QUALITY+ PARTNERSHIPS

2024 Quality Program Information

- BlueAdvantage (PPO)℠
- BlueAdvantage Freedom (PPO)℠
- BlueAdvantage Extra (PPO)℠
- BlueCare Plus (HMO D-SNP)℠
- BlueCare Plus Choice (HMO D-SNP)℠
- BlueCare Plus Select (HMO D-SNP)℠

of Tennessee

MA PPO — We're Right Here

BlueAdvantage (PPO)℠ **1-800-831-2583**

Provider Engagement and Outreach

Ashley Ward
Director, MA Provider Network Innovation
Office: (865) 588-4628
Mobile: (865) 266-9954
Email: ashley_ward@bcbst.com

Julie Mason, MSSW, LAPSW, CCM
Manager, Provider Engagement and Outreach
Office: (423) 535-6827
Mobile: (423) 618-2562
Email: julie_mason@bcbst.com

Trey Brown
Supervisor, Provider Quality Outreach
East Region
Office: (423) 535-4366
Mobile: (423) 486-8796
Email: treyb_brown@bcbst.com

Natasha Brasher
Supervisor, Provider Quality Outreach
Middle/West Region
Office: (423) 535-8102
Mobile: (731) 693-6364
Email: natasha_brasher@bcbst.com

Pharmacy Quality

Sarah A. Smith, PharmD, BCPS
Quality Pharmacy Director
Office: (423) 535-4566
Mobile: (423) 290-4873
Email: sarah_smith@bcbst.com

Lauren Tunney, PharmD
Manager, Clinical Pharmacy
Mobile: (615) 561-3752
Email: lauren_tunney@bcbst.com

Supplemental Data

Angela Booze, RN, BSN
Clinical Program Manager
Mobile: (901) 356-5967
Email: angela_booze@bcbst.com

Trish Harrell
Provider Quality Outreach Supervisor
Office: (423) 765-7069
Mobile: (423) 765-3614
Email: patricia_harrell@bcbst.com

Member Experience

Carmen Levally, RN, BSN
Manager, Member Experience
Office: (423) 535-8325
Mobile: (423) 888-7663
Email: carmen_levally@bcbst.com

Staci Zink
Member Experience Program Consultant
Office: (901) 544-2351
Mobile: (423) 682-1316
Email: staci_zink@bcbst.com

Brian Oney
Manager, Member Outreach and Retention
Office: (423) 535-6402
Mobile: (423) 255-6351
Email: brian_oney@bcbst.com

HMO D-SNP — We're Right Here

BlueCare Plus Tennessee **1-800-299-1407**

Provider Performance

Tiffany Jackson
Provider Quality Manager
West Region
Phone: (901) 544-2595
Email: tiffany_jackson@bcbst.com

Sam Hatch
Provider Quality Manager
East Region
Phone: (423) 463-4185
Email: sam_hatch@bcbst.com

Member Health Promotion

Rhonda Farriss
Director, Service Operations
Office: (423) 535-4887
Mobile: (423) 309-3664
Email: rhonda_farriss@bcbst.com

Angela Keylon
Manager, Health Promotion
Office: (423) 535-4413
Email: angela_keylon@bcbst.com

April Russell
Consultant, Member Experience
Mobile: (423) 716-7782
Email: april_russell@bcbst.com

Health Care Management

Care Management
1-877-715-9503

Utilization Management
1-866-789-6314

PACF Fax
1-423-591-9504

Table of Contents

INTRODUCTION

QUALITY+ PARTNERSHIPS PROGRAM MEASURES

QUALITY+ PARTNERSHIPS PROGRAM RESOURCES

QUALITY+ PARTNERSHIPS PROGRAM RESOURCES *continued*

QUALITY+ PARTNERSHIPS PROGRAM RESOURCES *continued*

BlueAdvantage (PPO)℠ 2024 Quality+ Partnerships

Your Partner in Quality Care

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

QUALITY+
PARTNERSHIPS

Recognizing providers who provide quality, value-based care

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

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

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

Additional reimbursement is available when you complete Provider Assessment Forms (PAFs). These forms are an important tool for collecting comprehensive information on each patient's current health status annually. They show how all active chronic and acute conditions are documented and managed. PAF forms also help identify opportunities for care and encourage treatment plan implementation throughout the year.

my healthpath®

Members are also rewarded

2024 My HealthPath® Wellness and Rewards Program

We're 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 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've 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 wellness and rewards section of this guide.

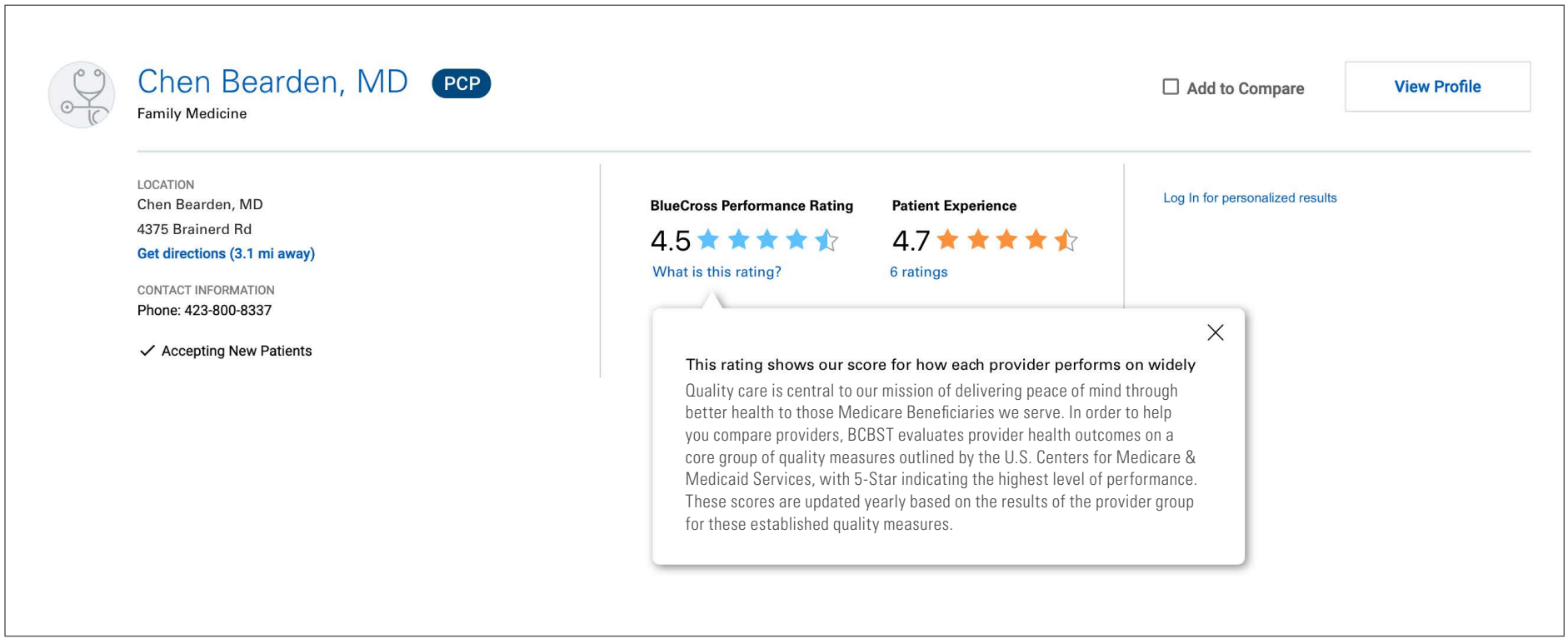
*Members must opt-in to the rewards program to be eligible to earn gift cards. Members may earn rewards for each screening only once per year. Date of service must occur within the calendar year.

> Primary Care Providers (PCPs) performing at 4.0 stars or above have the potential to earn as high as 110% of the current BlueCross Medicare fee schedule.

Highlighting Your Outcomes

We want to take every opportunity to highlight your hard work and success in our Medicare Advantage Star Quality Ratings program. It's important for your current and prospective patients to be able to see the quality outcomes you're achieving.

BlueAdvantage (PPO)℠ Star ratings (combined at the group level) are included in the provider directory for each individual provider. This rating is listed as the **"BlueCross Performance Rating"** and is simply the final Star rating that your group achieved at the end of the 2022 and 2023 program years. The **2022** program year scores display in the directory from April 2023 through March 2024. The **2023** program year scores display in the directory from April 2024 through March 2025.



Thank you for giving your patients peace of mind through better health.

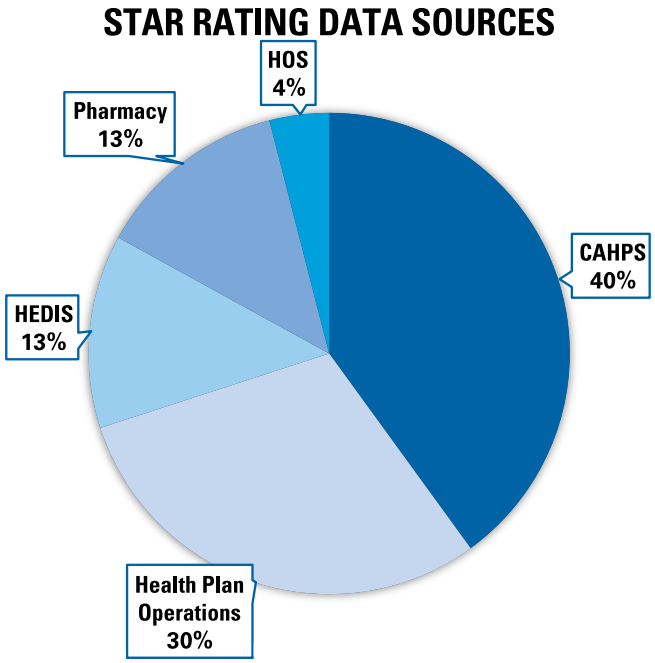
How the CMS Stars Program is Changing

Increasing Emphasis on Member Experience

The Centers for Medicare & Medicaid Services (CMS) has become increasingly focused on the member's quality of life, functional health status and experience with key aspects of their care over the past several years. CMS uses two surveys, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS), to measure the member's experience and self-reported outcomes. These surveys accounted for more than a quarter of overall CMS star quality ratings for health plans.

Specifically, the weight of the CAHPS survey that measures consumer and patient experience with their health plan and care services has been gradually increasing shifting the calculation of Star ratings from a focus on process, outcomes and improvement to a focus on member experience. In an effort to better balance the contribution of measures within the Stars Program, CMS chose to decrease the weight of the CAHPS survey results from 4 to 2 beginning with Stars 2026 (2025 CAHPS survey).

BlueCross and our valued providers share in the accountability of the member's experience by ensuring positive outcomes and providing optimal customer service. To realign with CMS' weight reduction to the CAHPS survey, the weight of the member experience survey measures that are a part of the Quality+ Partnerships program will decrease in 2025. BlueCross continues to recognize the importance of the members' experience and health outcomes. Concerted efforts and strategic focus remain on these quality measures.



Adjustments in Measure Thresholds

Because of continued year-over-year performance improvement across the Medicare Advantage industry, CMS adjusts the definition of "high quality" by moving the thresholds needed to achieve the various star ratings. The adjustment of the star measure thresholds, or cut points, is **retrospective.** CMS takes into consideration how the industry average, as well as outliers, are doing across the measures. These cut points are not made available until CMS performs their analysis of the previous one or two-years' worth of data. BlueCross strives to stay-ahead of the industry average by predicting and projecting these thresholds and applying them to the measures in the Quality+ Partnerships program each year.

In 2023, CMS implemented a methodology that improved the stability and predictability of star measure cut points and prevented them from being influenced by outliers. With this method, extreme outliers were removed from measure scores to prevent them from impacting cut points for all health plans.

2023 was a transition year for this new methodology for our health plan and valued providers. The largest impact to the measure cut points were seen in the 1, 2 and 3-Star thresholds. Providers saw changes to those thresholds for the measures included within our Quality+ Partnerships program for 2023. In 2024, measure thresholds are expected to stabilize and become more predictable, which enables us as a health plan and our providers to invest more confidently in quality improvement initiatives.

What's New for 2024

Measure Changes

- **The Kidney Health Evaluation for Patients with Diabetes (KED)** measure moves from the monitoring section of the program into the scored section of the program as a single-weighted measure.

Member Benefits

- Lower Maximum Out-of-Pocket (MOOP) on majority of plans
- $0 PCP copay on all plans
- Increase in dental allowance for select plans
  - Members have comprehensive dental allowance starting at $2500 for $0 premium plans and as much as $4500 for plans with member premiums.
  - Members also have a wide selection of dental providers in-network.
- Urgent Care visits lowered to $25 on all plans
- $0 copay for routine eye exams*, Medicare eye exams and glasses/frames/contacts allowance starting at $200 per year
- 100-day supply on Tier 1 and Tier 2 drugs

New BlueAdvantage Extra Plan

- Member premium is $0 for those who qualify for Extra Help
- Richer benefits for in-network services include:
  - $0 PCP copay/$25 Specialist copay
  - $175 advanced imaging copay
  - $195 inpatient stays
  - $250 allowance for glasses/frames/contacts
  - $2500 dental allowance
  - Transportation
  - Part D deductible is $0 for those who qualify for Extra Help

Diabetic retinal eye exams are not included in the $0 copay. These exams have a copay, however, members who are enrolled in the My HealthPath Wellness and Rewards program earn a gift card equal to or more than the amount of the copay when receiving a diabetic retinal eye exam.

This information applies to BlueAdvantage (PPO)℠ ONLY

2024 Calendar Year

Medicare Advantage Quality Amendment Measures

Measure Name	Measure Type	Weight	Member Gift Card Available*
Member Experience - CAHPS	CMS Member Survey	4	—
Controlling High Blood Pressure (CBP)	Outcome	3	—
Hemoglobin A1c Control for Patients With Diabetes (HBD)	Outcome	3	—
Medication Adherence for Cholesterol (Statins)	Outcome	3	—
Medication Adherence for Hypertension (RASA)	Outcome	3	—
Medication Adherence for Diabetes Medications (OAD)	Outcome	3	—
Plan All-Cause Readmissions (PCR)	Outcome	3	—
Member Experience - HOS	CMS Member Survey	2	—
Breast Cancer Screening (BCS)	Procedure	1	**$25**
Colorectal Cancer Screening (COL)	Procedure	1	**$20 - $50**
Eye Exam for Patients With Diabetes (EED)	Procedure	1	**$40**
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	Procedure	1	—
Kidney Health Evaluation for Patients With Diabetes (KED)	Procedure	1	—
Osteoporosis Management in Women Who Had a Fracture (OMW)	Procedure	1	—
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Procedure	1	—
Statin Use in Persons With Diabetes (SUPD)	Procedure	1	—
Transitions of Care (TRC)	Procedure	1	—
Measures for Display/Monitoring Status Only			
Annual Wellness Visit (AWV)	Procedure	0	**$20**
Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)	Outcome	0	—
Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)	Outcome	0	—
Member Experience - CAHPS	Cotiviti Mock Member Survey	0	—
Member Experience - HOS	Cotiviti Mock Member Survey	0	—

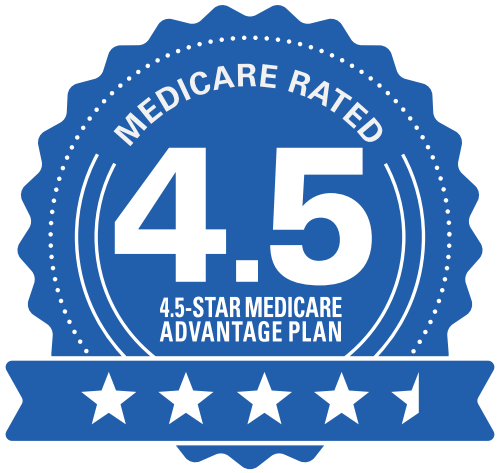
**Please see MA Member Wellness and Rewards table on page 84 for more information.*

This information applies to BlueAdvantage (PPO)℠ and BlueAdvantage Extra (PPO)℠ ONLY

All measures except the pharmacy-related measures apply to BlueAdvantage Freedom (PPO)℠

BlueCross BlueShield of Tennessee Provider Quality Program

The Centers for Medicare & Medicaid Services (CMS) measures BlueCross using 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.



Every year, Medicare evaluates plans based on a 5-star rating system. Rating is for the 2024 plan year.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Breast Cancer Screening (BCS) Percentage of patients **50-74** years old who had a mammogram to screen for breast cancer. **NOTE**: This measure may not apply to the following members any time during the measurement year: • Members in Hospice or using Hospice services any time during the measurement period • 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 • Members receiving palliative care	**Mammogram** between 10/1/2022 - 12/31/2024 for all patients 50-74 years **NOTE**: All of the following types and methods of mammogram qualify: • screening • diagnostic • film • digital • digital breast tomosynthesis Do not count biopsies, breast ultrasounds or MRIs.	**Encounter/Claim with Codes:** **CPT®:** 77055, 77056, 77057, 77061-77063, 77065-77067, 87.36, 87.37 **HCPCS:** G0202, G0204, G0206, **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 39150-8, 39152-4, 39153-2, 39154-0, 42168-5, 42169-3, 42174-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46342-2, 46350-5, 46351-3, 46354-7, 46355-4, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3	Any time during member's history through 12/31/2024: **Bilateral mastectomy** **ICD-10-CM:** 0HTV0ZZ, Z90.13 **CPT®:** 85.42, 85.44, 85.46, 85.48 **OR Unilateral mastectomy:** **CPT®:** 19180, 19200, 19220, 19240, 19303-19307, Z90.11 (absence of right breast), Z90.12 (absence of left breast) **ICD-10-CM:** 0HTU0ZZ, 0HTT0ZZ With bilateral modifier: 50, codes must be on the same claim 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. **Gender-Affirming chest surgery:** **CPT®:** 09318 The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history. The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women. The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.

Helpful Tips:

- Clearly document in the medical record the date the mammogram or mastectomy/mastectomies were performed.
- The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Colorectal Cancer Screening (COL) Percentage of members **45-75** 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 or using Hospice services any time during the measurement year • 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 • Members receiving palliative care **NOTE**: The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.	**Fecal occult blood test** (gFOBT, FIT) during 2024 • gFOBT requires 3 returned samples • FIT requires 1 returned sample **AND/OR** • **Flexible sigmoidoscopy** during 2024 or last 4 years **AND/OR** • **Colonoscopy** during 2024 or last 9 years • **CT Colonography** during 2024 or during the last 4 years • **Stool DNA with FIT Test** during 2024 or during the last 2 years **NOTE:** Clear documentation of gFOBT/FIT, colonoscopy, sigmoidoscopy, CT colonography or stool DNA test, including year performed, is required. • FOBT screenings performed in an office setting or performed on a sample collected by digital rectal exam do not count. • Clearly document type of FOBT screening performed with exact date(s) of sample(s) returned.	**Encounter/Claim with Codes:** **Fecal occult blood test** between 1/1/2024 and 12/31/2024 **CPT®:** 82270, 82274 **HCPCS:** G0328 **LOINC:** 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6 **Flexible sigmoidoscopy** between 1/1/2020 and 12/31/2024 **CPT®:** 45330-5, 45337-42, 45345-7, 45349-50 **HCPCS:** G0104 **Colonoscopy** between 1/1/2015 and 12/31/2024 **CPT®:** 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS**: G0105, G0121 **CT Colonography** between 1/1/2020 and 12/31/2024 **LOINC:** 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3 **CPT®**: 74261-74263 **FIT-DNA Test** between 1/1/2022 and 12/31/2024 **CPT®:** 81528 **HCPCS:** G0464 **LOINC:** 77353-1, 77354-9	Any time during member's history through 12/31/2024: **Colorectal cancer** **ICD-10-CM:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 **HCPCS:** G0213-G0215, G0231 **AND/OR** **Total Colectomy** **CPT®:** 44150-44153, 44155-44158, 44210-44212 **ICD-10-CM:** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Osteoporosis Management in Women Who Had a Fracture (OMW) Percentage of women **67-85** years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture. **NOTE:** Fractures of finger, toe, face and skull are not included in this measure **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice or using Hospice services any time during the measurement year • 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 • Members who received palliative care any time during the measurement period **NOTE:** For measurement year 2024, this measure looks at fractures that occur from July 1, 2023 through June 30, 2024.	• Perform **bone mineral density testing** within **six** months on members 67-85 years old who experience a fracture **AND/OR** • Prescribe a **medication to treat osteoporosis** within six months of a fracture **NOTE:** Calcium alone does not meet criteria to close the gap in care	**Encounter/Claim with Codes: Bone Mineral Density Testing** **CPT®:** 76977, 77078, 77080, 77081, 77085, 77086 **ICD-9-PCS:** 88.98 **ICD-10-PCS:** BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **AND/OR** **Pharmacy Claim for Osteoporosis Drug Therapy:** **HCPCS:** J0897, J1740, J3110, J3111, J3489, J3111	**Bone mineral density testing** during 24 months prior to fracture: **CPT®:** 76977, 77078, 77080-77081 **ICD-10-PCS:** BP48ZZ1, BP49ZZ1, BP4GZZ1-BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, B104ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **AND/OR** **Osteoporosis therapy** during 12 months prior to fracture: **Injectables** **HCPCS:** J0897, J1740, J3110, J3489 **AND/OR** **Dispensed or active oral prescription to treat osteoporosis** during 12 months prior to fracture: • Listing of Approved Therapies (next page)

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Osteoporosis Management in Women Who Had a Fracture (OMW) **(Continued)**		**HCPCS:** S2360 **ICD-10-CM (Common codes. Refer to HEDIS Technical Specifications and Value Sets for full list of codes):** S22.00A, S22.080A, S22.31XA, S22.32XA, S22.41XA, S22.42XA, S32.010A, S32.020A, S32.039A, S32.049A, S32.10XA, S32.591A, S32.592A, S32.810A, S42.201A, S42.202A, S42.211A, S42.212A, S42.241A, S42.252A, S42.291A, S42.292A, S42.301A, S42.302A, S52.501A, S52.502A, S52.531A, S52.532A, S52.571A, S52.572A, S52.611A, S72.001A, S72.002A, S72.012A, S72.031A, S72.141A, S72.142A, S72.22XA, S82.002A, S82.031A, S82.142A, S82.241A, S82.251A, S82.61XA, S82.831A, S82.841A, S82.842A, S82.851A, S82.852A, S92.352A	

