR), during the measurement year.

CPT® II code	Most recent HbA1c level
3044F	< 7%
3046F	> 9%
3051F	≥ 7% and < 8%
3052F	≥ 8% and ≤ 9%

CPT® II code	Retinal eye exam findings
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
CPT® code	Description
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral (interpreted by artificial intelligence)

CPT® code	Treatment
80047, 80048, 80050, 80053, 80069, 82565	eGFR Lab Test
82043	Quantitative Urine Albumin Test
82570	Urine Creatinine Lab Test

Medication Adherence & Statin Use Measures

Pharmacy Quality Alliance-endorsed performance measures

- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Stain Use in Persons with Diabetes (SUPD)
- SPC and SUPD exclusions must be captured through annual medical claim submission using appropriate ICD-10-CM code
- Medication Adherence
  - Diabetes Medications
  - Hypertension (RAS Antagonists)
  - Cholesterol (Statins)

Health Outcomes Survey (HOS)

Member perception Star Measures

Why is the HOS important?

The goal of the HOS is to gather clinically meaningful health status data from Medicare Advantage patients to support quality improvement activities, monitor health plan performance and improve the health of this patient population.

What is my impact?

Providers can significantly impact how patients assess their health care experience in response to HOS questions.

Improving/Maintaining Physical Health

Does your health now limit you in these activities?

- Moderate activities like vacuuming or bowling
- Climbing several flights of stairs

During the past four weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Monitoring Physical Activity

In the past 12 months, did:

- You talk with a doctor or other health care provider about your level of exercise or physical activity?
- A doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?

Tips for success

- ✓ Ask patients if they have pain, and if so, is it affecting their ability to complete daily activities? Ask what goals the patient has, then identify ways to improve the patient's pain.
- ✓ Determine if your patient could benefit from a consultation with a pain specialist, rheumatologist or other specialist.
- ✓ Consider physical therapy and cardiac or pulmonary rehab when appropriate.

- ✓ Talk to patients about their physical activity and the health benefits of staying active. Studies show that having patients fill out a questionnaire is not enough to gauge their activity level. Show interest in ensuring patients remain active.
- ✓ Develop a plan with your patient to take steps to start or increase physical activity. Offer suggestions based on the patient's physical ability, interests, and access. Schedule a check-in to discuss progress on this plan.
- ✓ Refer patients with limited mobility to physical therapy to learn safe and effective exercises.

Improving Bladder Control

In the past six months, have you experienced 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?

Reducing the Risk of Falling

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 health provider done anything to help you prevent falls or treat problems with balance or walking?

Tips for Success:

- ✓ Ask patients if they have any trouble holding their urine. If yes, ask additional questions.
- ✓ Communicate that urinary leakage problems can be common as we grow older, but there are treatments that can help. Discuss potential treatment options such as behavioral therapy, exercises, medications, medical devices and surgery.
- ✓ Use informational brochures and materials as discussion starters for this sensitive topic.

- ✓ Promote exercise, physical therapy and strengthening and balance activities (tai chi, yoga).
- ✓ Review medications for any that increase fall risk.
- ✓ Discuss home safety tips such as removing trip hazards, installing handrails and using nightlights.
- ✓ Suggest the use of a cane or walker, if needed.
- ✓ Recommend a vision or hearing test.

Consumer Assessment of Healthcare Provider and Systems (CAHPS®)

Member perception Star Measures

Why is the CAHPS important?

Research shows that a positive health care experience for patients is associated with positive clinical outcomes and better business outcomes, including lower medical malpractice risk and less employee turnover.

What is my impact?

Providers significantly impact how patients assess their health care experience.

Overall Rating of Health Care Quality

Using any number between zero and 10, where zero is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last six months?

Getting Appointments and Care Quickly

- How often did you see the person you came to see within 15 minutes of your appointment time?
- When you needed care right away, how often did you get care as soon as you needed?
- How often did you get an appointment for routine care as soon as you needed?

Tips for Success

✓ Survey your patients, asking how you can improve their health care experience
✓ Create a patient council for regular feedback
✓ Remember that every patient contact has an impact on patient perception

✓ Patients are more tolerant of delays if they know the reason for the delay.

✓ Consider implementing advanced access scheduling, offering telehealth, scheduling routine visits and follow-ups in advance.

Care Coordination

- How often did your doc have your medical records or other information about your care?
- When your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- How often did you and your personal doctor talk about all the prescription medicines you were taking?

Getting Needed Care

In the last six months:

- How often did you get an appointment to see a specialist as soon as you needed?
- How often was it easy to get the care, tests or treatment you needed?

Tips for Success

- ✓Administer the flu shot as soon as it's available each fall
- ✓Eliminate barriers to access by offering multiple locations and options for patients to get their shot (walk-in, flu shot clinics, flu shots at every appointment for eligible patients)
- ✓Promote flu shots through website, patient portal , and phone greeting

- ✓ Set realistic expectations
- ✓ When applicable, share how you can help secure an appointment sooner if you have an established relationship with the specialist
- ✓ Explain why certain test or treatments are ordered
- ✓ Patient ownership

Section Five

Risk Adjustment & Remote CDI

What is risk adjustment?

Predicting Health Care Costs

As defined by Centers for Medicare and Medicaid Services (CMS), risk adjustment (RA) predicts the future health care expenditures of individuals based on diagnoses and demographics. This model predicts health care costs based on the actuarial risk of enrollees which is established based on chronic conditions, age, race, socioeconomic status, and gender. The goal of risk adjustment is to mitigate the impact to insurers with higher-risk populations and help manage health insurance premiums annually

How it works?

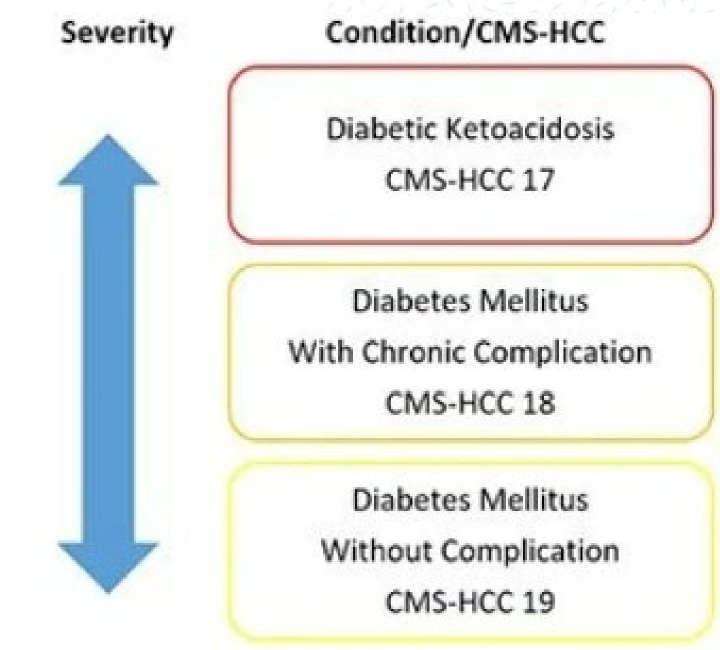
MA Risk Adjustment in Practice

- John and Jane enrolled in Blue Cross and Blue Shield of Kansas Medicare Advantage plans
- CMS Provides a premium to BCBSKS to provide healthcare services for John and Jane
- CMS premium to BCBSKS is not the same for the two

Hierarchical Condition Categories

CMS-HCC based MRA model

- Prospective cost prediction
- Groupings of similar or related diagnosis
- Most significant chronic and acute conditions are included
- Each condition category is assigned a numeric HCC code
- HCC Code assigned a score



Risk Adjustment Factor (RAF)

Risk Adjustment Documentation and Coding Accuracy

- Demographics
- Valid provider signature
- Code to the highest level of specificity
- Accurately document combination codes
- Document co-existing conditions
- Don’t code unconfirmed diagnoses
- Use ‘History of’ codes
- Standard Acronyms/Abbreviations

MEAT Guidelines

Documentation to support ICD-10-CM assignment

- M = Monitoring by ordering or reference labs, imaging studies or other tests
- E = Evaluation with a targeted part of the physical examination specific to a certain diagnosis
- A = Assessment of the status, progression or severity of the diagnosis
- T= Treatment with medication, surgical intervention or lifestyle modification. *Treatment also includes referral to a specialist for consultation or management.*

Examples of MEAT include:

Monitoring

Ordering diagnostic tests:
- "HgbA1c ordered"
- "Chest X-ray ordered"
- "Checking PT/INR"

Referencing test results
- "CT scan of abdomen shows stable AAA"
- "EKG reveals atrial fibrillation"
- "U/A negative for protein"

Evaluation

Targeted physical exam for specific diagnosis:
- PVD – "Dorsalis pedis and posterior tibial pulses are weak"
- Diabetic neuropathy – "Monofilament exam showed decreased sensation"
- COPD – "Diminished air entry with expiratory wheezing on lung exam"

MEAT

Assessment

Status:
- "Stable," "unstable"
- "Well controlled," "poorly controlled," "out of control"

Progression:
- "Worsening," "improving," "unchanged"
- "Doing better," "progressing as expected"