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 patients 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**: abaloparatide, denosumab, raloxifene, romosozumab, teriparatide
- The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Controlling High Blood Pressure (CBP) Percentage of members **18-85** years old who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during 2024. **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice or using Hospice services any time during the measurement year • 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 • Members who die during the measurement year • Members receiving palliative care any time in the measurement year **NOTE:** The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.	The **most recent** BP in 2024 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. **NOTE:** Blood pressure readings can be taken by the patient **during** interactive audio/video, telephonic, e-visit, or virtual check-ins as long as a **digital device** is used. • Blood pressure readings using a manual blood pressure cuff and stethoscope by the patient during interactive audio/video, telephonic, e-visit, or virtual check-ins cannot be used for the CBP measure. • Documentation in the medical record ***does not need to state*** that the BP was taken with a digital device or not taken with a manual device, but if the documentation specifically states that the BP was taken with a manual blood pressure cuff and stethoscope, it is not eligible for use in closing the CBP gap in care.	**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 **CPT® II**: • Systolic – If less than 130, use **3074F** – If between 130 and 139, use **3075F** • Diastolic – If less than 80, use **3078F** – If between 80 and 89, use **3079F** **NOTE:** If CPT® II codes are used for BP values ≥140 systolic and/or ≥90 diastolic (not listed above), the measure will not be considered compliant. Values for the last BP of the year must be ≤139/89 to be compliant.	**ESRD, dialysis, nephrectomy or kidney transplant** anytime on or before 12/31/2024: **CPT®:** 90935, 90937, 90945, 90947, 90997, 90999, 99512, 50360, 50365, 50380 **HCPCS:** G0257, S9339; S2065 **ICD-10-CM (ESRD):** N18.5, N18.6, Z99.2, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z **ICD-10-CM (kidney transplant):** 0TY00Z0-0TY00Z2, 0TY10Z0-0TY10Z2 **AND/OR** **Members with a diagnosis of pregnancy** anytime during 2024: **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 2024

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Eye Exam for Patients With Diabetes (EED) Percentage of members **18-75** years of age with diabetes (types 1 and 2) who had a retinal eye exam. **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice or using Hospice services any time during the measurement year • 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 • Members receiving palliative care any time during the measurement year **NOTE:** The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.	A **retinal or dilated eye exam by an optometrist or ophthalmologist** in 2024 **OR** A **retinal or dilated eye exam negative for retinopathy by an optometrist or ophthalmologist** in 2023 **OR** **Bilateral eye enucleation** anytime during the member's history through 12/31/2024 Encourage and/or refer member to see an eye care professional for a comprehensive eye exam in 2024. **Obtain and place copy of all 2023 and 2024 eye exams with results in the member's medical record.** **In order to use 2023 exams to close the eye exam gap for 2024, documentation in the medical record must clearly indicate results were negative for retinopathy.** **NOTE**: A standard or routine eye exam is not the same as a diabetic retinal eye exam. Patients with diabetes need to have a **retinal eye exam** to detect eye problems caused by diabetes. Encourage your patients to complete a **retinal eye exam** during their routine eye exams.	**Encounter/Claim with Codes:** **Retinal or Dilated Eye Exams (When billed by an eye care professional, i.e. optometrist, ophthalmologist)** **CPT®:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245 **CPT® II:** 2022F, 2023F, 2024F, 2025F, 2026F, 3072F **HCPCS:** S0620, S0621, S3000 **NOTE:** Providers performing retinal imaging in office and sending results to eye care professionals to review and interpret should use CPT® II codes 2022F, 2023F, 2024F, 2025F, 2026F, 2033F or 3072F. **Unilateral Eye Enucleation with a bilateral modifier OR Left Unilateral Eye Enucleation and Right Unilateral Enucleation on the same or different dates of service OR Two Unilateral Eye Enucleations with service dates 14 days or more apart** **CPT®:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114 **ICD-10-PCS:** 08T1XZZ, 08T0XZZ	**Non–diabetic members** during 2023 and 2024 and: **Diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes** during 2023 or 2024: **ICD-10-PCS:** O24.410-O24.439 **NOTE:** Blindness is not an exclusion for a diabetic eye exam.

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Hemoglobin A1c Control for Patients With Diabetes (HBD) Percentage of members **18-75** years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was ≤9.0% during 2024. **NOTE**: This measure may not apply to the following members anytime during the measurement year: • Members in Hospice or Hospice services any time during the measurement year • 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 • Members receiving palliative care any time during the measurement year	Diabetes management so that all members have the most recent **HbA1c in 2024 ≤9.0%**	**Encounter/Claim with Codes:** **CPT®:** 83036, 83037 **CPT® II:** 3044F, 3051F, 3052F **NOTE:** In order to meet criteria, HbA1c must be ≤9.0% A copy of all lab results should be kept in patient's medical record	**Non–diabetic members** during 2023 and 2024 and: **Diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes** during 2023 and 2024: **ICD-10-CM:** O24.410-O24.439

Helpful Tips:

The last documented A1C of the measurement year must be ≤9.0% in order to close the gap in care.

- Perform A1C screening earlier in the year to allow time for interventions to decrease result to ≤9.0%.
- Repeat screenings for readings >9.0%.
- Encourage lifestyle changes and adherence to treatment regimens that will help bring A1C under control.
- The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What to Report (Sample of Codes)	Exclusions
Kidney Health Evaluation for Patients With Diabetes (KED) The percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during the measurement year. **NOTE:** This measure may not apply to the following members anytime during the measurement year: • Members receiving palliative care any time during the measurement year • 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 • Members 81 years of age and older with frailty	Members must receive **both** of the following in 2024 on either the same or different dates of service: • At least one estimated glomerular filtration rate (**eGFR**) • At least one urine albumin-creatinine ratio (**uACR**) identified by either of the following: - **Both** a quantitative urine albumin test **and** a urine creatinine test with service dates **four** or fewer days apart. - A uACR	**Encounter/Claim with Codes:** **Estimated Glomerular Filtration Rate (eGFR)** **CPT®:** 80047, 80048, 80050, 80053, 80069, 82565 **LOINC:** 50044-7, 50210-4, 62238-1, 70969-1 **Quantitative Urine Albumin Test** **CPT®:** 82043 **LOINC:** 14957-5, 1754-1, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7 **Urine Creatinine Lab Test** **CPT®:** 82570 **LOINC:** 20624-3, 2161-8, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5 **Urine Albumin-Creatinine Ratio Lab Test** **LOINC:** 13705-9, 14958-3, 14959-1, 30000-4, 32294-1, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9, 9318-7	**Members in Hospice or using Hospice services any time during the measurement year** **Members with evidence of ESRD or dialysis** anytime in the member's history on or before 12/31/2024: **ICD-10-CM (ESRD):** N18.5, N18.6, Z99.2 **ICD-10-CM (Dialysis):** 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z **CPT® (Dialysis):** 90935, 90937, 90945, 90947, 90997, 90999, 99512 **HCPCS (Dialysis):** G0257, S9339 **Non-diabetic members** during 2023 and 2024 and: **Diagnosis of polycystic ovarian syndrome, gestational or steroid-induced diabetes** during 2023 and 2024: **ICD-10-CM:** O24.410-O24.439

Helpful Tips:

- The data for this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®.
- If attesting to this measure in the QCR, **you must perform multiple attestations** to capture all testing dates. The QCR doesn't support selection of multiple components on a single attestation. You will need to perform an attestation **separately for each testing date for each testing component and date of service.** If a urine albumin test and a urine creatinine test are used to satisfy the uACR test component, perform an attestation for each of those tests with appropriate dates of service in addition to an attestation for the eGFR test **(3 total attestations)**. Use the "Part 1" and "Part 2" attestation options to submit each uACR test component.

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What to Report (Sample of Codes)	Exclusions
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) The percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions, and who had a follow-up service within 7 days of the ED visit. **NOTE:** Eligible chronic conditions include: • COPD and asthma • Alzheimer's disease and related disorders • Chronic kidney disease • Depression • Heart failure • Acute myocardial infarction • Atrial fibrillation • Stroke and transient ischemic attack **NOTE:** If a member has more than one ED visit in an 8-day period, only the first ED visit is counted. ED visits that result in an inpatient stay aren't counted.	A follow-up service within 7 days after the ED visit (8 total days). Visits on the same day as the ED visit are included. • An outpatient visit • A telephone visit • Transitional care management services • Case management visits • Complex care management services • An outpatient or telehealth behavioral health visit • An intensive outpatient encounter or partial hospitalization • A community mental health center visit • Electroconvulsive therapy • A telehealth visit • An observation visit • An e-visit or virtual check-in **NOTE:** The data for this measure comes from administrative claims or attestation for **telephone visits only** in the Quality Care Rewards (QCR) application in Availity®. Supporting telephone visit documentation is **required** to be submitted with the attestation. Attestation for any other type of follow-up visit is not available.	**Encounter/Claim with Codes:** **Outpatient Visits** **CPT®:** 98960-98962,99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99429, 99455-99456, 99483, 99492-99494, 99510 **HCPCS:** G0155, G0176, G0177, G0402, G0409, G0438, G0439, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, M0064, T1015, **Telephone Visits** **CPT®:** 98966-98968, 99441-99443 **Transitional Care Management Services** **CPT®:** 99495, 99496 **Case Management Visits** **CPT®:** 99366 **HCPCS:** T1016, T1017, T2022, T2023 **Complex Care Management Services** **CPT®:** 99439, 99487, 99489, 99490, 99491 **HCPCS:** G0506 **Telehealth Visits** **CPT®:** 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255 **NOTE:** Telehealth visits must be filed with POS 02 in addition to CPT® code. **Observation Visits** **CPT®:** 99217-99220 **E-Visit or Virtual Check-Ins** **CPT®:** 98969-98972, 98980, 98981, 99421-99423, 99444, 99457, 99458 **HCPCS:** G0071, G2010, G2012, G2061-G2063, G2250-G2252	**Members in Hospice or using Hospice services any time during the measurement year**

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Transitions of Care (TRC) The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported: • Notification of Inpatient Admission • Receipt of Discharge Information • Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge **NOTE:** Members may be in the measure more than once if there are multiple discharges during the measurement year. • All discharges on or between January 1 and December 1 of the measurement year are included. • For direct transfers or readmissions within 30 days of discharge, only the last discharge counts. • The admission date could have occurred in 2023 if the discharge is between January 1 and December 1 of 2024. **NOTE:** Rates for this measure are calculated using the average of the rates of each of the four (4) components.	This measure has four distinct components that have to be met (in order of priority): **1. Patient Engagement After Inpatient Discharge** Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. **Any** of the following meet criteria **within 30 days after discharge:** • An outpatient visit, including office visits and home visits • A telephone visit • Transitional care management services • A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication. • An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and provider). **NOTE:** Don't include patient engagement that occurs on the date of discharge. • Use weekly discharge reports available in the Quality Care Rewards (QCR) application to schedule post-hospital visits with the member. • If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria. **2. Medication Reconciliation Post-Discharge** Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, or registered nurse, as documented through either administrative coding or medical record review on the date of discharge through 30 days after discharge (31 total days).	**1. Patient Engagement After Inpatient Discharge** **Encounter Claim with Codes:** **Outpatient Visits** **CPT®:** 99201-99205, 99211-99215, 99241-99245, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483; **Home Visits:** 99341-99345, 99347-99350 **HCPCS:** G0402, G0438, G0439, G0463, T1015 **UBREV:** 0510-0517, 0519-0523, 0526-0529, 0982, 0983 **Telephone Visits** **CPT®:** 98966, 98967, 98968, 99441, 99442, 99443 **Transitional Care Management Services** **CPT®:** 99495, 99496 (also closes medication reconciliation) **E-Visits or Virtual Check-Ins (Online Assessments)** **CPT®:** 98969, 98970, 97971, 98972, 99421, 99422, 99423, 99444, 99457, 98980, 98981, 99458 **HCPCS:** G0071, G2010, G2012, G2061, G2062, G2063, G2250-G2252 **2. Medication Reconciliation Post-Discharge** **CPT® II:** 1111F **CPT®:** 99495, 99496, 99483 • 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 medication reconciliation was performed during the ensuing face-to-face visit (see TCM billing requirements for additional information and billing requirements).	**Members in Hospice or using Hospice services anytime during the measurement year**

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Transitions of Care (TRC) (Continued)	Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet 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 the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications) • Documentation of the member's current medications with a notation that the discharge medications were reviewed • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service • Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review • Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record • Notation that no medications were prescribed or ordered upon discharge **NOTE:** A medication review is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. The member does **not** have to be present. • Clearly document **date of service and credentials** (prescribing practitioner, pharmacist, or registered nurse). Ensure that reconciliation matches pre-admission medications to discharge medications.	**3. Notification of Inpatient Admission** The data for this component comes from 100% medical record review. Administrative reporting/coding isn't available for this component. **4. Receipt of Discharge Information** The data for this component comes from 100% medical record review. Administrative reporting/coding isn't available for this component.	

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Transitions of Care (TRC) (Continued)	• Only patients **discharged home** are counted in this component. Discharges between facilities aren't 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 criteria, but a face-to-face visit isn't 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. • Use weekly discharge reports available in the Quality Care Rewards (QCR) application to plan for post-hospital visits and/or calls to the member. • Medication reconciliation **cannot** be performed by an LPN or MA. A transition of care phone call made by an LPN or MA is not acceptable. An RN **can** perform the medication reconciliation. • If using a post-discharge follow-up visit for this component, there **must** be evidence in the visit note documenting that the provider was aware of the recent discharge. • A medication reconciliation on the discharge summary **must** be a **complete** reconciliation of the home medication list and the discharge medication list. A list of discharge medications alone isn't acceptable. • Documentation of "post-op/surgery follow-up" without a reference to "hospitalization", "admission" or "inpatient stay" doesn't imply a hospitalization and isn't considered evidence that the provider was aware of a hospitalization. **3. Notification of Inpatient Admission** Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days) that includes evidence of the date when the documentation was received.		

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Transitions of Care (TRC) (Continued)	**NOTE:** The admission date could have occurred in 2023 if the discharge is between January 1 and December 1 of 2024. Any of the following examples meet criteria **within two days of admission:** • Communication between the emergency department, inpatient providers or staff, and the member's PCP or ongoing care provider (e.g., phone call, email, fax). Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via discharge and transfer (ADT) alert system; or a shared electronic medical record system. • Communication about admission to the member's PCP or ongoing care provider from the member's health plan. • Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider. • Indication that the PCP or ongoing care provider placed orders for test and treatments during the member's inpatient stay. • Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. **NOTE:** Documentation of notification that doesn't include a time frame or date when the documentation was received doesn't count. • If a provider receives communication from the facility, emergency department (ED) staff, specialist, etc. of an inpatient admission, the communication **must** be dated. If the facility faxes a notification, the date stamp on the fax is acceptable. Other communications must be dated with a stamp, signature or other written proof to show when the notification of the inpatient admission was received.		

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Transitions of Care (TRC) (Continued)	• If the provider shares an EMR with the discharging facility, a date stamp isn't necessary. The admission History and Physical or admit note can be used as long as BlueCross is aware that the EMR is shared. • If an ED visit results in an inpatient admission, notification that the provider sent the member to the ED does **not** meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission does meet criteria. • Documentation that the member or member's family notified the member's PCP of the admission does **not** meet criteria. **4. Receipt of Discharge Information** Documentation in the medical record must include evidence of receipt of discharge information on the day of discharge through two days after the discharge (three total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an electronic health record (EHR). At a minimum, the discharge information **must** include **all** of the following: • The practitioner responsible for the member's care during the inpatient stay • Procedures or treatment provided • Diagnoses at discharge • Current medication list • Testing results, or documentation of pending tests or no tests pending • Instructions for patient care post-discharge		

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Transitions of Care (TRC) (Continued)	**NOTE:** Documentation of notification that doesn't include a time frame or date when the documentation was received doesn't count. • There **must** be dated evidence when the discharge information or notification was received in the outpatient record. If a provider receives communication from the facility, ED staff, specialist, etc. of a discharge, the communication must be dated. If the facility faxes a notification, the date stamp on the fax is acceptable. Other communications must be dated with a stamp, signature or other written proof to show when the notification of the discharge was received. If the provider shares an EMR with the discharging facility, a date stamp isn't necessary. The discharge summary can be utilized if dictated within the time frame as long as BlueCross is aware that there's a shared EMR. • A discharge summary dictated before the date of discharge isn't acceptable. • If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record within the three-day time frame. • Documentation that the member or member's family notified the member's PCP of the discharge does **not** meet criteria.		

Helpful Tips:

- The data for the **Medication Reconciliation Post-Discharge (MRP)** component of this measure may come from administrative claims or attestation in the Quality Care Rewards (QCR) application in Availity®
- The data for the **Notification of Inpatient Admission (NIA)** and **Receipt of Discharge Information (RDI)** components of this measure are **only** collected by BlueCross Supplemental Data Collection staff through medical record review. These components can **not** be coded on administrative claims or attested to in the Quality Care Rewards (QCR) application in Availity®
- The data for the **Patient Engagement After Inpatient Discharge (PEID)** component of this measure may come from administrative claims or BlueCross Supplemental Data Collection staff through medical record review. This component may **not** be attested to in the Quality Care Rewards (QCR) application in Availity®

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Medication Adherence for Cholesterol (Statins) Percentage of members **18 years and older** with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	Assess all members with a prescription for a **cholesterol medication** for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage adherence.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**ESRD** **Members in Hospice**
Medication Adherence for Hypertension (RASA) Percentage of members **18 years and older** with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **Medications in the renin angiotensin system antagonist class:** • Angiotensin converting enzyme inhibitor (ACEI) • Angiotensin receptor blocker (ARB) • Direct renin inhibitor	Assess all members with a prescription for a **blood pressure medication** for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage adherence.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**ESRD** **One or more prescriptions for sacubitril/ valsartan (Entresto™)** **Members in Hospice**
Medication Adherence for Diabetes Medications (OAD) Percentage of members **18 years and older** with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **NOTE: Members taking insulin are not included in this measure.** **This measure is applicable to the following classes of Diabetes Medications:** • Biguanides • Sulfonylureas • Thiazolidinediones • DPP-IV inhibitors • GIP/GLP-1 receptor agonists • Meglitinides • SGLT2 inhibitors	Assess all members with a prescription for **diabetes medication** for adherence with prescription regimen. Identify any barriers to following their prescribed regimen and encourage adherence.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	**ESRD** **One or more prescriptions for insulin** **Members in Hospice**

Helpful Tips:

Prescriptions should be written to accurately reflect the regimen the prescriber and patient have agreed upon. Schedule follow-up visits before prescriptions expire. Encourage an extended day supply or mail order for stable, chronic medication regimens. Prescription quantities of 30, 90 or 100 day supplies for Tier 1 and Tier 2 prescriptions have the same co-pay when they are filled at preferred or mail order pharmacies. Educate and encourage patients about the purpose and effectiveness of their medications. Only prescriptions filled using the member's Part D benefit are reported to CMS.

These measures do not apply to BlueAdvantage Freedom (PPO)℠.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Statin Therapy for Patients with Cardiovascular Disease (SPC) Percentage of **male members 21-75** years of age and **female members 40-75** years of age who were identified as having clinical **atherosclerotic cardiovascular disease (ASCVD)** and who were dispensed at least one high or moderate-intensity statin. **NOTE:** ASCVD is identified by an event or diagnosis of the following • Ischemic vascular disease • Myocardial infarction, coronary artery bypass grafting, percutaneous coronary intervention or other revascularization event **NOTE:** This measure may not apply to the following members anytime during the measurement year: • 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 • Members receiving palliative care any time during the measurement year	One of the following moderate to high-intensity statin medications must be prescribed and **filled.** Only prescriptions filled using the member's Part D benefit are reported to CMS. • Atorvastatin ≥10 mg daily • Fluvastatin ≥40 mg twice daily • Lovastatin ≥40 mg daily • Pitavastatin ≥1mg daily • Pravastatin ≥40 mg daily • Rosuvastatin ≥5 mg daily • Simvastatin ≥20 mg daily • Amlodipine-atorvastatin ≥10 mg daily • Ezetimibe-simvastatin ≥20mg daily	The data for this measure comes from medical and pharmacy claims. **NOTE:** Attestations in the Quality Care Rewards (QCR) application in Availity® are **only allowed for exclusions and for medications received through cash pay, Patient Assistance programs or from the Veteran's Administration (VA).** A photo of the prescription bottle or pharmacy receipt showing the full label with the patient identification, medication name, dose, route and dispensed date is **required** to be uploaded with the attestation.	**Members in Hospice or using Hospice services any time during the measurement year** Any of the following in 2023 or 2024: • Members with a diagnosis of **pregnancy** • **In vitro fertilization** • Dispensed at least one prescription for **clomiphene** • **ESRD** • **Cirrhosis** Any of the following in 2024: • **Myalgia** • **Myositis** • **Myopathy** • **Rhabdomyolysis** **NOTE:** The diagnosis code for the applicable condition **should** be submitted on a claim to exclude the patient. Documentation of a statin intolerance or contraindication in the chart alone won't exclude the patient. Attestations for SPC exclusions can also be made in the Quality Care Rewards (QCR) application in Availity®. Attestations for exclusions to this measure require documentation to support the exclusion to be submitted with the attestation.

Helpful Tips:

- Muscle pain is a commonly reported adverse effect of statins. Assess for other causes of muscle pain such as fibromyalgia, hypothyroidism, or vitamin D deficiency. Ask about physical exertion and differentiate these symptoms from statin-related pain or weakness which usually affects large muscles on both sides. Try to avoid interacting medications and check for other drugs that can cause muscle symptoms. If muscle symptoms persist, try a low dose of the same or different statin. Consider a statin with fewer drug interactions such as pravastatin or rosuvastatin. Save intermittent dosing as a last resort.
- Ensure the medical record clearly documents the exclusion in the notes. Patients don't have to attempt taking a statin medication once a year to qualify for the muscle pain or muscular disease exclusion. The provider should document in the measurement year that the patient has myalgia or muscle cramps when taking statins as a reason for not being on them.