Severity:
- "Mild," "moderate," "severe"
- "Minimal," "significant," "extreme"

Treatment

Medication:
- "Cardizem added," "increased dose of Lasix"
- "Refilled metformin," "continue statins"

Surgical intervention:
- "Femoral artery stented"
- "Malignant melanoma excised"

Lifestyle modification:
- "Diet and exercise discussed"
- "Encouraged to attend AA meetings"

Referral to specialist:
- "Ophthalmologist managing exudative macular degeneration"
- "Follow up with nephrology for secondary hyperparathyroidism"

Documenting conditions managed by specialists

Documentation tips for primary care providers

- Addressing a condition in the medical record refers to the documentation of any monitoring, evaluation, assessment or treatment of the condition, including referral of the patient to a specialist.
- Managing a condition implies being directly involved in medical decision-making, workup, or treatment of the condition
- For MA, as long as the diagnosis is addressed by an approved provider during a face-to-face or A/V telehealth visit, and is supported by documentation, the corresponding ICD-10-CM code can be submitted on a claim.

The CMS Risk Adjustment Participant Guide states, *"Physicians should code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management."*

Clinical Documentation Improvement (CDI)

Better documentation results in better care for patients

The Remote Clinical Documentation Improvement program helps providers:

- Capture their patient's actual severity of illness in the medical record
- Improve risk score accuracy and medical record documentation
- Reduce the chance of a risk adjustment data validation audit
- Increase Star (quality) measure performance
- Earn a $100 incentive for addressing at least one historical or suspected condition

BlueCross BlueShield Kansas

Clinical Documentation Improvement Alert

Please use this alert as a guide during the face-to-face or telehealth (audio and visual component) patient visit. Exercise your independent clinical judgment when addressing these conditions; the fact that a question is asked does not imply that any particular answer is desired or expected. Please note that the alert may not include all conditions or quality measures that exist for this patient.

Select Yes if the documentation from this visit supports the diagnosis indicated, select No if the patient does not have the condition indicated, select Not Addressed if the condition was not addressed during this visit. You can refer to the Reference Tool for further guidance on documentation and coding of specific conditions.

Submit the alert with the office visit notes from the same date of service.

Provider Name: Dr. John Smith Location: Provider Office ABC

Member Name: Jane Doe Member DOB: 3/13/1948 Member ID: 123456 Appointment Date: 2/15/2022

Confirmation of Diagnosis- The following diagnoses have been submitted for this patient in prior claims or supplemental data sent to the payor.

Yes _No _Not Addressed I700 Atherosclerosis of aorta

Yes _No X Not Addressed F3342 Major depressive disorder, recurrent, in full remission

Yes X No _Not Addressed E1122 DM type 2 with diabetic chronic kidney disease

---

Clinical Documentation Improvement Opportunities- Based on medical record review of clinical indicators, we identified the below clinical documentation opportunities.

Yes _No _Not Addressed Obstructive sleep apnea (OSA) noted; please consider screening echocardiogram for pulmonary hypertension given documented risk factor

Yes _No _Not Addressed The following criteria for morbid obesity were noted: BMI >35 with comorbidities of HTN and DM; please assess for morbid obesity and document if appropriate

Yes X No _Not Addressed Patient has chronic asthma, on inhalers; please consider screening with PFT for asthma with chronic obstruction

---

Star Measure Gap Closure- Based on claims data, the following Star Measure Gaps need to be addressed during the patient visit. Please perform the steps indicated below and mark the box.

Test ordered / Patient referred / Service/Test completed _ Not Performed Colorectal Cancer Screening: Patient needs colorectal cancer screening. Please refer patient for colonoscopy for flex sig, or order FOBT or Cologuard test. If already done, please document DOS and place a copy of the report in the chart.

Test ordered / Service/Test completed X Not Performed Breast Cancer Screening: Patient needs mammogram. Please order test. If already done, please document DOS and place a copy of report in chart.

Provider Tax ID: 1234567 Contact Name: Sue Jones

Provider Signature: John Smith M.D. Date: 2/15/2022

2023

Remote CDI Incentive

Earn $100 per attributed patient by participating

Requirements:

- The patient must have Blue Medicare Advantage covered and be attributed to the provider
- Patients must have at least one open diagnosis gap identified from January 1 through September 30
- Open Diagnosis gaps addressed before December 31 during a face-to-face or audio and visual telehealth visit
- Alerts completed and returned with the office visit notes within 14 days of the patient visit

For more information, contact your BCBSKS Professional Relations Medicare Advantage Representative