This measure does not apply to BlueAdvantage Freedom (PPO)℠. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Statin Use in Persons with Diabetes (SUPD) Percentage of members age **40** to **75** who were dispensed at least **two prescriptions** for a **diabetes medication*** (including insulin) and also **received** a single prescription for a **statin medication**. **NOTE:** First diabetes medication fill must occur at least 90 days before the end of the measurement year. *Does not include dapagliflozin and empagliflozin.	One of the following medications must be prescribed and **filled.** Only prescriptions filled using the member's Part D benefit are reported to CMS. Statin Medications: • Atorvastatin (+/- amlodipine, ezetimibe) • Fluvastatin • Lovastatin (+/- niacin) • Pitavastatin • Pravastatin • Rosuvastatin (+/- ezetimibe) • Simvastatin (+/- ezetimibe/niacin)	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare. **NOTE:** This measure **cannot** be attested to in the Quality Care Rewards (QCR) application in Availity®.	**Members in Hospice or using Hospice services any time during the measurement year.** **ESRD** Members with any of the following events or conditions submitted on a claim in the measurement year: • Rhabdomyolysis, myositis or myopathy • Pregnancy, lactation or fertility treatment • Cirrhosis • Pre-Diabetes • Polycystic Ovary Syndrome **NOTE:** The diagnosis code for the applicable condition **must** be submitted on a claim to exclude the patient. Documentation of a statin intolerance or contraindication in the chart alone will not exclude the patient. The condition the diagnosis code refers to doesn't have to necessarily occur in the same year the diagnosis code was submitted. The member's medical chart should reflect a "history of" the condition if the condition isn't acute. These diagnosis codes are intended to close Star measure gaps and don't apply to payment or reimbursement. Only the diagnosis codes for the conditions above will exclude the member from the SUPD measure. Patients must be excluded each measurement year.

Helpful Tips:

Muscle pain is a commonly reported adverse effect of statins. Assess for other causes of muscle pain such as fibromyalgia, hypothyroidism, or vitamin D deficiency. Ask about physical exertion and differentiate these symptoms from statin-related pain or weakness which usually affects large muscles on both sides. Try to avoid interacting medications and check for other drugs that can cause muscle symptoms. If muscle symptoms persist, try a low dose of the same or different statin. Consider a statin with fewer drug interactions such as pravastatin or rosuvastatin. Save intermittent dosing as a last resort.

This measure does not apply to BlueAdvantage Freedom (PPO)℠. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
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 of at least 30 days for two (2) or more unique anticholinergic medications.	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. **NOTE:** Anticholinergic drugs can have adverse effects on many physiological functions, and affect the central and peripheral nervous systems. The use of multiple drugs with anticholinergic effect increases the risk of developing serious adverse effects which include cognitive impairment, an acceleration of neurodegenerative processes, the appearance of psychotic or confusional symptoms, and functionality disturbances. The frequency and severity of dry mouth, urinary retention, constipation and paralytic ileus, increased heart rate and blurred vision may increase when more than one anticholinergic agent is used.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	Members in Hospice

POLY-ACH-A: Anticholinergic Medications

Antihistamines	Antiparkinsonian Agents	Skeletal Muscle Relaxants	Antidepressants
brompheniramine carbinoxamine chlorpheniramine clemastine cyproheptadine dexbrompheniramine dexchlorpheniramine dimenhydrinate diphenhydramine (oral) doxylamine hydroxyzine meclizine triprolidine	benztropine trihexyphenidyl	cyclobenzaprine orphenadrine	amitriptyline amoxapine clomipramine desipramine doxepin (>6 mg/day) imipramine nortriptyline paroxetine protriptyline trimipramine

This measure does not apply to BlueAdvantage Freedom (PPO)℠. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

POLY-ACH-A: Anticholinergic Medications (Continued)			
Antipsychotics chlorpromazine clozapine loxapine olanzapine perphenazine thioridazine trifluoperazine	**Antiarrhythmic** disopyramide	**Antimuscarinics (urinary incontinence)** darifenacin fesoterodine flavoxate oxybutynin solifenacin tolterodine trospium	**Antispasmodics** atropine (excludes ophthalmic and injectable) belladonna alkaloids clidinium-chlordiazepoxide dicyclomine homatropine (excludes ophthalmic) hyoscyamine methscopolamine propantheline scopolamine (excludes ophthalmic)
Antiemetics prochlorperazine promethazine			

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS) The percentage of individuals **65 years and older** with concurrent use of **three (3) or more** unique central-nervous system (CNS)-active medications. **NOTES**: A lower rate indicates better performance. Concurrent use is identified using the dates of service and days' supply of an individual's prescription claims. The days of concurrent use is the count of days during the measurement year with overlapping days' supply of at least 30 days for three (3) or more unique CNS-active medications.	Use of multiple CNS-active medications in older adults represents a frequent cause of adverse medication effects, including problems with mobility, falls, and cognition in older patients. Screening patients' medication lists for multiple CNS-active medications promotes safe medication use and better outcomes for patients.	The data for this measure comes from Prescription Drug Event (PDE) data files submitted by drug plans to Medicare.	Members in Hospice Members with diagnosis of seizure disorders

POLY-CNS-A: CNS-Active Medications				
Antipsychotics aripiprazole asenapine brexpiprazole cariprazine chlorpromazine clozapine fluphenazine haloperidol iloperidone loxapine lumateperone lurasidone molindone olanzapine paliperidone perphenazine pimavanserin pimozide quetiapine risperidone thioridazine thiothixine trifluoperazine ziparasidone	**Antiepileptics** brivaracetam cannabidiol carbamazepine divalproex sodium eslicarbazepine ethosuximide ethotoin felbamate fenfluramine gabapentin lacosamide lamotrigine levetiracetam methsuximide oxcarbazepine perampanel phenobarbital phenytoin pregabalin primidone rufinamide stiripentol tiagabine topiramate valproic acid vigabatrin zonisamide	**Benzodiazepines and Nonbenzodiazepine Sedative/ Hypnotics** alprazolam chlordiazepoxide clobazam clonazepam clorazepate diazepam estazolam eszopiclone flurazepam lorazepam midazolam oxazepam quazepam temazepam triazolam zaleplon zolpidem	**Opioids** benzhydrocodone buprenorphine butorphanol (includes nasal spray) codeine dihydrocodeine fentanyl (includes nasal spray) hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone tapentadol tramadol	**Antidepressants: SNRIs, SSRIs, & TCAs** amitriptyline amoxapine citalopram clomipramine desipramine desvenlafaxine doxepin duloxetine escitalopram fluoxetine fluvoxamine imipramine levomilnacipram milnacipram nortriptyline paroxetine protriptyline sertraline trimipramine venlafaxine

This measure does not apply to BlueAdvantage Freedom (PPO)℠. HEDIS codes can change from year to year. The codes in this document are from the 2023 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 (any diagnosis). 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 a 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 • Members with the principal diagnosis of pregnancy on the discharge claim • The principal diagnosis of a condition originating in the perinatal period on the discharge claim **Exclude non-acute inpatient stays**

This measure applies to all BlueCross Medicare plans. HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What to Report (Sample of Codes)	Exclusions
Member Experience – CAHPS This measure is scored on the combination of two of the Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS) component measure categories: • **Getting Appointments and Care Quickly** • **Care Coordination** **Getting Appointments and Care Quickly Actual Survey Questions** • In the last 6 months, when you needed care right away, how often did you get care as soon as you needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed? **Care Coordination Actual Survey Questions** • In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did they have your medical records or other information about your care? • In the last 6 months, 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? • In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them? • In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? • In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? • In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	Your interaction with patients has a direct impact on their response to the CAHPS survey. Incorporating some simple techniques like those listed below into your daily interactions with patients can provide them with a better experience, help them achieve better health outcomes, and can lead to better patient retention. **Getting Appointments and Care Quickly Survey Tips** • Acknowledge wait times of longer than 15 minutes by apologizing, providing an explanation and giving an approximate time patients can expect to be seen. • Manage patients' expectations when they are significantly early for their appointments, i.e. thank them and explain they may wait longer than 15 minutes. • If you are running behind schedule, please let patients know before they come to the office so they can adjust their arrival or reschedule their appointment. • Ensure a few appointments each day are available to accommodate urgent or unplanned visits. • Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away. • Offer appointments with an NP or PA to patients who want to be seen on short notice but can't be seen by their doctor. • Encourage patients to make their routine appointments for checkups or follow-up visits as soon as they can (weeks or even months in advance). • Proactively schedule patients weeks or months before their tests, screenings or physicals are due. Don't wait for patients to call. • Consider limited-hour Saturday appointments weekly or bimonthly. **Care Coordination Survey Tips** • Establish a system to follow-up on each diagnostic or lab result. • Set appropriate time frames for result communication, i.e. 5 days for normal results, 24 hours for stat results. • Educate patients on established time frames and result communication avenues such as phone calls, mail, patient portal and follow-up visits. • Ask patients how they would prefer to receive test results and provide as requested. • Educate patients on why they are being referred to a specialist and help coordinate the scheduling of referrals and transfer of records rather than assigning this task to the patient. • Educate patients on time frames for obtaining specialist appointments according to their symptoms. Discuss and plan for possible appointment delays. • Standardize your referral tracking process. Set up a system for tracking outstanding referrals once a week and follow-up to ensure care is moving forward. Monitor the response times of referral partners and provide feedback when response times are not satisfactory. • Establish workflow processes to ensure that the PCP is informed of lab results and specialist reports. • If you know patients received specialty care, discuss their visit and the treatment plan they received at their next clinic or telehealth visit.	The data for this measure comes from results of CMS CAHPS ratings for BlueCross BlueShield of Tennessee's Medicare plans.	Members who are not continuously enrolled in the health plan for 6 months.

This measure applies to BlueAdvantage (PPO)℠ plans ONLY.

Measure	What Service Is Needed	What to Report (Sample of Codes)	Exclusions
Member Experience (HOS) This measure is scored on the combination of two of the Health Outcomes Survey (HOS) component measure categories: • **Improving Bladder Control** • **Reducing the Risk of Falling** **Improving Bladder Control Actual Survey Questions** • 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? **Reducing the Risk of Falling Actual Survey Questions** • 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?	Your interaction with patients has a direct impact on their response to the HOS survey. Incorporating some of the simple techniques like the ones listed below into your daily interactions with patients can provide them with a better experience, help them achieve better health outcomes, and can lead to better patient retention. **Improving Bladder Control Survey Tips** • 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. **Reducing the Risk of Falling Survey Tips** • Discuss balance problems, falls, difficulty walking and other risk factors for falls. • Perform the "Get Up and Go" (GUG) test to assess the patient's balance. • Recommend the use of a walker or cane, if appropriate. • Check standing, sitting and reclining blood pressures. • Recommend a physical therapy or exercise program, if appropriate. • Recommend vision and hearing tests, if appropriate. • Perform bone density screenings, especially for patients at risk. • Consider home health performing a home safety assessment to look for risks for tripping.	The data for this measure comes from results of CMS HOS ratings for BlueCross BlueShield of Tennessee's Medicare plans.	

This measure applies to BlueAdvantage (PPO)℠ plans ONLY.

The following measures apply to Medicare Special Needs Plans Only (BlueCare Plus HMO D-SNP)

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Medication Review Percent of plan members age **66 years and older** whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year. **(This information about a yearly review of medications is collected for Medicare Special Needs Plans only.)** **NOTE:** An outpatient visit isn't required to meet criteria for the medication review nor is the member required to be present for the medication review under this measure.	**Medication Review** in 2024 includes any of the following: **Medication list** in the record **AND notation in the medical record of medication review** in 2024 by the prescribing practitioner or clinical pharmacist **AND the date the medication review was performed** **OR** **Medication list signed and dated** in 2024 by practitioner or pharmacist in the medical record **OR** Notation in the medical record in 2024 that the member is **not taking any medication AND the date it was noted** **NOTE**: **Services provided in an acute inpatient setting aren't counted.**	**CPT®:** **Medication Review:** 90863, 99605, 99606, 99483 **CPT® II:** 1159F, 1160F **Transitional Care Management:** 99495, 99496 **HCPCS:** G8427	Members in Hospice Members who die any time during the measurement year

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 isn't sufficient.

HEDIS codes can change from year to year. The codes in this document are from the 2023 specifications.

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Functional Status Assessment Percent of plan members age **66 years and older** whose doctor has performed a functional status assessment to see how well they are able to do "activities of daily living" (such as dressing, eating, and bathing). **(This information about the yearly assessment is collected for Medicare Special Needs Plans only.)**	Documentation of a Functional Status Assessment must include **evidence of a complete functional status assessment performed** in 2024 **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 five 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 four 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 Members who die any time during the measurement year

Measure	What Service Is Needed	What To Report (Sample Of Codes)	Exclusions
Care for Older Adults (COA) - Functional Status Assessment (Continued)	A **Standardized Functional Status Assessment Tool** including but not limited to: • SF-36®. • Assessment of Living Skills and Resources (ALSAR). • Barthel ADL Index Physical Self-Maintenance (ADLS) Scale®. • Bayer ADL (B-ADL) Scale. • Barthel Index®. • Edmonton Frail Scale®. • Extended ADL (EADL) Scale. • Groningen Frailty Index. • Independent Living Scale (ILS). • Katz Index of Independence in ADL®. • Kenny Self-Care Evaluation. • Klein-Bell ADL Scale. • Kohlman Evaluation of Living Skills (KELS). • Lawton & Brody's IADL scales®. • Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales® **NOTE:** The components of the functional status assessment may take place in separate visits in 2024. Functional status assessment related to a single condition, event or body system doesn't meet criteria for a comprehensive functional status assessment. **NOTE: Services provided in an acute inpatient setting aren't counted.**	**CPT® II:** 1170F **HCPCS:** G0438,G0439 **CPT®:** 99483	Members in Hospice Members who die any time during the measurement year

HEDIS codes can change from year to year. The codes in this document are from the 2023 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 2024. (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 2024. 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 don't meet criteria for a pain assessment:** • Notation of a pain management plan alone • Notation of pain treatment alone • Notation of screening for chest pain or documentation alone of chest pain **NOTE: Services provided in an acute inpatient setting aren't counted.**	• **CPT®:** 1125F, 1126F	Members in Hospice Members who die any time during the measurement year

Helpful Tip:

Assess patient's pain at every visit using 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.

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.

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.

QUALITY+ PARTNERSHIPS

Program Resources

of Tennessee

In-Home Screening Partners

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

Vendor	Measure Addressed	Service Provided	Service Site	Communication to Provider
Everly Health	• Hemoglobin A1c Control for Patients With Diabetes • Kidney Health Evaluation for Patients With Diabetes • Colorectal Cancer Screening	**Kits for in-home testing/screening:** • HbA1c • Urine Microalbumin/eGFR/uACR • iFOBT/FIT	In-home kits mailed to patients or provided at BlueCross-sponsored events	Alert values by fax Within range results by mail
Quest Health Connect	• Osteoporosis Management in Women who had a Fracture	**Bone Mineral Density Screening**	In-home	Letter and results by fax
Retina Labs	• Eye Exam for Patients With Diabetes • Hemoglobin A1c Control for Patients With Diabetes • Kidney Health Evaluation for Patients With Diabetes • Colorectal Cancer Screening • Osteoporosis Management in Women who had a Fracture	**Diabetic Retinal Eye Exams** **Kits for in-home screening:** • HbA1c • Urine Microalbumin/eGFR/uACR • iFOBT/FIT **Bone Mineral Density Screening**	In-home or BlueCross-sponsored events	Diabetic Eye Exam urgent results by phone Lab-kit alert values by fax Diabetic Eye Exam and lab-kit negative results by mail Bone Density Screening results by mail
Signify Health™	• Adult BMI Assessment • Annual Wellness Visit* • Hemoglobin A1c Control for Patients With Diabetes • Eye Exam for Patients With Diabetes • Kidney Health Evaluation for Patients With Diabetes • Colorectal Cancer Screening • Controlling Blood Pressure • Osteoporosis Management in Women who had a Fracture	**In-home comprehensive history and physical by a Physician, Physician Assistant or Nurse Practitioner, as well as the following, as appropriate:** • iFOBT/FIT • HbA1c • Urine Microalbumin/eGFR/uACR • Diabetic Retinal Eye Exam • Bone Mineral Density Screening • Peripheral Artery Disease Testing • Spirometry Testing	In-home, virtual/telehealth	Letter and results by mail

This information applies to all BlueCross Medicare plans. *Providers may complete and bill for an Annual Wellness Visit and Provider Assessment Form with patients even when Signify Health completes this service.

In-Office Health Screening Event Partnerships

We're right here to help support you with flexible in-office screening events which can help your patients get recommended preventive screenings.

Services can include:

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

Completed by BlueCross vendor, provider partner and/or your office

*Block-scheduling availability or mammography coach as available

**Facility (block or partner scheduling) or in-home kit

***Block scheduling or in-home scheduling

****In-office or in-home kit

If your patient completes a test that's included in the Medicare Advantage Quality+ Partnerships program, you'll get credit from us and your patient may earn gift cards. BlueCare Plus D-SNP members aren't required to be in the MyHealth Path program to earn gift cards. Gift cards can be used at certain retailers. Check with the plan for more details. Gift card eligibility requirements and some restrictions may apply.

Onsite Support and Education

The BlueAdvantage and/or BlueCare Plus Quality Outreach Team will work together with your office to create a campaign or event which screens your BlueCross BlueShield of Tennessee patients.

Benefits of In-Office Events

- Assistance with educating your patients on the importance of prevention and screening tests
- Increase probability of 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 through increased gap closure and positive member experience
- BlueCross can assist with scheduling your patients for these events

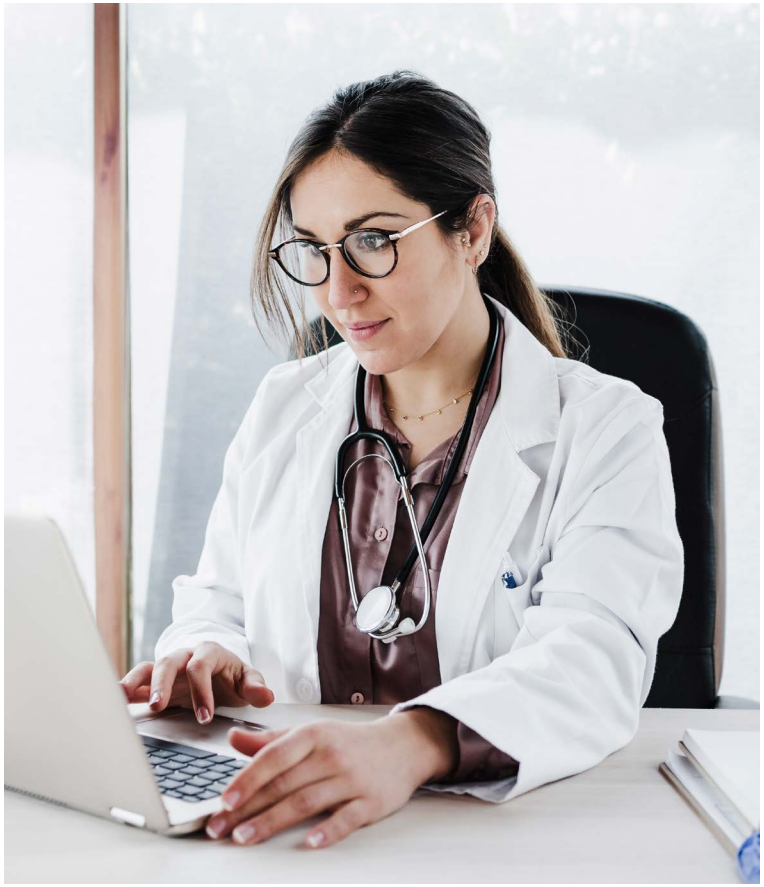
For more information about wellness events or to schedule an event, contact one of our Medicare Advantage Member Experience or Provider Quality Outreach contacts; or one of our BlueCare Plus D-SNP Member Health Promotion or Provider Performance contacts listed at the back of this guide.

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 around **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).
- Ideally, reviews are done through remote access, which are less obtrusive to your office operations. If you're not able to provide remote access, we can make arrangements for onsite visits to obtain the data.
- Our record review is focused on the collection of data that helps you with your practice's performance in the BlueCross Medicare Advantage quality program.
- Practices who grant the quality team remote access to their BlueCross patient records can potentially increase their Stars score by enabling our nurses to record closed gaps earlier and more frequently throughout the year so that you can focus on only the open gaps that are still remaining.



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:

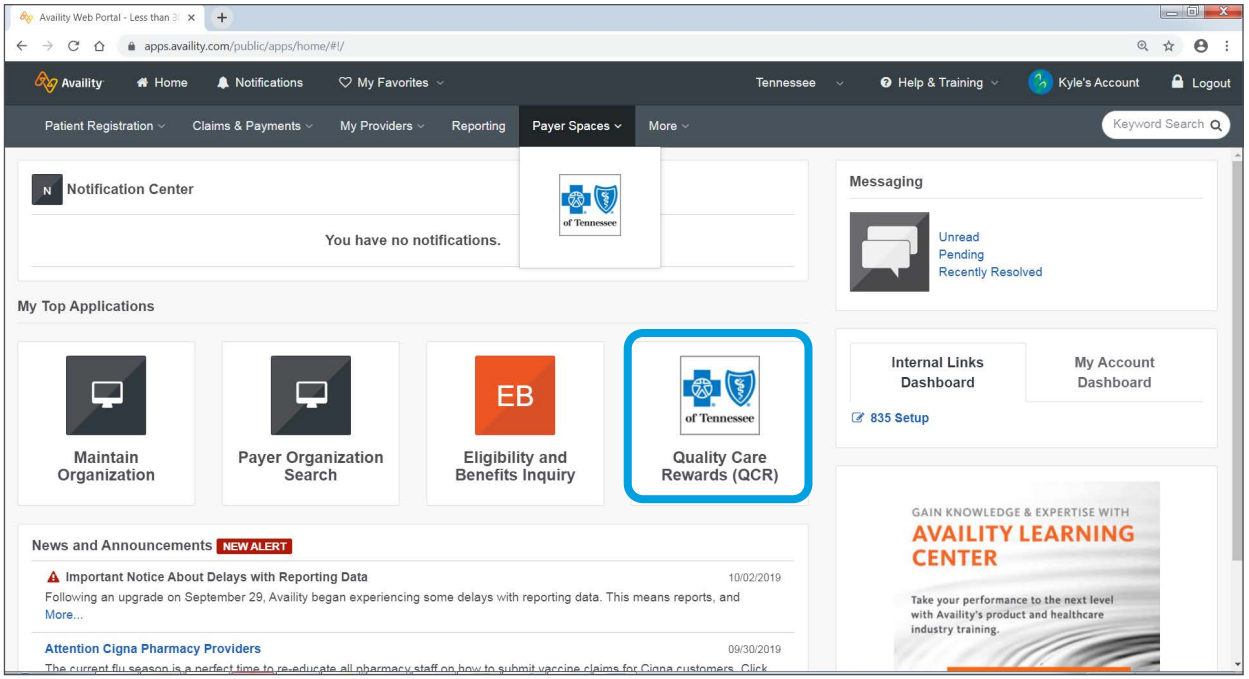
If your practice doesn't have dedicated staff to attest to gap closure in the Quality Care Rewards (QCR) application, our remote access nurses can help.

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, check eligibility status and benefits and review quality program performance online. You can also interact with other managed care plans who use Availity.

For FAQs and more information about using Availity, visit https://availity.com/.

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

Monday through Thursday,
8 a.m. to 6 p.m., ET and
Friday, 9 a.m. to 6 p.m., ET
P: (423) 535-5717, Select Option 2
Email: eBusiness_service@bcbst.com

East Tennessee

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

Middle Tennessee

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

West Tennessee

Vivian Williams
(901) 544-2622
Vivian_Williams@bcbst.com

This information applies to all BlueCross Medicare plans.

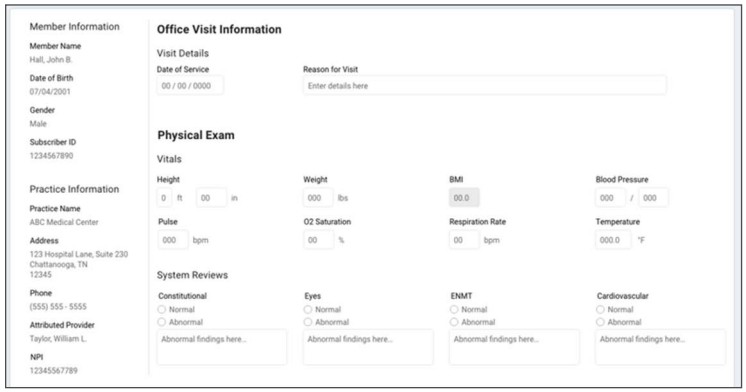
Quality Care Rewards Application

The Quality Care Rewards (QCR) application 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 and/or upload 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.

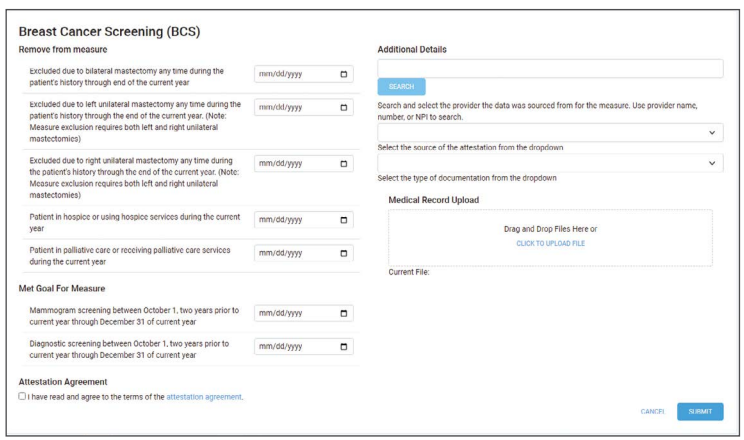
Scorecard

Measure Name	# Elig.	# Comp.	Your Rate	Region Rate	Quality Score	To 1 Star	To 2 Stars	To 3 Stars	To 4 Stars	To 5 Stars	Weight
Comprehensive Diabetes Care (CDC) - HbA1c Control < 9%	628	531	84.55%	81.22%		-250	-124	-49	0	10	3
Controlling High Blood Pressure (CBP)*	2,160	1,689	78.19%	74.22%		-590	-352	-72	0	83	3
Medication Adherence for Cholesterol (Statins)	2,155	1,995	92.58%	92.67%		-252	-144	-80	0	10	3
Medication Adherence for Hypertension (RAS Antagonists)	2,267	2,133	94.09%	93.59%		-345	-186	-118	-50	0	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	653	590	90.35%	90.10%		-49	-23	-10	0	18	3
Plan All-Cause Readmissions (PCR)	400	32	8.00%	8.06%		17	9	1	0	-12	3
Breast Cancer Screening (BCS)	974	843	86.55%	80.28%		-387	-221	-124	-56	0	1
Colorectal Cancer Screening (COL)*	2,136	1,824	85.39%	80.08%		-673	-438	-225	-75	0	1
Comprehensive Diabetes Care (CDC) - Eye Exam*	628	502	79.94%	75.35%		-145	-82	-32	0	13	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	31	25	80.65%	65.88%		-16	-12	-9	-3	0	1
Statin Therapy for Patients with Cardiovascular Disease (SPC) - Received Statin Therapy	304	252	82.89%	80.04%		-10	0	7	13	25	1
Statin Use in Persons with Diabetes (SUPD)	491	419	85.34%	79.08%		-22	-3	0	9	23	1
Transitions of Care (TRC)											1

Provider Assessment Form (PAF)



Attestations



For assistance or more information about the Quality Care Rewards application, 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 Application Tips

General

- The application 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 application after submission.
- All attestations and Provider Assessment Forms completed within the application must be submitted by Jan. 31, 2025 to be processed for the 2024 measurement year.
- Member rosters, located under the Member Roster tile, are updated with the first refresh after the 15th of each month.
- Attestations and assessments completed by a non-clinical user role will show a status of "Pending" and will go into queues for submission by a clinical-level role.
- Check queues under the Approval Queue tile regularly for any attestations or Provider Assessment Forms that need to be submitted by a clinical-level role.
- Pending attestations and assessments that haven't been submitted by a clinical-level role from the queues are automatically deleted after 90 days.
- Use the ADT and Discharge Reports located under the Quality Reports tile to contact members who have had a discharge within the last 30 days for medication reconciliation and/or post-hospital follow-up visits.
- Access the Pharmacy Reports under the Quality Reports tile to view and take action on members needing fills for medications.

Attestations

- Check non-compliant gap lists under the Gap List tile and attest to screenings documented in the medical record that may not have been closed by a claim.
- Use the measure and medical record documentation guidelines and tips found in this program guide when attesting to screenings.
- Practices are **encouraged** to include supporting documentation from the medical record when submitting attestations to close gaps in care. Providing supporting information from the medical record may prevent BlueCross from requesting this information from you during our annual audit and possible attestation removal.
- Supporting documentation from the medical record is **required when attesting to measure exclusions, and attestations to meet criteria for the Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) and the Statin Therapy for Patients with Cardiovascular Disease (SPC) measures.**
- Attestations that have been submitted in error (wrong member, wrong date of service, incorrect information, etc.) can be deleted by the user that entered the attestation. For assistance with attestations submitted by other users, please contact eBusiness.
- Focus on the measures with a red "x" in the Measure Compliance column on the member's page first. This indicates non-compliance in a measure.
- Attestations with a status of "Submitted" have been submitted by the user and are awaiting data refresh for processing.
- Attestations with a status of "Pending" are in a queue to be submitted for processing by a clinical role user.
- Attestations with a "Reconciled" status have been processed for the current measurement year.
- A measure's attestation status can be "reconciled" and the measure still be non-compliant for various reasons (values out of range to meet criteria, attestation from previous year, date of service out of range to meet criteria, etc.).

Quality Care Rewards Application Tips (Continued)

Provider Assessment Forms

- Use the Provider Assessment Form (PAF) (complete online or export) under the Assessments tile or the member page to confirm existing chronic conditions and medications as well as document new chronic conditions and medications.
- Provider Assessment Forms are **now** available for members that are attributed to your practice as well as members who are not attributed to your practice.
- If you search for a member to complete a PAF (or attest to gaps in care) and that member doesn't appear in the search results, they may not be attributed to you. You may use the **Unattributed MA Member Search** link from the search results page to go to the Assessments tile and search for the member using their subscriber ID and date of birth in the Unattributed Member Search tab. Once you locate the member, you'll be asked to attest that the member is your patient by member choice, is being seen in your office for medical care, and has a signed HIPAA form on file in the medical record authorizing the release of information to your practice. The attestation also includes that you understand this attestation doesn't attribute the member to the provider under your contract and that for this member to be attributed to the provider under your contract, the member must complete a PCP Change Form or contact Member Service using the number on the back of their ID card to request a PCP update. Once the attestation is completed, both the Provider Office Reporting and Assessment tabs will be available for this member. You'll then be able to use the Provider Office Reporting tab to attest to gaps in care and the Assessments tab to complete or export the Provider Assessment Form.
- Members may not be on your member roster and have a PAF available without searching for them using their subscriber ID and date of birth for several reasons:
  - Members who have Chronic Kidney Disease (stages 4 or 5) or End Stage Renal Disease are attributed to our renal disease management program partner, **Somatus**. You may still see these members, perform screenings and complete PAFs.
  - Members who have **chosen** another provider for their PCP selection upon enrollment/re-enrollment. You may still complete PAFs for these members after attesting that you're the member's PCP.
  - Members who didn't identify a PCP with BlueCross upon enrollment/re-enrollment and are attributed to another provider via **claims attribution** process. You may still complete PAFs for these members after attesting that you're the member's PCP.
  - Members who didn't identify a PCP with us upon enrollment/re-enrollment **and** aren't attributed via claims to **any** provider in the past two years. You may still complete PAFs for these members after attesting that you're the member's PCP.
  - Members who are **newly attributed** to the practice and aren't on the current member roster yet. You may still complete PAFs for these members after attesting that you're the member's PCP.
  - Members who are members of an **out-of-state blue plan**. Only TN BlueAdvantage members have PAFs available and you will not be able to locate these members using their subscriber ID and date of birth.
- Members who have been coming to your practice for years may not be officially attributed to you and on your current member roster if they haven't identified/selected you as their PCP with us or are CKD/ESRD members attributed to Somatus. You may still complete PAFs for these members after attesting that you're the member's PCP.
- The PCP listed on the ID card isn't always the current PCP to whom the member is attributed. The PCP listed on the card is who the member was attributed to at the beginning of the year when the ID cards were printed. If attribution changes, either because the member chooses another provider or the claims process updates their attribution because the member hasn't officially selected a PCP with us, they don't get a new ID card unless they request one. You may still complete PAFs for these members after attesting that you're the member's PCP.

NOTE: Attestation that you're the PCP for a member **does not** attribute the member to your practice. To update member attribution, a PCP Change Form must be submitted or the member must contact us using the number on the back of their ID card and request a PCP update.

Quality Care Rewards Application Tips (Continued)

Accessing PAFs in the QCR

1. Go to www.availity.com to log in
2. Click **Payer Spaces**
3. Click the BCBST logo icon
4. Click the **Quality Care Rewards (QCR Platform)** application tile
5. Once in the QCR: search for your practice name in the **Select Contract** box in the top right-hand corner
6. Click on **Select Contract** for the contract that lists the MA program
7. To locate members to complete the PAF, choose the Assessments tile. Click **GO TO PAGE**.
8. Make sure you're on the **PAF** tab at the top once you are on the **Assessments** page.
9. Choose the member's name from the list and click on their name. Once on the member's page, select the **Assessments** tab.
10. If a member doesn't appear in your list of members on the PAF tab in the Assessment tile, they may not be attributed to you. Click on the **Unattributed MA Member Search** tab.
11. Enter the date of birth and Subscriber ID for the member you're attempting to locate and then click the acknowledgment attesting that the member is your patient by member choice, is being seen in your office for medical care, and has a signed HIPAA form on file in the medical record authorizing the release of information to your practice. The attestation also includes that you understand this attestation doesn't attribute the member to the provider under your contract and that for this member to be attributed to the provider under your contract the member must complete a PCP Change Form or contact Member Service using the number on the back of their ID card to request a PCP update.
12. The search results will display and you'll select the member that matches your search results.
13. The **Provider Office Reporting** and **Assessment** tabs will now be available for this member. You will then click on the **Assessments** tab.
14. You have two options to complete the PAF:
    a. **To complete the PAF within the QCR:** In the **2024 – PAF** box, click **Start New PAF** to complete the form within the application.
        i. Click **Get Started** to begin completing the PAF within the QCR.
        ii. Complete all sections of the form and click **Submit Form**
        iii. Click on **Export** in the **2024 – PAF** box after the form is complete. Print and place in the patient's medical record.
    b. **To export the PAF to complete by paper:** In the **2024 – PAF** box, click **Export**
        i. Print the form.
        ii. The provider completes the form manually and signs.
        iii. Scan and upload to the QCR using the **Upload** hyperlink in the **2024 – PAF** box or fax the form to **1-877-922-2963**.
        iv. Keep the original in the patient's medical record.
15. File the claim with **CPT 96161** with a charge of **$225.00** for dates of service Jan. 1, 2024 through Dec. 31, 2024 in addition to your visit E/M code. Be sure to also include all applicable ICD-10 codes on the claim.

We're Right Here

For assistance with Quality Care Rewards access or training, please contact eBusiness.

For assistance with Provider Assessment Form access, please contact your local Provider Quality Outreach Consultant.

Pharmacy Resources

BlueCross is committed to supporting your quality pharmacy measures. Your pharmacy resources include:

- A team of quality pharmacists who work with both members and providers to offer pharmacy education and support.
- Pharmacy reporting located within the Quality Care Rewards (QCR) application that supports medication adherence, Statin Therapy for Patients With Cardiovascular Disease (SPC), and Statin Use in Persons With Diabetes (SUPD). The reports provide timely information including the following:
  - Medication name and strength
  - Filled date
  - Next fill due date
  - Day supply and quantity
  - Refills remaining
  - Prescribing provider
  - Pharmacy
  - Proportion of days covered percent
  - Compliance status
  - Trend reports
  - Absolute fail date
  - Late to fill indicator (available in 2024)
- A team of certified pharmacy technicians who reach out to members who are at risk of becoming nonadherent.

NOTE: If you would like more information on our pharmacy reports, please contact our Medicare Advantage Manager of Clinical Pharmacy or a member of our Provider Engagement and Outreach team listed in this guide.

Medication Therapy Management Program (MTM)

Medication Therapy Management (MTM) is a free program that BlueCross offers to eligible Medicare Advantage prescription drug plan members. It's intended to help improve medication use, lower the risk of medication interactions, and help members take medications as prescribed.

Members receive:

- A one-on-one consultation with a pharmacist or other qualified health care provider to review prescription and OTC medications.
- A copy of their listed medications, topics discussed, and action plan.

Providers receive:

- Information on opportunities identified during the consultation that could enhance safety, quality of care, and therapeutic outcomes.
- Safety concerns include drug-drug interactions, duplications in therapy, or side effects.

2024 Formulary

Our pharmacy strategy is focused on giving members access to the most appropriate, affordable, and effective medications for their needs. The 2024 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 is first approved by the BlueCross Corporate Pharmacy & Therapeutics Committee composed of various health care professionals and then receives final approval from the Centers for Medicare & Medicaid Services (CMS). The formulary is focused on helping patients with adherence by strategic tier placement, $0 copays on Tier 1 Preferred Generics at preferred pharmacies, $35/month insulin caps, and by covering many commonly used generic medications through the coverage gap (donut hole).

The BlueAdvantage (PPO)℠ 2024 Formulary can be found at https://www.bcbst-medicare.com/get-care/pharmacies-and-prescriptions/medicare-pharmacy.

The BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-SNP)℠ 2024 Formulary can be found at https://bluecareplus.bcbst.com/get-care/pharmacies-and-prescriptions/bluecare-plus-pharmacy.

This information does not apply to BlueAdvantage Freedom (PPO)℠.

BlueAdvantage (PPO)℠ Member Cost Share

Sapphire & Garnet	Preferred Retail and Mail Order Pharmacy 30/100 Day Supply	Standard Retail Pharmacy 30/100 Day Supply
Tier 1: Preferred Generic	**$0/$0** Copay	**$6/$15** Copay
Tier 2: Generic	**$10/$10** Copay	**$15/$35** Copay
Sapphire & Garnet	**Preferred Retail and Mail Order Pharmacy** 30/90 Day Supply	**Standard Retail Pharmacy** 30/90 Day Supply
Tier 3: Select Insulin Drugs	**$35/$105** Copay	**$35/$105** Copay
Tier 3: Preferred Brand Drugs	**$42/$105** Copay	**$47/$135** Copay
Tier 4: Non-Preferred Drugs	**$94/$230** Copay	**$99/$290** Copay
Tier 5: Specialty Tier	**33%** of the cost/Specialty medications are limited to a 30-day supply	**33%** of the cost/Specialty medications are limited to a 30-day supply

Emerald	Preferred Retail and Mail Order Pharmacy 30/100 Day Supply	Standard Retail Pharmacy 30/100 Day Supply
Tier 1: Preferred Generic	**$0/$0** Copay	**$6/$15** Copay
Tier 2: Generic	**$5/$5** Copay	**$10/$25** Copay
Emerald	**Preferred Retail and Mail Order Pharmacy** 30/90 Day Supply	**Standard Retail Pharmacy** 30/90 Day Supply
Tier 3: Select Insulin Drugs	**$35/$90** Copay	**$35/$100** Copay
Tier 3: Preferred Brand Drugs	**$35/$90** Copay	**$40/$100** Copay
Tier 4: Non-Preferred Drugs	**$80/$200** Copay	**$85/$215** Copay
Tier 5: Specialty Tier	**33%** of the cost/Specialty medications are limited to a 30-day supply	**33%** of the cost/Specialty medications are limited to a 30-day supply

NOTE: During the coverage gap and catastrophic coverage stage, costs will differ. However, Tier 1 Preferred Generics are covered through the coverage gap. Formulary insulins are capped at $35/month through all stages of Medicare coverage.

BlueAdvantage (PPO)℠ Member Cost Share (Continued)

Ruby	Preferred Retail and Mail Order Pharmacy 30/100 Day Supply	Standard Retail Pharmacy 30/100 Day Supply
Tier 1: Preferred Generic	**$0/$0** Copay	**$6/$15** Copay
Tier 2: Generic	**$5/$5** Copay	**$10/$25** Copay
Ruby	**Preferred Retail and Mail Order Pharmacy 30/90 Day Supply**	**Standard Retail Pharmacy 30/90 Day Supply**
Tier 3: Select Insulin Drugs	**$28/$70** Copay	**$33/$95** Copay
Tier 3: Preferred Brand Drugs	**$28/$70** Copay	**$33/$95** Copay
Tier 4: Non-Preferred Drugs	**$65/$165** Copay	**$70/$185** Copay
Tier 5: Specialty Tier	**33%** of the cost/Specialty medications are limited to a 30-day supply	**33%** of the cost/Specialty medications are limited to a 30-day supply

Diamond	Preferred Retail and Mail Order Pharmacy 30/100 Day Supply	Standard Retail Pharmacy 30/100 Day Supply
Tier 1: Preferred Generic	**$0/$0** Copay	**$6/$15** Copay
Tier 2: Generic	**$5/$5** Copay	**$10/$25** Copay
Diamond	**Preferred Retail and Mail Order Pharmacy 30/90 Day Supply**	**Standard Retail Pharmacy 30/90 Day Supply**
Tier 3: Select Insulin Drugs	**$28/$70** Copay	**$33/$95** Copay
Tier 3: Preferred Brand Drugs	**$28/$70** Copay	**$33/$95** Copay
Tier 4: Non-Preferred Drugs	**$50/$125** Copay	**$55/$145** Copay
Tier 5: Specialty Tier	**33%** of the cost/Specialty medications are limited to a 30-day supply	**33%** of the cost/Specialty medications are limited to a 30-day supply

NOTE: During the coverage gap and catastrophic coverage stage, costs will differ. However, Tier 1 Preferred Generics are covered through the coverage gap. Formulary insulins are capped at $35/month through all stages of Medicare coverage.

BlueAdvantage (PPO) members can get up to a 100-day supply of drugs in Tier 1 and 2 for the 30-day copay at preferred pharmacies.

BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-SNP)℠ Member Cost Share

What members pay for a 30-day or 90-day supply of Standard Retail and Mail Order Drugs

BlueCare Plus and BlueCare Plus Select Members

- $0 copay for generic drugs
- $0 copay for brand drugs

BlueCare Plus Choice Members

- $0-$4.50 copay for generic drugs
- $0-$11.20 copay for brand drugs

NOTE: Copays and coinsurance may vary based on the level of 'Extra Help' members receive. Members may contact the plan for further details.

This information does not apply to BlueAdvantage Freedom (PPO)℠ or BlueAdvantage (PPO)℠.

Network Pharmacies

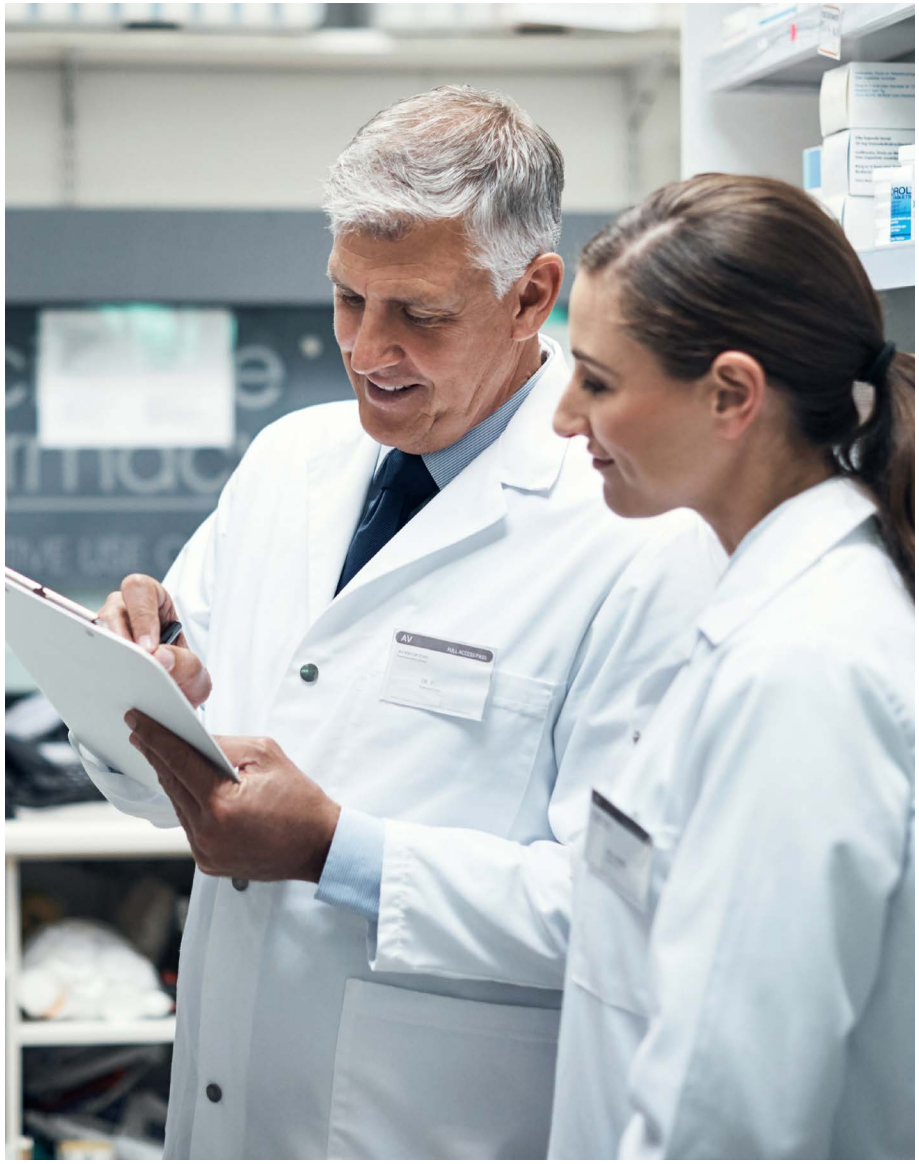
In most cases, prescriptions are covered only if a patient fills the medication at a network pharmacy. A network pharmacy is a pharmacy that has a contract with the plan to provide covered prescription drugs. While a patient can go to any network pharmacy, some pharmacies provide preferred cost sharing.