Section six

2024 CMS Updates and What's ahead for MA

2024 MA Behavioral Health Highlights

- LPCs and LMFTs allowed to offer services under general supervision of Medicare practitioner in 2023. Effective January 1, 2024, will be eligible to enroll as Medicare providers
- Add Clinical Psychology and LSCSWs to network adequacy standards
- Appointment wait times for Primary Care and Behavioral Health
- Require care coordination programs

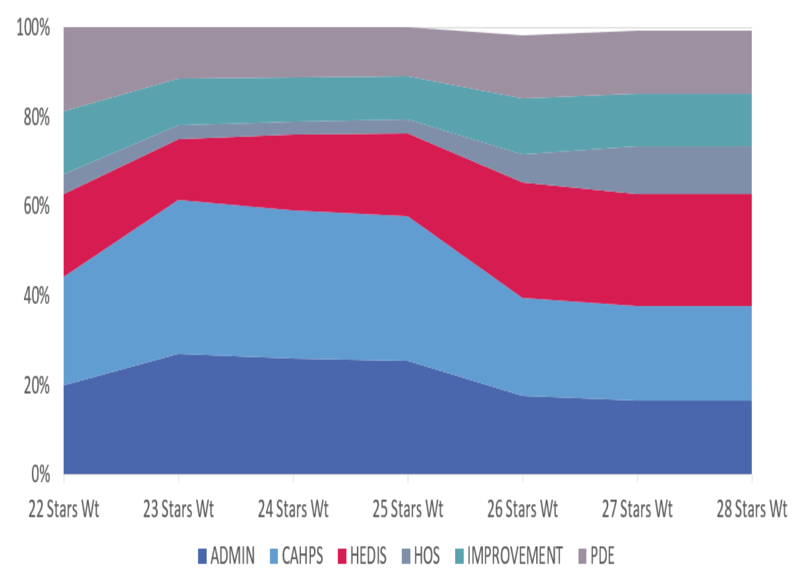
MA Stars Ratings Changes Ahead

Measures and Ratings Changes Addressed in 2024 Final Rule

2024 Measurement Year / 2026 Stars Ratings:

- Patient Experience (CAHPS/HOS) and Access measures drop from 4x to 2x weight
- Add Kidney Health Evaluation for Patients with Diabetes (KED) HEDIS measure
- Implement continuous enrollment to the three Medication Adherence measures
- Not addressed in 2024 Final Rule from December 2022 Proposed Rule:
  - Concurrent Use of Opioids and Benzodiazepines (COB)
  - Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH)
  - Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS)
  - Return of Care for Older Adults – Functional Status Assessment (COA-FSA)
  - Retirement of stand-alone Medication Reconciliation Post-Discharge (MRP)

2025 Measurement Year/ 2026 Stars Ratings – Add Health Equity Index (HEI)



Section Seven

Credentialing and Contracting

Credentialing and Contracting

Preferred Blue Medicare Advantage Network

MA Addendum

Becoming a Preferred Blue MA provider is easy, reach you to your Professional Relations Representative

Benefits of Blue

The value in contracting

The insurer Kansans trust with their health for over 80 years.

- Local member contracts
- Opportunity to earn additional revenue
- Detailed claim-payment information
- Direct payment
- Dedicated field staff
- Electronic remittance advice
- Access to Provider Network Services
- Liaison committees
- Provider directories
- Workshops

Section Eight

Who to Contact

Who to Contact

Provider Services and Requests for Organization Determinations			
	Phone	**Fax**	**Hours of Operation**
Provider Services	800-240-0577	800-976-2794	8 a.m. – 6 p.m. Monday-Friday
Host Member Claim Inquiries	800-432-3990	785-290-0711	7 a.m. – 4:30 p.m. Monday- Friday
Prior Authorization			
	Phone	**Fax/Web Address**	**Hours of Operation**
Prior Authorization Program	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
New Directions Behavioral Health	877-589-1635	https://webpass.ndbh.com/	
Utilization Management and Care Transition			
	Phone	**Fax**	**Hours of Operation**
Utilization Management/ Care Transition	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
After Hours	800-331-0192	877-218-9089	6 p.m. – 8 a.m. Monday-Friday; 24 hours Saturday-Sunday

Professional Relations

- Patrick Artzer, CPC – Medicare Advantage Professional Relations Representative
- Joseph Scherr – Medicare Advantage Professional Relations Support Rep
- Provider Network Services

Institutional Relations

- Beth Downie, CPC –Specialty & Contract Provider Consultant
- Jessica Moore –Provider Consultant
- Karlene Clarke – Provider Consultant

Questions?

bcbsks.com

Patrick Artzer, CPC

Professional Relations

Medicare Advantage Representative

785-291-6289

Patrick.Artzer@bcbsks.com

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