To see if a pharmacy is in network and/or its preferred network status, visit bcbst.com and select Find Care.

Mail Order Information

Providers will need to send all mail order prescriptions to our mail-order pharmacy, CVS Caremark. Please allow up to 14 days from the date the prescription was ordered before the member receives the medication.

- CVS Caremark Provider Services: **866-693-4620**
- CVS Caremark Mail Order: **844-740-0602**



Insulin Savings

One in every three Medicare beneficiaries has diabetes. For some of these beneficiaries, access to insulin can be a critical component of their medical management, with gaps in access increasing the risk of serious complications including vision loss, kidney failure, foot ulcers/amputations, and heart attacks. Cost of insulin can be a barrier to appropriate medical management of diabetes.

In 2024, members will pay no more than $35 per month for formulary insulins. This will include members in the Coverage Gap and Catastrophic Coverage stages, those receiving low income subsidies, and members using an insulin pump.

2023 Formulary Insulins

- Basaglar
- Lantus
- Novolin N
- Relion Novolin N
- Soliqua
- Fiasp
- Levemir
- Novolin R
- Relion Novolin R
- Toujeo
- Humulin R U-500
- Novolin 70/30
- Novolog and Novolog 70/30
- Relion Novolog
- Treisbia

Diabetic Supplies

Preferred products include:

- LifeScan One Touch Strips/Meter
- Ascensia Diabetes Care (formerly Bayer): Contour Strips/Meter
- All other products require a coverage review with the BlueCross Utilization Management Department

Quantity Limits

- **Strips: 300** per 90 days
- **Lancets: 600** per 90 days
- **Meters: 1** per year
- **Calibration Solution: 1** bottle per year
- **Lancet Device: 1** device per year

The BlueCross Utilization Management Department also handles quantity limit requests. Contact:

- Medicare Advantage: **800-924-7141**
- DSNP: **866-789-6314**

Statin Therapy Star Measures

CMS has three statin measures in the star ratings program. Along with medication adherence for statins, CMS includes statin therapy in persons with cardiovascular disease and statin use in persons with diabetes. These measures are focused on two of the major statin benefit populations described in American College of Cardiology/American Heart Association guidelines and align with recommendations from the American Diabetes Association. Both statin prescribing measures recommend statin therapy for people with either cardiovascular disease or diabetes regardless of cholesterol levels. The following comparison chart helps to highlight the differences between the three statin measures in the CMS Star Ratings program for Medicare Advantage plans.

Statin Star Measures Comparison Chart

Measure	Adherence (Statins) 3-weight	Cardiovascular Disease (SPC) 1-weight	Diabetes (SUPD) 1-weight
Criteria to Meet Measure	Prescription claims for a **statin** to cover **80% or more of the time that they are supposed to be taking the medication**	**One** prescription claim for a **moderate to high-intensity statin**	**One** prescription claim for **statin**
Inclusion Criteria	**Two prescription claims** for a **statin** medication	**Diagnosis:** Ischemic vascular disease OR **Event:** MI, CABG, or a revascularization event such as a percutaneous coronary intervention	**Two prescription claims** for a **diabetes** medication, including insulin
Age	All Patients 18 years and older	Males 21–75 Females 40–75	All Patients 40–75 years old
Exclusion Criteria	ESRD Hospice	Any of the following in the current measurement year or the year prior: • ESRD • Cirrhosis • Pregnancy • IVF • Clomiphene therapy Any of the following in the current measurement year: • Myalgia • Myositis • Myopathy • Rhabdomyolysis • Patients age 66 and over enrolled in an institutional SNP or living long-term in an institution • Patients age 66 and over with frailty and advanced illness • Patients receiving palliative care or hospice **NOTE:** The diagnosis code for the applicable condition may be submitted on a claim or an attestation may be made in the Quality Care Rewards application located in Availity® to exclude the patient.	Any of the following in the current measurement year: • Hospice • ESRD • Rhabdomyolysis, myositis or myopathy • Pregnancy, lactation, or fertility • Cirrhosis • Pre-diabetes • Polycystic ovary syndrome (PCOS) **NOTE:** The diagnosis code for the applicable condition **must** be submitted on a claim to exclude the patient.

Managing Statin-Related Muscle Pain

Muscle symptoms are the most common adverse effects reported by statin users. Mounting evidence suggests that **statin-associated muscle pain is driven by a patient's expectation of harm.** However, it's still how the patient feels, and it leads to poor adherence. Consider these tips for patients with mild to moderate symptoms.

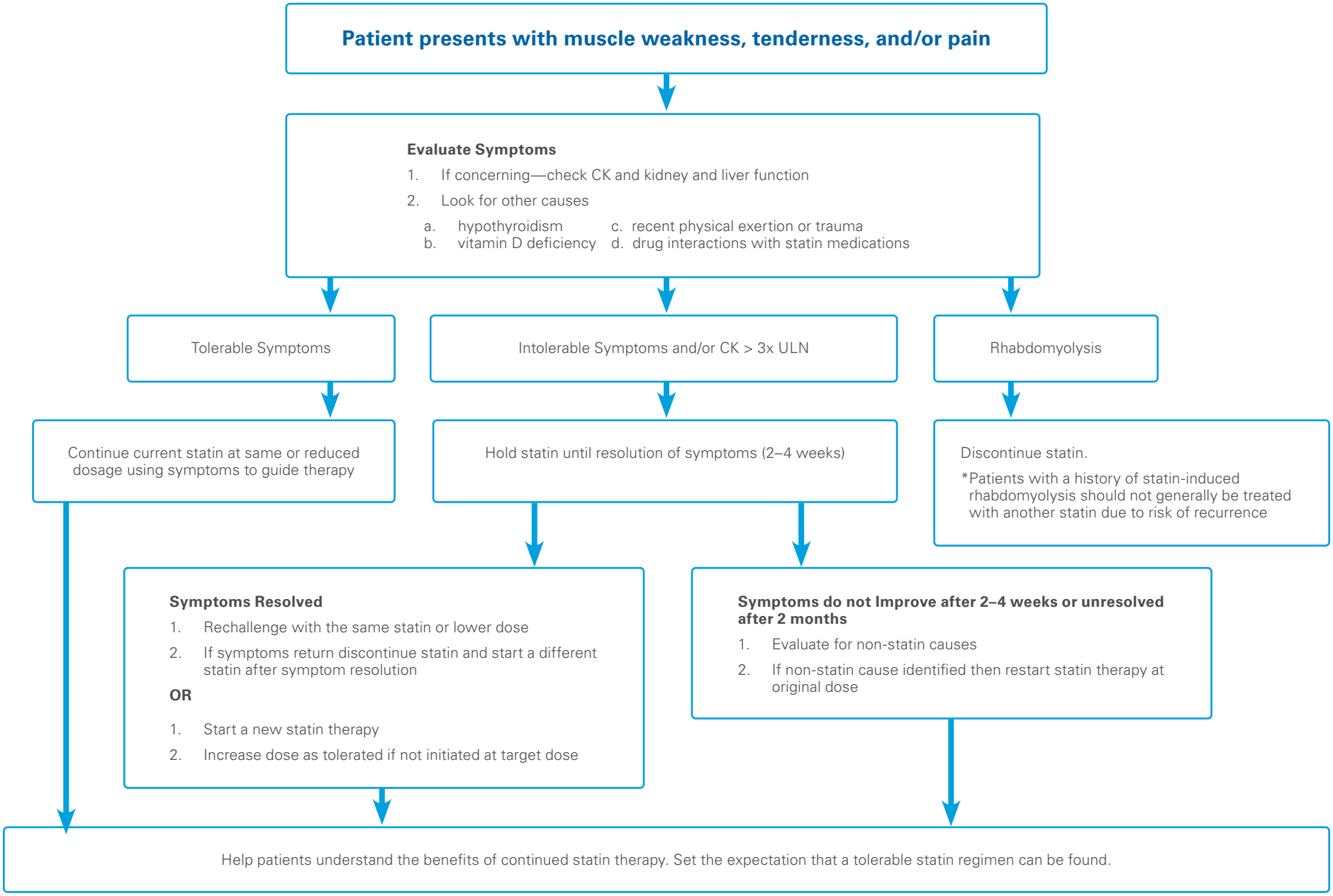
Assess:

- Assess for other causes of muscle pain such as fibromyalgia, hypothyroidism, or vitamin D deficiency.
- Ask about physical exertion. Differentiate these symptoms from statin-related pain or weakness which usually affects large muscles (back, thighs, etc.) on both sides, often in the first months of use.
- Avoid interacting medications (colchicine, fibrates, verapamil, etc.) and check for other medication causes of muscle symptoms (steroids, etc.).

Discuss:

- Discuss options for another attempt.
- Try a low dose of the same or different statin and titrate.
- Consider a statin with fewer drug interactions such as pravastatin or rosuvastatin.
- If considering intermittent dosing (alternate day) use a long-acting statin such as rosuvastatin or atorvastatin.

Managing Statin Intolerance



Clinical Resource, Statin Muscle Symptoms: Managing Statin Intolerance. Pharmacist's Letter/Prescriber's Letter. August 2022.[380801]

Medication Adherence Tips

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:

New Therapies (or therapies associated with frequent dose changes)

- Write for a 30-day supply. This will allow for titration, potential dose changes due to side effects, and avoid patient stockpiling if a dose is changed.
- Provide an adequate number of refills until patient's next appointment or until anticipated new prescription is available.

Established Maintenance Medications

- Write for 90-day or 100-day* supplies when possible.
- Provide adequate number of refills.

NOTE: Prescriptions (non-controlled) expire one year after written date and all refills remaining are canceled.

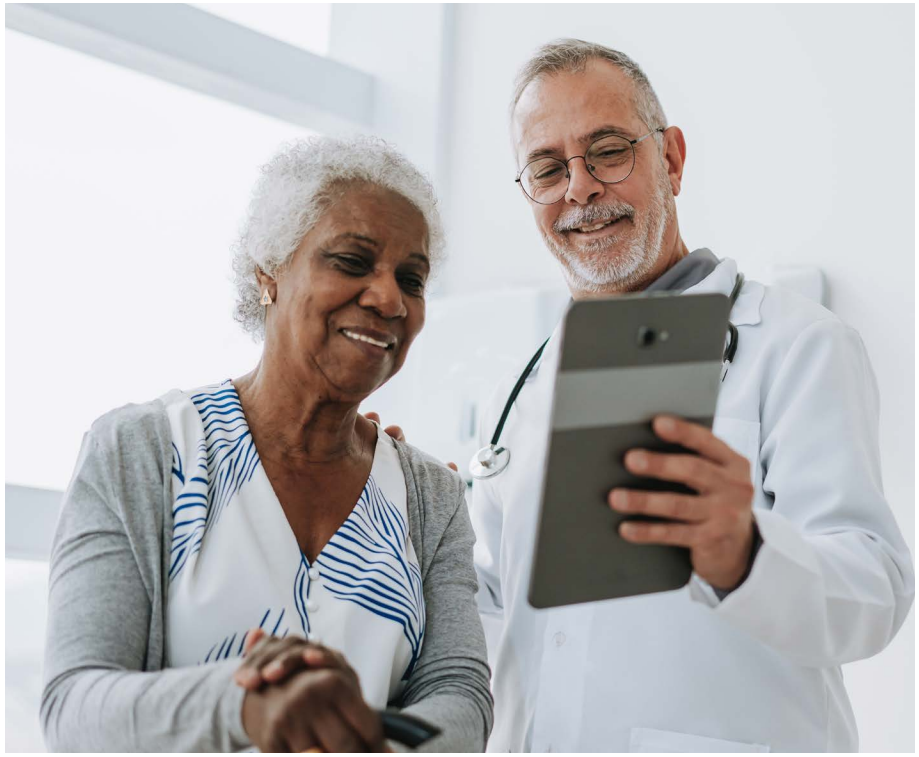
*Only applies to BlueAdvantage (PPO)℠

Dose Changes

- Write a new prescription with the updated directions. The pharmacy claim for quantity and day-supply should reflect how the patient is taking the medication to increase adherence scores.
- Instruct the pharmacy to cancel/discontinue the old prescription either through a phone call or note on the updated prescription.
- These tips will prevent the patient from filling an old prescription and halving the pills, which would make them appear as noncompliant.

Prescription Directions

- Include the intended use of the medication in the directions. This will help the patient keep track of what the medication is used for, e.g., take one tablet daily for blood pressure; or take one tablet twice daily for blood sugar.



Medication Adherence Tips (Continued)

Discuss Drug Cost When Initiating a New Prescription

- Patients can be reluctant to come forward with financial concerns due to fear of social bias/stigma, or because they are afraid their quality of care will be jeopardized.
- If a patient can't afford a medication, they may ration the medication, skip days, delay refilling, or stop taking the medication altogether resulting in a worsening condition, increased comorbid diseases, and secondary hospital stays.
- Be conscious of the coverage gap. A medication cost can increase drastically if the patient enters the coverage gap (donut hole).

Set Expectations for therapy, especially for medication classes with known side effects

- Example: For metformin, reassure that GI problems (diarrhea, nausea, etc.) are usually short-lived especially when "starting low and going slow."

Consider medication adherence packaging for patients on multiple medications with multiple comorbidities

Refer your MA PPO 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, a pharmacist and a dietitian available to help.

Refer your BlueCare Plus HMO D-SNP patients to our Care Management program at **1-877-715-9503** for assistance with other barriers to medication adherence. We have nurse case managers, social workers and pharmacy technicians available to help.

Understanding Part D Coverage Phases in 2024

Deductible	Initial Coverage	Coverage Gap (Donut Hole)	Catastrophic
BlueCross doesn't have a deductible for our members.	Patients pay a copayment/ coinsurance for their medications. The cost depends on the drug's cost-share tier. Once the total cost of what the patient pays AND what the drug plan pays exceeds $5,030, the patient enters the Coverage Gap, where they may pay higher cost.	Patient will pay 25% of the cost of generic and brand name drugs. Patient remains in the Coverage Gap until their True-Out-of-Pocket (TrOOP) costs reach $8,000. **NOTE**: Tier-one generics are covered through the Coverage Gap.	Patient will pay the rest of the calendar year (the greater of): $0 coinsurance

NOTE: Depending on Low Income Subsidy Level, not every plan member will go through all the phases of coverage.

Coverage Determination

Prior Authorization Criteria for BlueAdvantage PPO members can be found at https://www.bcbst-medicare.com/use-insurance/documents-forms/blueadvantage under **Pharmacies and Prescriptions**.

Prior Authorization Criteria for BlueCare Plus members can be found at https://bluecareplus.bcbst.com/use-insurance/documents-forms/bluecare-plus under **Pharmacies and Prescriptions**.

Types of Coverage Determinations

Prior Authorizations (PA):

- Part B versus Part D
- Clinical prior authorizations

Exceptions:

- Quantity limits
- Non-formulary reviews
- Tier exception reviews
- Safety edits

Primary requests and appeals are reviewed by the BlueCross Med D Coverage Determinations and Appeals team. Requests can be made verbally, in writing or electronically.

Fax: 423-591-9514

Phone:

- Medicare Advantage: 1-800-831-2583
- D-SNP: 1-800-299-1407

Electronic Prior Authorization (ePA) via Availity®

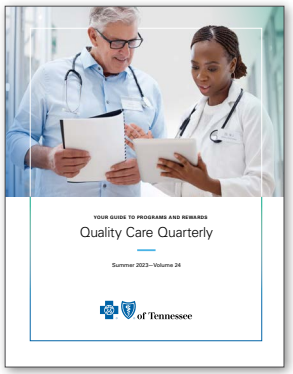
This information does not apply to BlueAdvantage Freedom (PPO)℠.

Keeping You Up-to-Date

To keep you informed of changes and best practices, we provide monthly, quarterly and annual publications. We also offer a range of services and events, as well as on-site visits and e-mail updates to support your success in the Quality+ Partnerships program.

Monthly BlueAlert Provider Newsletter

The BlueAlert newsletter gives you timely information on forms and process changes, coding tips, drug coverage and more. The current edition and archives are located on provider.bcbst.com/news-updates.



Quality Care Quarterly Newsletter

Each quarter, we send providers who participate in any of our quality programs a link to the quality newsletter. In it you'll find a variety of informative articles including best-practice highlights from your peers, helpful information on important HEDIS measures, tips on using the QCR application, and upcoming events and training opportunities. The current edition of the Quality Care Quarterly is at provider.bcbst.com/news-updates. Previous editions are in the archived newsletters at Provider News and Updates.

Provider Outreach Notification Emails

Our Provider Outreach team sends regular emails with notifications and updates related to the Quality+ Partnerships program.

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 Evaluation & Management (E&M) medical claims and pharmacy claims back two years.
- Provider selected/attributed must be from an approved provider type and be on the inclusion list with contract type of primary care. Approved provider types include family practitioner, general practice, internal medicine, pediatrics, physician assistants, and nurse practitioners.
- 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.
- You can locate your current member attribution list in the Quality Care Rewards application located in Availity® under the Member Roster tab. Member rosters update with the first refresh after the 15th of the month, each month.
- The attribution process outlined above is overridden for members diagnosed with Chronic Kidney Disease (CKD Stages 4 and 5) within the last two years and members diagnosed with End Stage Renal Disease (ESRD) with dialysis in the last six months without a successful transplant. These members are automatically attributed to our renal disease management vendor partner, Somatus. The process above may also be overridden for members in specific central Tennessee counties agreeing to receive coordinated palliative care from our vendor partner, Amedisys.

Note: With so many choices for primary care providers, it's a testament to your practice's reputation if a member chooses you for their PCP. If a member has selected you as their PCP and you haven't yet had a visit with them, we encourage you to contact them and schedule a visit as soon as possible in order to address any health care needs.

Primary Care Provider Change Request

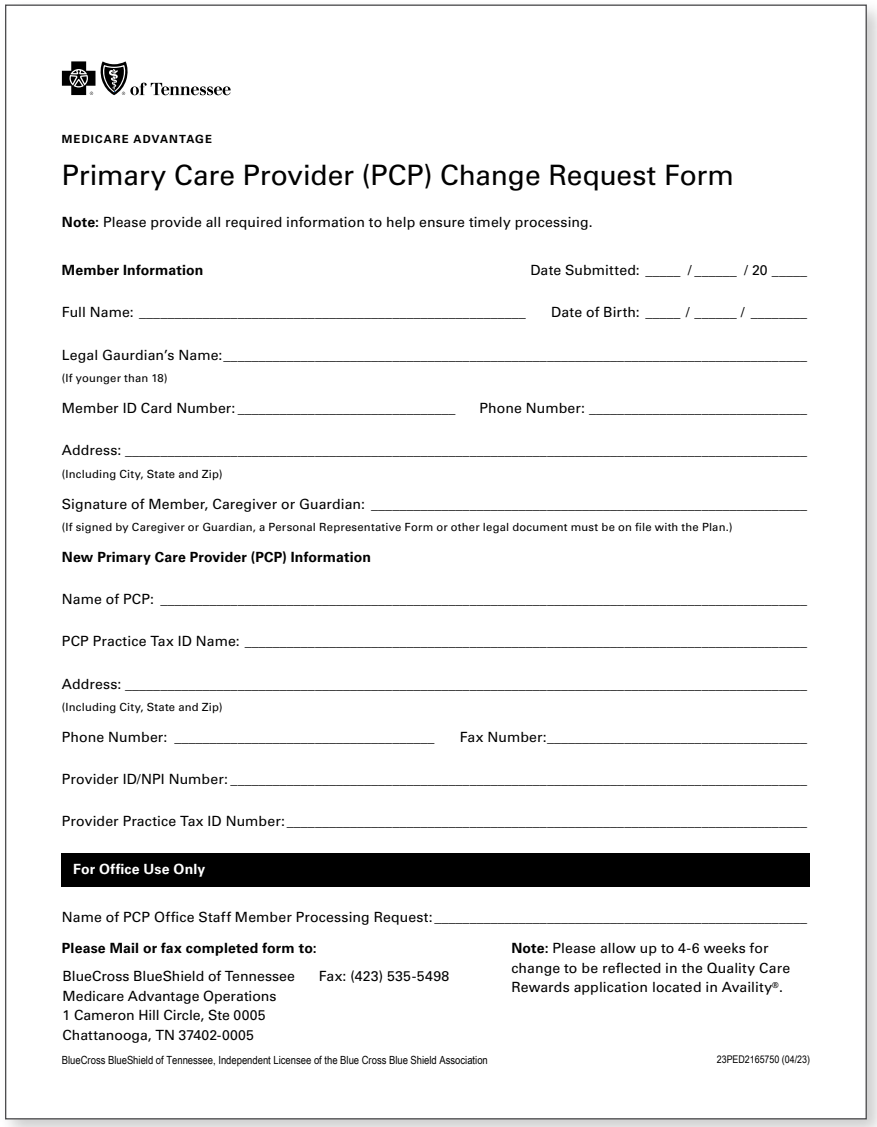
In the event your patient would like to update their selected Primary Care Provider information with us, we have a form to help you with this process right from your office. The form can be found online at https://www.bcbst.com/docs/providers/quality-initiatives/Medicare-Advantage-PCP-Change-Form.pdf.

Please fax the form with the patient's signature to **(423) 535-5498**. Once we receive the completed form, we will update the patient's PCP information. While it will update in our system quickly, it may take 4-6 weeks to update in the Quality Care Rewards application within Availity®.

A patient signature is required for the form to be processed.

Did you know?

In-home test kits for several preventive screenings are available to patients who are unable to come to your office for a face-to-face visit. Contact a member of our Provider Quality Outreach Team (listed in the front of this guide) for more information or to order in-home test kits.



of Tennessee

MEDICARE ADVANTAGE

Primary Care Provider (PCP) Change Request Form

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

Member Information Date Submitted: ____ /_____ / 20 ____

Full Name: _____ Date of Birth: ____ / _____ / _____

Legal Gaurdian's Name: _____
(If younger than 18)

Member ID Card Number: _____ Phone Number: _____

Address: _____
(Including City, State and Zip)

Signature of Member, Caregiver or Guardian: _____
(If signed by Caregiver or Guardian, a Personal Representative Form or other legal document must be on file with the Plan.)

New Primary Care Provider (PCP) Information

Name of PCP: _____

PCP Practice Tax ID Name: _____

Address: _____
(Including City, State and Zip)

Phone Number: _____ Fax Number: _____

Provider ID/NPI Number: _____

Provider Practice Tax ID Number: _____

For Office Use Only

Name of PCP Office Staff Member Processing Request: _____

Please Mail or fax completed form to:

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

Fax: (423) 535-5498

Note: Please allow up to 4-6 weeks for change to be reflected in the Quality Care Rewards application located in Availity®.

BlueCross BlueShield of Tennessee, Independent Licensee of the Blue Cross Blue Shield Association

23PED2165750 (04/23)

This information applies to BlueAdvantage (PPO)℠ plans ONLY.

Member Selection and Attribution Tips and Reminders

General Reminders

- Member attribution updates in the BlueCross system monthly and is reflected in the Quality Care Rewards (QCR) application with the first refresh after the **15th of each month**.
- Depending on when the member is attributed to the PCP, please give the attribution process up to 3-6 weeks to reflect newly attributed members on the member roster in the QCR after they have either been assigned to the PCP by member selection or attributed by claims.
- Members who have been coming to your practice for years may not be officially attributed to you and on your current member roster if they haven't identified/selected you as their PCP with BlueCross, are palliative care members attributed to Amedisys, or CKD/ESRD members attributed to Somatus.
- The PCP listed on the ID card isn't always the current PCP to whom the member is attributed. The PCP listed on the card is who the member was attributed to at the beginning of the year when the ID cards were printed. If attribution changes, either because the member chooses another provider or the claims process updates their attribution because the member hasn't officially selected a PCP with us, they don't get a new ID card unless they request one.

Members not on your member roster

- Members who have Chronic Kidney Disease (stages 4 or 5) or End Stage Renal Disease are attributed to our renal disease management program partner, **Somatus**.
- Members who have been identified for our palliative care program in the middle Tennessee region and have agreed to receive palliative care services are attributed to our palliative care program partner, **Amedisys**.
- Members who have actively **chosen** another provider for their PCP selection upon enrollment/re-enrollment.
- Members who didn't identify a PCP with BlueCross upon enrollment/re-enrollment and are attributed to another provider via **claims attribution** process.
- Members who didn't identify a PCP with us upon enrollment/re-enrollment and aren't attributed via claims to **any** provider in the past two years.
- Members who are **newly attributed** to the practice and aren't yet on the current member roster.
- Members who are members of an **out-of-state BlueCross plan**.

Member's selection of the PCP is generally best

- This ensures appropriate attribution and allows access to gap in care information and the PAF within the QCR.
- This prevents the member from being attributed through the claims process if they haven't seen the PCP in a while but see another provider with a PCP designation in between visits with your practice.
- Once the member selects a PCP with us, their attribution can only be overridden if they change their selection again or become eligible for attribution with our renal disease management Somatus and Amedisys.
- You can identify how members are attributed to you by viewing the attribution reason column on the member roster in the QCR. Members on your roster without "Member has selected a PCP" in the attribution reason column are subject to attribution changes depending on what other providers they may see with a PCP designation.
- Encourage members to officially select their PCP with us by contacting the customer service number on the back of their ID card or to complete a PCP change form and send to us.

This information applies to BlueAdvantage (PPO)℠ plans ONLY.

Member Selection and Attribution Tips and Reminders (Continued)

Members can't be added manually by BlueCross to member rosters

- Members must either choose the PCP actively (at enrollment, AEP, contacting customer service, completing a PCP change form or notifying one of our in-home vendors) or receive attribution by medical or prescriptions claims.

Member attribution can be updated

- Member may contact customer service by using the number of the back of their ID card and update their PCP selection
- Practices may provide members with a PCP Change Form to sign and the practice returns to BlueCross: https://www.bcbst.com/docs/providers/quality-initiatives/Medicare-Advantage-PCP-Change-Form.pdf
- Contact your local Provider Outreach Consultant for assistance with attribution questions or patient dismissals.

Providers Moving Practices or Retiring

- Practices must submit provider changes using CAQH ProView® located at caqh.org and the **Provider Enrollment, Updates, and Changes** section in our Availity® Payer Spaces.
- This will help us make changes more efficiently, since our systems are regularly updated from CAQH and Availity data.
- For more information, please see the **Provider Enrollment Updates and Changes** Quick Reference Guide under the **Resources** tab in our Payer Spaces at availity.com.
- If you notice a discrepancy in your provider directory information, or you need help with your online submission, please contact us at **1-800-924-7141** and follow the prompts to **Network Contracts or Credentialing** or email us at Contracts_Reqs_GM@bcbst.com.
- If you need help with CAQH ProView, please contact CAQH at **1-888-599-1771**.
- For assistance with Availity, you can contact Availity Client Services at **1-800-282-4548**.

Annual Wellness Visit Facts

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

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

Welcome to Medicare Exams

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

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

Annual Preventive Exams

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

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

This information applies to BlueAdvantage (PPO)℠ plans Only.

Annual Wellness Visit Facts (Continued)

Provider Assessment Form

Frequency: Once per **calendar year**

Service	Codes	Coverage Notes
Provider Assessment Form (PAF)	96161	This is a BlueCross Medicare Advantage benefit and isn't covered by Original Medicare. A PAF may be submitted once per member, per calendar year. **Providers don't need to wait 365 calendar days from the last PAF submission or wellness exam**. A PAF may be completed in conjunction with the Welcome to Medicare Annual Preventive Exam or Annual Wellness Visit.

Member Rewards

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**

The primary diagnosis code for the problem-oriented E/M code should reflect the condition/reason the patient is being treated for and not billed with a preventive care diagnosis code, i.e. Z0000 (Encounter for general adult medical exam without abnormal findings), Z0001 (Encounter for general adult medical exam with abnormal findings).

Annual Wellness Visit Facts (Continued)

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.
- This is an excellent time to document all active acute and chronic conditions your patient may have, so the documentation reflects the true health history of the patient.
- 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** code G0101 (along with Q0091 if a screening pap is performed) and don't use an Annual Preventive Physical Exam code.
- A **PAF** must be completed during a patient's face-to-face visit and submitted within 90 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 retained as part of the patient's permanent medical record.

Note: CMS allows telehealth visits to be acceptable for PAF and Annual Wellness Visit completion when the call is conducted with audio and video components (phone calls alone don't satisfy the face-to-face requirement). These visits are reimbursed on parity with face-to-face visits. Check with your local Provider Outreach Consultant for updated information.

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.

Immediate and Future Benefits to You

PAF submission should be billed on your encounter claim for reimbursement. Beginning with measurement year 2024, there's only one option for PAF submission*.

- **Electronic PAF:** The brief, hierarchical chronic condition (HCC) focused electronic PAF is located within the Quality Care Rewards (QCR) application in Availity®. This form may be completed within the QCR application or exported and completed and then either uploaded to the QCR or faxed. The electronic PAF provides the most thorough identification of patients' chronic conditions.

NOTE: The previously accepted Non-Standard PAF is no longer accepted. Additionally, the previous standard, blank PAF form has been retired and is no longer accepted.

Submit **CPT®** code 96161 once per calendar year in addition to your visit E/M code. No modifier is needed.

Reimbursement for completion of the electronic PAF is $225 for dates of service from January 1 through December 31.

You may also perform the Medicare Annual Wellness Visit at the same time, however an Annual Wellness Visit isn't required in conjunction with a PAF.

NOTE: CMS has continued to allow telehealth visits to be acceptable for PAF and annual wellness visit completion for risk adjustment encounter data when the call is conducted with audio and video components (phone calls alone don't satisfy the face-to-face requirement). These visits are reimbursed on parity with face-to-face visits. Check with your local Provider Outreach Consultant for updated information.

- Use G0438, G0402 or G0439 with your E/M codes or E/M codes 99387 or 99397.
- Member rewards 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 aren't covered under this benefit, and the member may have a separate copayment for those services.

**Practices utilizing an approved third party application or ingesting our risk adjustment dropped code reporting into their EMR and billing CPT code 96160 for PAF completion may continue to do so for 2024.*

Important PAF Details

- Must be completed during a patient's **face-to-face visit*using the electronic PAF in the Quality Care Rewards (QCR) application (either completed within the application or exported and completed by hand).** Must be submitted via online or fax **within 90 days** of face-to-face visit or a new encounter must be completed.
- Must submit claim with CPT code within **six months** of face-to-face visit to receive reimbursement.
- 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 electronic PAF from the QCR after receiving a PAF reimbursement claim, a member of our provider outreach team will contact you and request a complete electronic PAF from the QCR to be submitted within the next 30 days. PAFs remaining incomplete, submitted with non-standard forms/medical record notes, or missing after that time will be subject to PAF reimbursement 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 provide 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
- When completed online through Availity®, print and retain as part of the patient's permanent medical record. When exported and completed by hand, retain a copy as part of the patient's permanent medical record.

*CMS continues to allow telehealth visits to be acceptable for PAF and annual wellness visit completion for risk adjustment encounter data when the call is conducted with audio and video components (phone calls alone don't satisfy the face-to-face requirement). These visits are reimbursed on parity with face-to-face visits. Check with your local Provider Outreach Consultant for updated information.

PAF Completion Options

Beginning with 2024, you have one option for completing and submitting PAFs:

- Online within or exported from the Quality Care Rewards application via secure Availity® portal: availity.com. Exported forms may be faxed or uploaded back into the QCR.

NOTE: EMR extracts or notes, non-standard forms and blank PAF forms will not be accepted for PAF submission.

Training and Assistance

For training and assistance with the BlueCross PAF 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)℠ plans ONLY.

Q&A Additional Information / Frequently Asked Questions

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

A. No. Of course, we would like to encourage you to participate for the overall health and well-being of our senior population. You also have the opportunity to earn reimbursement for each PAF you complete.

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 don't 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 96161.
- 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 96161 for reimbursement.

Submit the completed electronic PAF from the QCR via fax, online completion or upload to the Quality Care Rewards application within 90 days of the face-to-face visit. Submit the claim for reimbursement within six months of the face-to-face visit.

NOTE: CMS has continued to allow telehealth visits to be acceptable for PAF and annual wellness visit completion for risk adjustment encounter data. These visits are reimbursed on parity with face-to-face visits. Check with your local Provider Outreach Consultant for updated information.

If we are **not** in receipt of a complete electronic PAF from the QCR after receiving a PAF reimbursement claim, we will request a complete electronic PAF from the QCR to be submitted within the next 30 days. PAFs remaining incomplete, submitted with non-standard form/medical records notes or missing after that time will be subject to PAF reimbursement recovery.

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

A. No, this method is no longer accepted for PAF submission.

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. 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 beprinted 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's important to differentiate between acute/unspecified versus chronic. Consider using CPT Category II codes (CPTII). Use of these codes enables your office to monitor internal performance of key measures throughout the service year. By identifying opportunities for improvement, interventions can be implemented to improve overall quality of care.

Q. Why should I perform this coding?

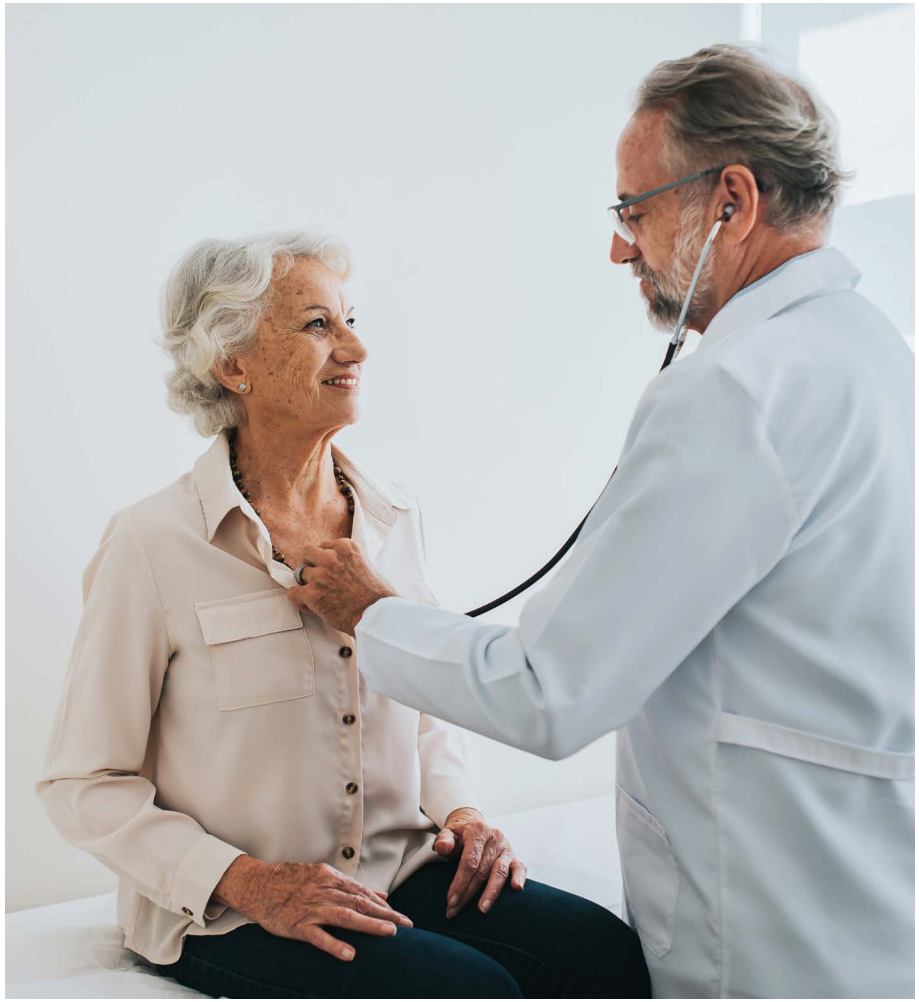
A. CMS requires that services and conditions are coded to the correct level of specificity. This information is used by CMS to determine the reimbursement for services and whether programs should be developed to address particular problems. BlueCross BlueShield of Tennessee is required to ensure that coding is performed correctly. BlueCross also uses the information to plan for future programs.

Q. How does the PAF close gaps in care?

A. Providers completing the PAF online have the opportunity to attest to gaps in care in the Quality Care Rewards application located within Availity as they complete the PAF.

Q. How can I find out how many PAFs I've submitted?

A. Providers can view a list of all members and current PAF status in the Assessments tile of the Quality Care Rewards application in Availity.



Quality Care Rewards (QCR) Application Provider Assessment Form (PAF) Frequently Asked Questions

Q. Why has the PAF program been changed, non-standard EMR notes are no longer accepted, and there is no longer a blank form?

A. We have made changes to focus the PAF documentation on the conditions that need to be addressed by the PCP. Historically, PAF documentation has primarily focused on the primary purpose of the office visit and did not consider or address all chronic conditions previously reported on the patient by PCPs as well as Specialists, hospital and ER visits. Upon an extensive review of historical non-standard EMR notes and blank form PAFs received, it was determined that year over year, nearly 1/3 of the average patient's chronic conditions have not been re-diagnosed /redocumented as required by CMS using the previous PAF documents. The PAFs received were deemed **insufficient** in terms of redocumenting conditions. In turn, the reimbursement paid by BlueCross for these forms was significantly more than the value of the documentation in the PAFs in terms of risk adjusted premium received from the Centers for Medicare & Medicaid Services (CMS) for the health plan to cover the medical expenses of the members.

Q. Why should I complete the PAF in the QCR application?

A. In addition to a more valuable PAF, there are many positive aspects to the PAF in the QCR:

- Much, much shorter than previous versions.
- Focuses only on addressing and substantiating patient's conditions. No preventive services, extra assessments, etc.
- Puts all the chronic conditions in front of the provider to address, including conditions diagnosed by specialists, hospitals and ER visits*.
- Pre-populates information that BlueCross already has, including conditions diagnosed and medications prescribed by other providers, i.e., specialists*.
- Allows the provider to remove any diagnosis not applicable to patients for the current year by marking them inactive/resolved.
- Can significantly help provider's chronic condition recapture rate and risk score.
- Can be exported and completed (then faxed or uploaded to the QCR) or completed within the QCR application.
- Reimbursement rate stays the same all year.

*To comply with HIPAA, we mask conditions reported by Medication-Assisted Treatment (MAT) providers. However, your documentation of these conditions is permitted under HIPAA. If you are treating or monitoring any of them, please record their presence. Providers will need to redocument these conditions each year.

Q. Do I have to use the PAF in the QCR?

A. To improve your practice's risk score and HCC recapture rate as well as receive PAF reimbursement of $225 all year long (CPT 96161), the electronic PAF in the QCR is recommended. Previously approved non-standard PAF forms have historically been proven to not provide sufficient information for risk adjustment reporting to CMS and are no longer accepted for PAF submission.

Q. If I don't want to use the QCR PAF, can I just use the old blank standard form or submit notes from the medical record instead?

A. No. Non-standard forms, notes from the EMR and the previous BCBST standard form (blank form) has been retired and is no longer accepted for a PAF. If we receive anything other than an electronic PAF form from the QCR, we will return it and request a QCR PAF form be completed.

Q. How do I complete QCR PAFs for out-of-state BlueCross (BlueCard/Interplan) members?

A. PAFs from the QCR application are not available for out-of-state BlueCross members. These members are not typically loaded in our systems and we don't have historical information for them. As the host plan, we also cannot submit risk adjustment data on these members to CMS if they are not BlueAdvantage PPO members. You, however, may still perform an Annual Wellness Visit and/or Annual Preventive Exam on these members.

Q. Can a nurse or office staff member besides the provider complete the electronic form based off documentation from a visit with the patient?

A. The QCR PAF should **not** be completed based off visit documentation alone. If the provider does not see the PAF from the QCR, they could be missing the conditions that BCBST shows that need to be addressed. For practices utilizing non-provider staff to assist with PAF completion, we recommend that non-provider staff export and print the PAF; provide to the provider prior to or during the visit; the provider reviews and addresses the conditions and medications on the form and signs; and then the non-provider staff faxes or uploads the PAF back into the QCR.

Q. Why are some (or none) of my patient's diagnoses not displayed or pre-populated on the QCR PAF form?

A. The QCR PAF will display all diagnoses that BlueCross currently has in our system that have been reported from claims or previous PAFs for the past two years that map to a hierarchical condition category (HCC) and those that don't map to an HCC. If there are diagnoses that you feel are missing, you can add them on the form. If you don't know if a diagnosis maps to an HCC, you can search for the diagnosis and the search tool will indicate if the diagnosis maps to an HCC. You can choose to add the diagnosis whether it maps to an HCC or not, but you don't have to spend time adding conditions that don't map to an HCC. If the patient is a new member to BCBST this year, we may not have any information on them yet (until we receive claims) and you can add their diagnoses and medications.

Q. My medication list is very thorough. Can I skip the medication section and just attach my medication list from the medical record?

A. The QCR PAF will list all the medications that have been prescribed for the patient within the last six months from any provider. Some of these medications you may not be aware of and therefore may not be in your medication list in the patient's record. All medications listed on the PAF need to be addressed within the PAF, not a separate medication list, to validate the diagnoses listed and reported.

Q. Can I just attach my note to the QCR PAF so I don't have to complete it all?

A. The QCR doesn't allow for additional documents to be uploaded when completing the PAF within the application. Also, **do not write "see attached" on an exported/printed out PAF and include an office note when faxing or uploading**. We will return these documents and request a complete PAF be re-submitted.

Q. There are acute medications listed on the medication list such as antibiotics that the patient was only one for a short period of time. What do we need to do about those?

A. The QCR PAF will list all medications that have been prescribed for the patient within the last six months from any provider, whether it is acute or chronic. For any medication that is no longer active, simply mark that medication as "Inactive" or "Discontinued".

Q. How do I mark a status and treatment plan for a condition that I did not diagnose, such as diagnoses from specialists?

A. All diagnoses that we currently have in our system that have been reported from claims or previous PAFs from any provider for the past two years will be displayed if they map to an HCC. As the PCP, you should indicate whether this diagnosis is active or inactive for the current year to the best of your knowledge. You can indicate "Followed by another provider" for the treatment plan if necessary.

Q. How do I mark a status for a condition or medication that is incorrect?

A. If you have determined that a condition or medication is incorrect, discontinued or no longer active, you can mark that condition/medication as "Inactive" or "Discontinued". This is an important step in the recapture process as it will remove that diagnosis from future reports and can positively impact your HCC recapture rate.

Q. When adding an additional diagnosis, what date should I put if I don't know when they were originally diagnosed?

A. You may use the date of the visit/exam with your patient if you are unsure of the date of the original diagnosis.

Q. When adding a medication, what date should I put if I don't know when they last refilled it? What if I don't know when it was prescribed?

A. You may use the date that the medication was prescribed if you are unsure when the last refill occurred. If you are unsure of the refill or prescribed date and the medication is still active, you may use the date of the exam.

Q. How do I address the masked sensitive conditions and medications?

A. Due to HIPAA, we are not permitted to display some sensitive conditions and medications on the PAF, even if you are the provider who diagnosed/prescribed. You, however, can add them when completing the PAF. If you see these in a patient's PAF, noted as "**********" you won't need to mark a status or treatment plan for those. Noticing these can serve as an indicator to you to add those conditions and medications to the patient's PAF if you're aware that the patient has a sensitive condition or medication. These are especially important for mental health and substance abuse diagnoses and medications. If you're unaware/unsure of any sensitive conditions or medications, you won't be expected to add them.

Q. Who is Censeo and why did they diagnose my patient with a condition?

A. Censeo is the former name for our vendor partner, Signify Health. Signify Health performs health risk assessments for risk adjustment purposes on our BlueCross Medicare Advantage members who have been identified as having no listed PCP or claims evidence of provider visits within the past year, have gaps in chronic condition documentation, have potential undocumented co-morbidities, have evidence of the use of medication indicating the presence of a condition without a documented diagnosis or other qualifications. If your patient has been seen by Signify and you have been identified as their PCP, you should have received an assessment report for your files to reference.

Q. On an exported PAF, how do I address the Quality Measures listed?

A. The measures listed on the Quality page on the exported PAF are for information only. There are no answers required. This simply shows the compliance status of the measures that apply to that patient so that you can address any open gaps with the patient at the time of the visit.

Q. Some of my patients only have a couple of quality measures where others have more. Should they all have the same list of quality measures?

A. The PAF only shows the quality measures that apply to each patient. Some patients aren't in the denominator for some measures, therefore they won't all have the same list.

Q. How do I attest to Quality Measure gaps from the PAF in the QCR?

A. There is a link at the top of the PAF that can be used to go to the member's page and attest to gaps in care from the PAF.

Q. The practice information is not correct as far as our place of service. How do I correct that?

A. The practice information that displays is based on your contract. It won't show the actual practice location in some cases. This information doesn't impact any data or PAF submission.

Q. Where do we put additional information for additional diagnoses or medications if we have used all the blank spaces available on the export/printed form?

A. You may copy the blank medication and diagnosis pages for additional blank pages and include them with the PAF when faxing or uploaded back in.

Q. When I add a new diagnosis on an exported paper form, can I just write the name of the diagnosis if I don't know the ICD-10 code?

A. ICD-10 codes should be included to the highest level of specificity along with the name of the diagnosis when adding a diagnosis to the PAF. If a diagnosis is included without an ICD-10 code and the severity of the illness isn't indicated, BCBST will only be able to use the lowest value ICD-10 code and this can negatively impact the risk score for both the provider and BCBST.

Q. How do I edit or delete a PAF in the QCR application if I used the wrong date of service, wrong patient, etc.?

A. If the PAF is in the "In Progress" status, the user who started the PAF may edit or delete it. To edit, choose "View", make your changes and then save/submit. To delete, choose "Delete". If the PAF is in the "Completed' status, it cannot be edited or deleted by the provider/provider practice. It must be deleted by BCBST. If you have a PAF that needs to be removed, please contact eBusiness at ecomm_techsupport@bcbst.com.

Q. How should I handle the claim when the patient has more than 12 diagnosis codes, but the claim only allows 12?

A. Please submit an additional claim for the same date of service with CPT 99499 and a charge of $0.01 to list additional diagnosis codes beyond 12. Each claim can list up to 12 codes per claim. Remember to include all ICD-10 diagnoses on your claims for PAFs.

For additional information, please reference the release notes available in the QCR under the Resources section.

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

Risk Adjustment

Risk Adjustment is a mechanism used by CMS to set premium levels paid to Medicare Advantage plans for managing Medicare beneficiaries' health care costs. Each member is assigned a risk score based on their age and gender demographics and diagnoses. ICD-10 codes for significant conditions map to Hierarchical Condition Categories (HCCs). The HCCs are 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**.

Risk scores are derived from five primary sources:

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

Appropriate documentation results in premium levels that:

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

Tips to Improve Risk Scores

- **Code all diagnoses on claims**
  - All conditions evaluated during the office visit (must be a face-to-face* encounter)
  - Any conditions taken into consideration during active treatment of other conditions
  - Use CPT 99499 to transmit additional ICD-10 codes beyond 12, if necessary
  - All active conditions should be documented in the medical record using **M.E.A.T.**
    - **M**onitor
    - **A**ssess
    - **E**valuate
    - **T**reat
- **Submit all requested medical records**
- **Submit PAFs annually on as many patients as possible**

*Telehealth visits conducted with both audio and video components are considered face-to-face.

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's 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" can't 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" doesn't 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
- COPD
- Diabetes
- Drug/Alcohol Abuse
- Morbid Obesity
- Vascular Disease
- CHF
- Depression
- Heart Arrhythmias
- Rheumatoid Arthritis

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're assessed or treated, or when they're a consideration in the patient's care, otherwise they must be documented at least once annually.

Signing off

Stamped signatures aren't accepted.

- A typed signature alone doesn't 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. Don't use this term to describe a disease or condition that the patient is managing or you're 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 don't 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.

Peripheral Artery Disease reminders

If diagnosing Peripheral Artery Disease, be sure to specifically identify a treatment plan which may include any of the following:

- Self-Care including diet, exercise or smoking cessation
- Medications which may include statins, vasodilators and anticoagulants
- Procedures such as angioplasties

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 isn't 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.
- Document the reason for each medication prescribed.

Additional Resources: For more information related to risk adjustment, visit the Centers for Medicare & Medicaid Services website at http://csscoperations.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. 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.

How to Submit Medical Records for Risk Adjustment

Documentation Adequacy Begins with You

The Centers for Medicare & 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.

You may receive a request for medical records from us. Please follow the instructions on your request packet for submitting 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.

Medical Records Submission Instructions - Time Sensitive

Please submit 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 submission include:

- Uploading to the provider portal
- Remote EMR retrieval
- Faxing to a HIPAA compliant fax
- Practices with 100 or more requested records may be eligible for an 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**.

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 $.01 charge claim using CPT® code 99499 can be submitted if there are more than 12 active diagnoses.

Signify Health™ In-Home Health Assessments

Sometimes it can be difficult to get your patients in your office for necessary testing and screenings. To help, we've partnered with Signify Health. 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 wouldn't be able or willing to come to the office.
- Assess current health conditions.
- Ensure the patient is following your prescribed treatment plan.

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

You can still bill for an annual wellness visit and completion of a provider assessment form (PAF), even if an in-home health assessment was already performed by Signify Health.

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.

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 doesn't 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
- Spirometry Testing

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

*Signify will continue to conduct telehealth visits if convenient for the member.

Reminder: Annual Wellness Visits and Provider Assessment Forms are encouraged to be completed at the same time each calendar year. Remember, both the AWV and/or PAF are aligned to a calendar year benefit so you don't have to wait 365 days between these annual services.

My HealthPath®

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

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

A. BlueCross' My HealthPath® Wellness and Rewards Program offers BlueAdvantage members gift cards to focus on better health outcomes in 2024 as well as support the Star ratings for both the provider and the health plan.

Q. How do members sign up to participate?

A. Members can join the program by calling Member Service, by logging in at bcbstmyhealthpath.com, downloading the mobile app "AlwaysOn® Wellness" or returning the business reply card attached to the 2024 My HealthPath introduction letter that is mailed to new members.

Q. How can members start earning gift cards?

A. Enroll in My HealthPath. Once enrolled, they're eligible to earn gift cards for certain preventive services that you're ordering.

Visit Tips: Use G0402, G0438, G0439 plus E/M codes appropriate for the Annual Wellness Visit. Or use 99387, 99397, 99385, 99395, 99386, 99396, or 96161 (Provider Assessment Form).

NOTE: In the Annual Wellness Visit 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 aren't covered under this benefit and the member may have a separate copayment for those services.

Gift cards can be used at certain retailers. Check with the plan for more details.

Available Member Rewards for 2024

Measure/Activity	Gift Card Amount	Gift Card Criteria
Annual Wellness Visit (AWV)	**$20**	Available for all members annually who complete an Annual Wellness Visit
Breast Cancer Screening (BCS)	**$25**	Available for members every year who complete a mammogram at a provider facility
Colorectal Cancer Screening (COL)	**$20**	Available for members annually who complete a gFOBT/iFOBT. Gift card only available in absence of FIT-DNA in the previous three years, sigmoidoscopy or CT Colonography within the previous 5 years or colonoscopy within the previous 10 years
	$30	Available for members every three years for members that complete a FIT-DNA (Cologuard®)
	$50	Available for members every 5 years who complete a CT Colonography or Sigmoidoscopy at a provider facility
	$50	Available for members every 10 years who complete a Colonoscopy at a provider facility
Eye Exam for Patients With Diabetes (EED)	**$40**	Available for diabetic members 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
Health Needs Assessment (HNA)	**$20**	Available for all members annually who complete a health needs assessment online, by phone or mail

Gift cards can be used at certain retailers. Check with the plan for more details.

You Make a Big Difference in Your Patient's Experience

The Centers for Medicare & Medicaid Services (CMS) is increasingly focused on the member's quality of life, functional health status and experience with key aspects of their care. CMS uses two surveys, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Health Outcomes Survey (HOS), to measure the member's experience and self-reported outcomes. These surveys account for more than a quarter of overall CMS star quality ratings for health plans.

BlueCross BlueShield of Tennessee's Medicare Advantage plan introduced two new member experience survey measures into the Quality+ Partnerships program beginning with the 2021 program measurement year.

Member Experience – CAHPS

This measure is scored on the combination of two of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey component measure categories (for randomly selected members who are enrolled continuously with the health plan for at least six months):

- Getting Appointments and Care Quickly
- Care Coordination

Member Experience – HOS

This measure is scored on the combination of two of the Health Outcomes Survey (HOS) component measure categories (for a randomly selected group of members that serve as a baseline and a follow up with the same group of members from the two years previous baseline group):

- Improving Bladder Control
- Reducing the Risk of Falling

Please encourage your patients to participate in the CMS surveys so we're better able to identify opportunities for improvement.

Survey Questions Members Receive

To assist our provider groups with the two new member experience measures, we've included the actual survey questions for both the CAHPS and HOS component measure categories below.

Actual CAHPS Survey Questions for the Component Measure Categories

Answer options for the following questions include "Always", "Usually", "Sometimes" and "Never". Answers of "Always" and "Usually" positively impact your scores in this component measure the most.

Getting Appointments and Care Quickly

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a checkup or routine care as soon as you needed?

Care Coordination

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, 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?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

Actual HOS Survey Questions for the Component Measure Categories

Answer options for the following questions include "Yes", "No" and "I don't know". Depending on the question, answer options of "Yes" and "No" both positively impact your scores in this component measure.

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?

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?

Helpful Tips and Techniques: Your interaction with patients has a direct impact on their response to the CAHPS and HOS surveys. Below you'll find some simple techniques shared by high-performing provider groups. They've found that using these in their daily interactions with patients can provide pateints with a better experience, help them achieve better health outcomes, and can lead to better patient retention.

CAHPS: Getting Appointments and Care Quickly Survey Tips

- Acknowledge wait times of longer than 15 minutes by apologizing, providing an explanation and giving an approximate time that patients can expect to be seen.
- Manage patients' expectations when they're significantly early for their appointments, i.e., thank them and explain they may wait longer than 15 minutes.
- If you are running behind schedule, please let patients know before they come to the office so they can adjust their arrival or reschedule their appointment.
- Ensure a few appointments each day are available to accommodate urgent or unplanned visits.
- Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away.
- Offer appointments with an NP or PA to patients who want to be seen on short notice but cannot be seen by their doctor.
- Encourage patients to make their routine appointments for checkups or follow-up visits as soon as they can (weeks or even months in advance).
- Proactively schedule patients' appointments weeks or months before their tests, screenings or physicals are due. Don't wait for patients to call.
- Consider limited-hour Saturday appointments weekly or bimonthly.

CAHPS: Care Coordination Survey Tips

- Establish a system to follow up on each diagnostic or lab result.
- Set appropriate timeframes for result communication, i.e., five days for normal results, 24 hours for stat results.
- Educate patients on established timeframes and communication avenues for results, such as phone calls, mail, patient portal and follow-up visits.
- Ask patients how they would prefer to receive test results and provide as requested.
- Educate patients on why they're being referred to a specialist and help coordinate the scheduling of referrals and transfer of records rather than assigning this task to the patient.
- Educate patients on timeframes for obtaining specialist appointments according to their symptoms. Discuss and plan for possible appointment delays.
- Standardize your referral tracking process. Set up a system for tracking outstanding referrals once a week and follow up to ensure care is moving forward. Monitor the response times of referral partners and provide feedback when response times aren't satisfactory.
- Establish workflow processes to ensure that the PCP is informed of lab results and specialist reports.
- If you know patients received specialty care, discuss their visit and the treatment plan they received at their next clinic or telehealth visit.

High performance with HOS survey measures is largely dependent upon the patient **remembering** that they discussed bladder control and falling with a provider. Screening patients for bladder control issues and fall risk are recommended to be conversational rather than a list of screening questions, as patients don't want to feel tested or appear frail.

HOS: Survey Tips, Improving Bladder Control

- Screen all patients for urinary incontinence and discuss treatment options if positive through conversations rather than reading through a list of screening questions. For example, educate female patients about the prevalence of urine leakage with age and ask "Has that ever happened to you?".
- Recommend treatment options no matter the frequency or severity of the bladder control problem.

HOS: Survey Tips, Reducing the Risk of Falling

- Discuss balance problems, falls, difficulty walking and other risk factors for falls.
- Ask patients **how many times** they have fallen over the past year rather than **if** they have fallen or not.
- Have educational and encouraging conversations with patients about falls, specifically how to prevent falls and how to "fall well" should they experience falls in the future.
- Perform the "Get Up and Go" (GUG) test to assess the patient's balance.
- Recommend the use of a walker or cane, if appropriate.
- Check standing, sitting and reclining blood pressures.
- Recommend a physical therapy or exercise program, if appropriate.
- Recommend vision and hearing tests, if appropriate.
- Perform bone density screenings, especially for patients at risk.
- Consider home health performing a home safety assessment to look for risks for tripping.

This information applies to all BlueCross Medicare plans.

Matter of Balance Program Available for Your Patients

A Matter of Balance is an evidence-based approach to fall prevention in older adults. It was developed from a grant by National Institute on Aging and later developed into a volunteer lay leader model by MaineHealth's Partnership for Healthy Aging. The goal is to train lay leaders within communities to offer these programs to older adults.

The program enables participants to achieve significant goals. They gain confidence by learning to:

- View falls as controllable
- Set goals for increasing activity
- Make changes to reduce fall risk at home
- Exercise to increase strength and balance

This program is being offered by the BlueCross Medicare Advantage Health Outcomes Survey (HOS) Fall Prevention and Urinary Incontinence work group as part of our overall fall prevention strategy. Health Navigators and others are trained as certified Matter of Balance Coaches and can instruct members during health needs assessments, fall prevention call campaigns, and teach classes offered through the plan. For more information contact your local Provider Quality Outreach Consultant.

Common Urinary Incontinence Assessment Tools:

The Urinary Distress Inventory (UDI-6):
https://www.bestresultspt.com/userfiles/files/Urogenital%20Distress%20Inventory%20UDI%206.pdf

The Incontinence Impact Questionnaire (II Q-7):
https://www.ohsu.edu/sites/default/files/2019-06/Female-Urology-Questionnaire-7.pdf

Common Fall Risk Assessment Tools:

The Stopping Elderly Accidents, Deaths & Injuries (STEADI) Assessment:
https://www.cdc.gov/steadi/pdf/STEADI-Form-RiskFactorsCk-508.pdf

The Get Up and Go (GUG) Test: https://www.cgakit.com/

Additional CAHPS/HOS Measure Categories Not Included in the Quality+ Partnerships Program

Below includes information about additional CAHPS and HOS survey measure categories that your patients may be asked that aren't included in the current Quality+ Partnerships program. Although these categories aren't included, you can play a part in impacting the responses.

Actual CAHPS Survey Questions

Answer options for the following questions include "Always", "Usually", "Sometimes" and "Never". Answers of "Always" and "Usually" positively impact your scores in this component measure the most.

Getting Needed Care

- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Annual Flu Vaccine

- Have you had a flu shot since July 1?

Actual HOS Survey Questions

Answer options for the following questions include "Yes", "No" and "I don't know". Depending on the question, answer options of "Yes" and "No" both positively impact your scores in this component measure.

Improving or Maintaining Physical Health

- In general, would you say your health is:
  - Excellent
  - Good
  - Poor
  - Very Good
  - Fair
- 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 a result of your physical health?
- During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Improving or Maintaining Mental Health

- 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 any emotional problems (such as feeling depressed or anxious)?
  - Accomplished less than you would like as a result of any emotional problems?
  - Didn't do work or other activities as carefully as usual as a result of any emotional problems?

- These questions are about how you feel and how things have been with you during the past four weeks. How much time during the past four weeks:
  - Have you felt calm and peaceful?
  - Have you felt downhearted and blue?
  - Did you have a lot of energy?
- During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

Monitoring Physical Activity

- In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity?
  - For example, a doctor or other health provider may ask if you exercise regularly or take part in physical exercise.
- In the past 12 months, did a doctor or other health provider advise you to start, increase or maintain your level of exercise or physical activity?
  - For example, in order to improve your health, your doctor or other health provider may advise you to start taking the stairs, to increase walking from 10 to 20 minutes every day or to maintain your current exercise program.

Helpful Tips and Techniques: Your interaction with patients has a direct impact on their response to the CAHPS and HOS surveys. Below you'll find some simple techniques shared by high-performing provider groups. They've found that using these in their daily interactions with patients can provide patients with a better experience, help them achieve better health outcomes, and can lead to better patient retention.

Getting Needed Care

- Assist with scheduling the appointment rather than assigning this task to the patient.
- Educate patients on timeframes for obtaining specialist appointments according to their symptoms. Discuss and plan for possible appointment delays.
- Request the soonest appointment date. If needed, request patients be put on an "on call" list to be contacted if an earlier appointment time opens up.

Annual Flu Vaccine

- Encourage flu shots starting in July. Patients are more likely to get the flu vaccine when it's recommended and/or offered by their PCP.
- Address any concerns the patient may have about getting the flu from the flu shot.

Improving or Maintaining Physical Health

- 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.
- Recommend appropriate physical activity, and provide educational materials, suggested exercise and information on fitness programs and other community resources.
- Assess pain and intervene, if appropriate.
- Follow up and encourage patients to continue being active.
- Encourage patients to use their Silver & Fit benefit.

Improving or Maintaining Mental Health

- Consider screening for cognitive impairment, dementia and depression (PHQ9 screening).
- Assess and discuss mental health status at every appointment, whether or not the patient screens positive for a mental health condition.
- Refer patients to a mental health provider for counseling and further evaluation when appropriate.
- Use motivational interviewing to improve treatment, engagement and behavioral and physical health outcomes.

Monitoring Physical Activity

- Discuss and assess your patients' physical activity level over the past year.
- Discuss health benefits and advise patients to start, increase or maintain their level of physical activity as appropriate for their individual health status.
- Develop physical activity plans with patients that match their abilities. Include these in the post-visit instructions.
- Refer patients with limited mobility to physical therapy to learn safe and effective exercises.
- Encourage participation in a gym, fitness and exercise programs, such as the Silver&Fit program, and local community resources.
- Write a physical activity prescription for patients.

Did You Know? BlueAdvantage (PPO)℠, BlueAdvantage Plus (PPO)℠, BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-SNP)℠ members have a free Silver&Fit® benefit. This free fitness program for seniors includes access to more than 15,000 participating fitness centers. The program also offers fitness classes for all abilities at many fitness centers as well as on-demand digital workout videos and health and nutrition tips.

Silver&Fit®

The Silver&Fit® Program

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:

Fitness Centers Nationwide

- No-cost membership at participating fitness centers
- Many fitness centers offer:
  - Group fitness classes tailored to older adults
  - Dance or yoga studios and/or swimming pools

Member Resources

- The Well-Being Club
- The *Silver Slate*® quarterly newsletter

Talk to your patients about starting, increasing or maintaining their level of exercise and refer them to the Silver&Fit Program at their next visit.

BlueCross BlueShield of Tennessee includes the Silver&Fit program at no additional cost for members of these Medicare Plans:

BlueAdvantage (PPO)℠
BlueAdvantage Plus (PPO)℠
BlueCare Plus (HMO D-SNP)℠
BlueCare Plus Choice (HMO D-SNP)℠
BlueCare Plus Select (HMO D-SNP)℠
BlueElite℠ Medicare Supplement

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

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. Persons shown are not Silver&Fit members. Silver&Fit and the Silver&Fit logo are federally registered trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. ASH Fitness is an independent company that provides the Silver&Fit Healthy Aging and Exercise program for BlueCross BlueShield of Tennessee, Inc. (BCBST). ASH Fitness does not provide BCBST branded products and/or services. ASH Fitness is solely responsible for the products and/or services they provide.

Population Health – BlueAdvantage (PPO)℠

The Medicare Advantage Population Health program is a fully integrated medical and behavioral health care management team which includes registered nurses, licensed social workers, registered dietitians, and health navigators 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/Chronic Care Management
- Transition of Care Assistance
- Behavioral Health Care Management
- Specialized Support Services through Licensed Social Workers and Registered Dietitians
- Renal Disease Management for ESKD and Stage 4 & 5 CKD
- Coordination of Care Services
- Digital Case Management

Targeted Interventions

- Coordinate access to services for members with complex illnesses and chronic care conditions
- Educate members and/or their designated caregivers on any diagnoses
- Identify potential risks through proactive outreach
- Support and reinforce the provider's plan of care
- Develop plans of care with SMART goals based on member's and/or designated caregiver's consent/agreement
- Work with members and/or caregivers to identify and mitigate barriers to care to ensure effective progression towards care plan goals
- Empower members and/or designated caregivers to take control of their member's health and maintain to ensure good outcomes
- Communication options to allow members to engage in the way that's most comfortable to them

To make a referral, contact the BCBST Medicare Advantage Case Management Referral Inbox: MA_Case_Management@bcbst.com 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:

Heather Williams, BSBA, RN, CCM

Supervisor, MA Population Health
Phone: (423) 535-7028
Email: Heather_Williams@bcbst.com

Jennifer Phillips, MSN, MBA, RN, CCM

Supervisor, MA Population Health
Phone: (423) 535-7571
Email: Jennifer_Phillips@bcbst.com

This information applies to BlueAdvantage (PPO)℠ plans ONLY.

Population Health – BlueCare Plus HMO (D-SNP)SM

The BlueCare Plus Tennessee D-SNP Population Health program is a fully integrated medical and behavioral health care management team which includes registered nurses and licensed social workers 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 Social Workers
- Transplant Care Management
- CareTN Digital Care Management App
- Respiratory Care Program
- Palliative Care Program
- Telemonitoring Care Program

Targeted Interventions

- Coordinate access to services for members with complex illnesses
- Support and reinforce the provider's plan of care through Interdisciplinary Care Team (ICT) participation
- Educate members and their caregivers on any diagnosis made by their provider
- Member and Caregiver education for chronic illnesses, wellness and preventive care
- Motivational Interviewing through Patient Activation Methods
- Follow Up for Emergency Department episodes

To make a referral or contact our Population Health Department, call **1-877-715-9503**.
For assistance with escalated or urgent issues, please contact a member of our Population Health Management Team:

Angela Keylon

Manager, Health Promotion
Phone: (423) 535-4413
Email: Angela_Keylon@bcbst.com

Haley Copeland

Stars Quality Manager
Phone: (423) 535-1739
Email: Haley_Copeland@bcbst.com

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 diabetes prevention program 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 D-SNP)℠
BlueCare Plus Choice (HMO D-SNP)℠
BlueCare Plus Select (HMO D-DNP)℠
Phone: 1-877-715-9503
Fax: 1-866-325-6694

If you have any questions about this benefit, please call our MA PPO Provider Service line at **1-800-924-7141** or BlueCare Plus D-SNP HMO Provider Service line at **1-800-299-1407**, Monday through Friday from 8 a.m. to 6 p.m. (ET).

Telehealth Services

Telehealth services through Teladoc™ Health 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.

Teladoc Health 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 Teladoc Health 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.

Teladoc Health providers don't write prescriptions for controlled substances or refills for chronic medical conditions.

It's easy for members to get started using Teladoc Health

Members can use Teladoc Health 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.

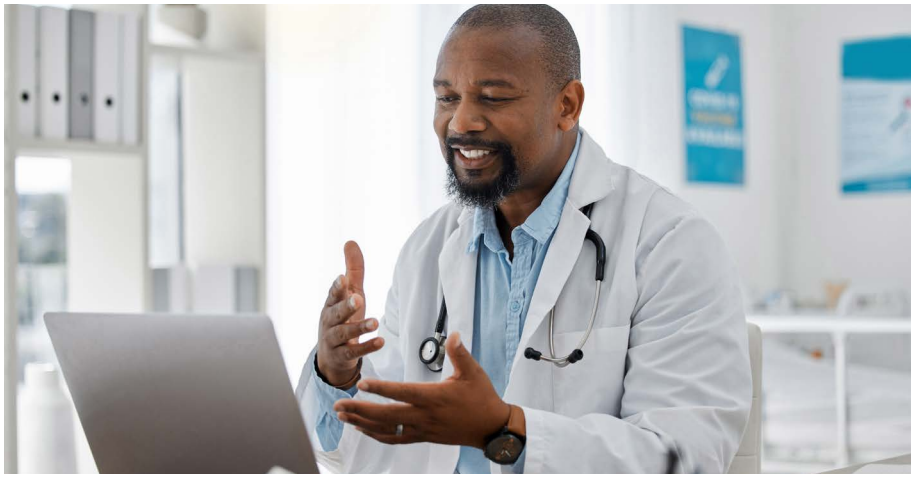
Setting up an account is free, but members will have to pay the equivalent of their PCP copayment for the consultation. Customer Service can help anyone with questions about Teladoc Health benefits or cost-share.

Members can download the Teladoc Health app

The mobile app is available at the Apple® App Store® or Google Play™.

Teladoc Health is safe and private

Teladoc Health 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 MA PPO Customer Service at **1-800-924-7141** or BlueCare Plus HMO D-SNP Customer Service at **1-800-332-5762**, Monday through Friday, 8 a.m. to 6 p.m. (ET).



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

Member Home Meal Benefit After Discharge

All BlueAdvantage (PPO)℠ plan, BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-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® and Senior Solutions at Home, Inc. to provide this service at no cost to our members.

Question	Answer
What is Home Delivered Meals?	• Mom's Meals NourishCare and Senior Solutions at Home Inc. will supply members with the meals after discharge to home. • **BlueAdvantage plan** members will receive **a total of 14 meals** following discharge from an acute hospital observation or inpatient stay or skilled nursing facility. • **BlueCare Plus** members will receive **two meals per day for fourteen days** following discharge from an acute inpatient hospital or skilled nursing facility. • **BlueCare Plus Choice** members will receive **two meals per day for twenty-eight days** following discharge from an acute inpatient hospital or skilled nursing facility. • **BlueCare Plus Select** members will receive **two meals per day for twenty eight days** following discharge from an acute inpatient hospital or skilled nursing facility. • All 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 NourishCare and Senior Solutions at Home Inc.?	• Members are eligible for Home Delivered Meals based on the plan definitions above. - The inpatient acute care setting includes the following settings: • Inpatient in the hospital • Long-Term Care Facility • Acute Inpatient Rehabilitation • 23-hour Observation • 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. • 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 meals are delivered at one time. • Most meals only need to be microwaved to be ready to eat. - If a member doesn't have a microwave, the Home Delivered Meal provider can suggest options that don't require a microwave. • Home Delivered Meal provider can accommodate most dietary restrictions or special diets.
How does a member know if they qualify for the Home Delivered Meals benefit?	• The Inpatient Nurse or a Nurse Case Manager will advise the member and/or discharging facility if the Home Delivered Meal benefit is an option for them. - If the member wants to use the Home Delivered Meal benefit, an MA PPO Nurse Case Manager or BlueCare Plus Tennessee HMO D-SNP Care Coordination team member will activate the benefit upon member discharge. • Members can call and request the benefit from the Home Delivered Meal provider. - If the member calls to request the benefit, the Home Delivered Meal provider will verify with the appropriate Population Health Team that the member meets the qualifications to start the benefit.
What happens after the member has used their Mom's Meals NourishCare and Senior Solutions at Home Inc. benefit?	• If the member likes the Home Delivered Meal from their provider, they will have the option to purchase additional meals at their own cost, after the meal benefit has ended. The cost of Mom's Meals are currently $7.99/ $8.99 + shipping included, if the member wishes to purchase additional meals directly.

Transportation Benefit for Health-Related Treatments

VERIDA

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

Question	Answer
What is the transportation benefit?	• **BlueCare Plus** members are eligible for up to **one hundred fifty (150) 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.** • **BlueCare Plus Choice** members are eligible for up to **sixty (60) 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.** • **BlueCare Plus Select** members are eligible for up to **sixty (60) 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?	• **BlueCare Plus**, **BlueCare Plus Choice** and **BlueCare Plus Select** 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**. • **BlueCare Plus** members are limited to **one hundred fifty (150)** and **BlueCare Plus Choice** members **sixty (60)** one-way trips per calendar year with **fifty (50) miles per-one way** trip distance. **BlueCare Plus Select** members are limited to **sixty (60)** 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 • **BlueCare Plus**, **BlueCare Plus Choice** and **BlueCare Plus Select** 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)℠ plans

PPO Over-the-Counter (OTC) Catalog Benefit

All BlueAdvantage (PPO)℠ plan 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 CVS to provide this service at no cost to our members.

Question	Answer
What is the Over-the-Counter (OTC) benefit?	• **BlueAdvantage PPO plan** members are eligible for **four quarterly benefit credits** (amounts vary between $100 and $200 per quarter depending on the member's plan) that can be used to purchase items from a catalog of covered over-the-counter health and wellness products. This benefit includes certain health and personal items like bandages, pain relievers, cold remedies, toothpaste and more. Items can be purchased in store or ordered and shipped directly to the member.
What are the costs and limitations?	• There is **no cost-share** for the member with the OTC benefit. • Quarterly benefit credits may only be used to purchase items from the **OTC catalog**. • Members have **no limit of the number of items** they order. There is, however, a **quantity limit of nine per any single item**, per quarter. There are some select products marked in the catalog with a "star" or a "square" that have special limits.
Will benefit credits carry-over from quarter to quarter?	• Unused allowance amounts **do not carry over** from quarter to quarter.
Can members order more than their benefit amount?	• Members can't exceed their benefit amount when ordering online or by phone. However, they may exceed their benefit amount at an OTC Health Solutions-enabled CVS Pharmacy® store and pay the difference out of pocket.
Are all items available at the stores?	• Not all items are available in stores. Items marked with a "bullet" in the catalog can only be ordered over the phone or online.
How long will it take for members to receive their items once they order?	• Most orders will arrive in less than seven business days. There may be exceptions during peak volume periods as well as for orders containing hazardous items. • Once the order has been completed, members will receive a confirmation number. Members can use the automated IVR system or opt in to receive tracking information via email or text. • Orders may only be canceled within 30 minutes of processing by using the automated IVR system or speaking with a live agent.
How does a member access the OTC benefit?	• Members have three ways to order OTC catalog items: - **In-Store:** To find the nearest location for Over-the-Counter Health Solutions (OTCHS), members may go to bcbstmedicare.com/OTC or call OTCHS at **1-888-628-2770, TTY 711**. It's important to note that not all CVS stores accept this benefit. - **Online:** Order online at bcbstmedicare.com/OTC - **Phone:** Order by phone **1-888-6282770, TTY 711**. Live agents available Monday through Friday 9:00 am to 8:00 pm ET.

DSNP Over-the-Counter (OTC)/Healthy Food Benefit

BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-SNP)℠ members have access to a monthly supplemental benefit that allows them to purchase certain, covered over-the-counter and healthy food. BlueCross has partnered with PayForward to provide this service at no cost to our members.

Question	Answer
What is the Over-the-Counter (OTC)/ Healthy Food benefit?	• **BlueCare Plus**, **BlueCare Plus Choice** and **BlueCare Plus Select** members receive a flex card that gives them a certain amount depending on the member's plan each month to buy certain OTC products and healthy food at participating retail locations. They may also place an order for OTC products online, over the phone, or by mail through the OTC catalog that's sent to them. Items are shipped directly to them. This card is used for both benefits and provides a combined monthly allowance.
What are the costs and limitations?	• There is **no cost-share** for the member with the OTC/Healthy Food benefit through PayForward. • **BlueCare Plus**, **BlueCare Plus Choice** and **BlueCare Plus Select** members are allowed **one order per month** not to exceed **the monthly allowance** (product price + applicable sales tax).
Will benefit amounts carry over from quarter to quarter?	• Amounts **do not carry over** from month to month. Any unused amount will expire at the end of each month.
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/Healthy Food benefit?	• **BlueCare Plus**, **BlueCare Plus Choice** and **BlueCare Plus Select** members can order OTC items the following ways: - **Online:** visit bcptncard.com - **Mail:** fill out and return the order form provided to: BlueCare Plus Tennessee OTC Orders 4613 N. University Drive, #586 Coral Springs, FL 33067 - **Phone:** place an order by phone by calling **1-800-384-2038, TTY 711**, Monday through Friday from 8 a.m. to 8 p.m.. ET. - **In-Store:** Use the member's myFlexCard in-store by visiting a participating pharmacy or retailer to buy eligible OTC items with available funds. Participating retailers and OTC categories can be found under the Over-the-Counter Benefit section of the online portal at bcptncard.com.

AbleTo Behavioral Health Program

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

Question	Answer
What is the goal of the behavioral health program?	• 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.
What does the behavioral health program offer?	• **8-week** behavioral health program providing customized, structured support and coaching. • Sessions are conducted in the comfort of the member's home confidentially over the **phone** or by **video**. • Virtual and digital therapy programs are available to meet members' varying needs: - The **Therapy 360** program provides twice-weekly therapy and coaching sessions with an LCSW and behavioral coach, delivered via phone or video up to 15 sessions, with digital tools included. Members who are appropriate for this program are more complex and have a comorbid medical condition, accompanying life stressor event, or are in care management. - The **Therapy+** program provides one-on-one virtual therapy sessions with an LCSW delivered via phone or video up to 8 sessions, with digital tools included. Members who are appropriate for this program are seeking high quality, flexible convenient one-on-one therapy. - The **Digital+** program provides a self-guided emotional support program with digital tools and a live coach. Members who are appropriate for this program want a self-paced digital experience with the support of a personal coach.
Who will the members work with?	• The member's personal team includes a licensed therapist and a behavioral coach. • 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. • All behavioral coaches have master's-level education in a health-related field and experience in counseling.
What are the costs and limitations?	• There is **no cost-share** for the member with the behavioral health program through AbleTo. • Prior authorization is **not required**. • 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. • Currently, AbleTo doesn't provide any psychiatric services and can't prescribe any medications.
What are the hours that the behavioral health program is available?	• Sessions are available **24 hours a day, seven days a week**. • Members can participate from the comfort and privacy of their home at times that best fit their schedule. • Appointments are available as soon as the very next day.
How does a member begin participation in the program?	• AbleTo will contact members that are referred by BlueCross. • Members may also be referred by their providers for this program by contacting BlueCross MA PPO Population Health at **1-800-611-3489** or BlueCare Plus HMO D-SNP Population Health at **1-877-715-9503**.

CareTN Digital Chronic Condition Management Programs

All BlueAdvantage (PPO)[SM] plan, BlueCare Plus (HMO D-SNP)[SM], BlueCare Plus Choice (HMO D-SNP)[SM] and BlueCare Plus Select (HMO D-SNP)[SM] members have access to digital care management programs designed to engage and support members in managing their chronic conditions. Access to these programs are available through a free, secure mobile app called CareTN. BlueCross has partnered with Wellframe Inc. to provide this service at no cost to our members.

Question	Answer
What is CareTN?	CareTN is a mobile app that offers on-the-go access to care management support for members with chronic conditions. Like telephonic care management, CareTN provides one-to-one digital connection to a BlueCross nurse, social worker, pharmacist, health navigator and/or dietitian.
How do members qualify for CareTN?	**BlueAdvantage, BlueCare Plus**, **BlueCare Plus Choice** and **BlueCare Plus Select** members are automatically qualified for CareTN.
What are the costs and limitations?	• There is no **cost-share** for the members. • The member must have a smart device such as an Apple iPhone®, iPad® or Android® device in order to download and use the CareTN app.
What programs are available?	The programs available through CareTN include, but are not limited to: • Diabetes • Wellness & Prevention • Atrial Fibrillation • Coronary Artery Disease • Hyperlipidemia • Hypertension • Physical ActivityCare Transitions: Surgical, Medical, and Post-Discharge Behavioral Health & Wellness • Weight Loss • Smoking Cessation • Stress Management • Chronic Back Pain • Chronic Care & Complex Care: Diabetes Prevention, Asthma, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease • Oncology • Gaps in Care • Fall Prevention
What features does the CareTN app have?	• HIPAA-secure text messaging • Access to nurses, social workers, and dietitians • Medication list and reminders • Goal setting and progress monitoring • Appointment reminders • Access to a curated health library of articles and videos • Checklist of things to do related to a condition
How does a member access the CareTN program?	Members are first mailed invitations to participate in the CareTN digital care management program. There are two options for enrollment once the member has been determined to meet eligibility and agrees to participate: • A BlueCross case manager or health navigator can assist the member with enrollment • Self-enrollment is available through the CareTN app directly

Somatus® Kidney Disease Management Program

All BlueAdvantage (PPO)℠ plan members have access to an integrated kidney disease management program for stages 4 and 5 chronic kidney disease and end-stage kidney disease. BlueCross has partnered with Somatus®, Inc. to provide this service at no cost to our members.

Question	Answer
What is the Somatus program?	The Somatus kidney disease management program provides wrap around renal care coordination for clinical and psychosocial needs. This program deploys a specialized team to work side-by-side with members, PCPs, nephrologists, and dialysis centers for members with end-stage kidney disease (ESKD) and late stage chronic kidney disease (Stages 4 and 5 CKD). Field-based, virtual and telephonic care coordination is provided to assist members in managing their kidney disease through education about their condition, treatment options, diet, information on transplantation, dialysis modality alternatives, and assistance with social determinants of health barriers. The program also includes reminders about routine screenings covered under their BlueCross plan.
How do members qualify for the program?	**BlueAdvantage ESKD and Stages 4 and 5 CKD** members are automatically qualified for the Somatus program.
What are the costs and limitations?	There is no **cost-share** for the members.
What is included in the program?	Members in the Somatus program are connected to a care team, comprised of a nurse care manager, community health worker, nurse practitioner, renal pharmacist, renal dietitian, and social worker. This care team supports the member Home Modality in the following areas: • Nutrition and Health Coaching • Behavioral Health • Social Services • Home Modality Education and Access Management • Medication Management • Closing Quality Gaps in Care • Transplant Options • Advanced Care Planning
What benefits do members gain from the program?	Members who participate in the Somatus program receive a detailed assessment of needs with a leave-behind care plan they can share with their doctor, along with access to the member engagement application which provides supportive educational resources, the ability to track goals, engage in on-demand learning, and connect with peers on topics of interest. The program features ongoing follow-up at a frequency needed to address all aspects of their health or social needs. Some of the services members have access to are: • Hospital transition services • Diet and lifestyle management and health coaching • Home modality education • Access to community resources

Question	Answer
What outcomes can members expect from this program?	Depending on the member's kidney care needs and other chronic conditions or social needs, they might expect different outcomes. The Somatus goal is to keep members healthier at home and out of the hospital by: • Using the latest in scientific evidence and care guidelines, medication management, member support and member education to delay or stop the progression of CKD • Coordinating permanent dialysis access to reduce the risk of infections and complications • Discussing all renal replacement treatment options, including home dialysis and transplantation, and coordinating any transition with the provider • Teaching self-management skills and engaging the family/caregiver • Teaching appropriate system monitoring and management
How do members participate?	Members participate in the program by engaging with the Somatus care team members in the assessment, care planning, and ongoing follow-up process. To engage, members can email Care@somatus.com or call **(855) 851-8354**. Contact frequency is determined by the member's needs or wishes and will be either in-person (home, dialysis center, doctor's office), virtually through a mobile device, or by phone. Members not wishing to engage at that level can still participate by accessing video education through the member engagement application.
How can providers work with Somatus?	Somatus asks that providers collaborate with the Somatus care management team on a regular basis. Somatus will likewise collaborate with network providers. Providers can also assist by encouraging members to engage with the care team members. Additionally, providers can support home dialysis options where appropriate, especially for members newly transitioning to dialysis.
How can providers refer members?	Providers may refer members or reach out with questions by contacting the Somatus Tennessee care management team by phone at **(855) 851-8354** or e-mail at Care@somatus.com.

Reminder: Your patients may be contacted for participation in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and/or the Health Outcomes Survey (HOS) each year. Encourage your patients to participate in these standardized CMS surveys, as they are useful tools to measure the member's experience with their care as well as self-reported outcomes. Additionally, these surveys account for more than a quarter of overall CMS star quality ratings.

Best Practice Tips

Provider Assessment Form (PAF/PACF) Completion

- Begin scheduling Annual Wellness Visits in late December for the following year or early January.
- Review your list of BlueAdvantage and BlueCare Plus patients on at least a quarterly basis to identify those that still need a PAF/PACF.
- Review the Quality Care Rewards application before each PAF to prepare to address conditions that may have been documented in previous years, and help identify any existing open quality measure gaps.
- Encourage office staff to see if a PAF/PACF 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 using nurses or pharmacists before the actual provider visit to pre-populate PAF/PACF documentation or perform medication reconciliation.
- If you do an Annual Wellness Visit with the PAF, BlueAdvantage members will qualify for a $20 gift card if they are enrolled in the member wellness and rewards program. BlueCare Plus members will receive a $50 gift card. BlueCare Plus members don't have to be enrolled in the member wellness and rewards program.
- Remind patients that a regular, routine eye exam isn't the same as a diabetic retinal eye exam. Encourage diabetic patients to complete a retinal eye exam during or in addition to their routine eye exams and remind them that a $40 gift card is available for this specific exam if they are enrolled in the Member Wellness and Rewards program.

Transitions of Care

- Partner with local hospitals that you may not be receiving ADT feeds from to make sure you're receiving admission and discharge information for patients.
- Use on-hold messaging opportunities to remind your patients to schedule a follow-up visit within five (5) days of being discharged.
- Follow the guidelines for Transitional Care Management after a discharge to close the Patient Engagement After Inpatient Discharge and Medication Reconciliation Post-Discharge component gaps, and also receive higher reimbursement than a traditional office visit.
- Contact patients as soon as possible after discharge to schedule a visit (office, home, telephone, telehealth, e-visit or virtual check-in).
- Confirm that check boxes used to document medication reconciliation in your EHR contain the language that's required.
- Use the ADT and/or discharge report located in the Quality Care Rewards application to proactively identify patients who have been discharged from an in-patient facility that may need a post-hospital follow-up visit and medication reconciliation.
- Ensure that communication from facilities, facility staff, other providers, etc. of inpatient admissions and inpatient discharges are dated and placed in the outpatient medical record to show proof of when the notifications were received.

Best Practice Tips Continued

Breast Cancer Screening

- Remind patients that if they participate in the member wellness and rewards program, they can receive a gift card for getting their mammogram. "Did you know you can receive a $25 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 a gift card for completing a colorectal cancer screening may be available to them. Gift card amounts will vary depending on screening type and BlueCross product (MA PPO, BlueCare Plus HMO D-SNP).

Home Bound Patients

- Let your outreach consultant know if you have patients with transportation issues. We work with companies who specialize in several preventive screenings and can complete these for your patients in the comfort of their home. The results are always faxed/mailed to the member's primary care provider so they can be incorporated in your patient's chart.
- Consider a telehealth visit for patients who are unable to come into the office for a face-to-face visit.

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 with documented osteoporosis.
- Determine if your patient meets criteria for advanced illness and frailty exclusions.
- Talk about the benefits of screening after fracture, which include confirming the diagnosis of osteoporosis, predicting the chance of future fractures and determining the rate of bone loss.
- Discuss available options for testing (X-rays, dual-energy X-ray absorptiometry (DEXA or DXA) or a CT scan to determine bone density of the hip or spine).
- Review common risk factors so patients can take steps to manage their risk of low bone mass. In addition to advancing age, these include smoking, excessive alcohol use, certain medical conditions (rheumatoid arthritis, type 1 diabetes, liver disease, kidney disease, hyperthyroidism or hyperparathyroidism), a family history of hip fracture, and using steroids long-term.
- Let patients know that treatment is available and starting treatment early helps minimize bone loss and prevent future fractures.

Best Practice Tips Continued

Advanced Illness and Frailty Exclusions

- Consider implementing a process to identify and add appropriate advanced illness and/or frailty diagnoses for patients with upcoming appointments and/or during PAF/PACF completion.
- If the documentation exists for an advanced illness and/or frailty diagnosis from a previous visit, you may bill CPT® 99499 for the date of service of the previous visit and include the applicable advanced illness and/or frailty code.

Diabetic Eye Exams

- Consider developing a program to incorporate a mobile retinal scanner and ophthalmology interpretation in your office for your patients who don't routinely see an eye care professional.
- Remind patients that a gift card for getting a diabetic retinal eye exam may be available. "Did you know you can receive a $40 gift card for having a diabetic retinal eye exam?"
- Talk to your local eye care professional about reserving blocks of time for your diabetic patients that need a retinal eye exam.
- Establish a process to receive results from local eye care specialists for all diabetic eye exams.
- Remind patients that a regular, routine eye exam isn't the same as a diabetic retinal eye exam. Encourage diabetic patients to complete a retinal eye exam during or in addition to their routine eye exams and remind them that a $40 gift card is available for this specific exam if they are enrolled in the Member Wellness and Rewards program.

Statin Therapy for Patients with Cardiovascular Disease

- Document statin intolerance in the patient's medical record and include appropriate ICD-10® code(s) on claims for diagnoses of myalgia, myositis, myopathy and/or rhabdomyolysis.
- Determine if your patient meets criteria for advanced illness and frailty exclusions.
- Ensure the medical record clearly documents the exclusion in the notes. Patients don't have to attempt taking a statin medication once a year to qualify for the muscle pain or muscular disease exclusion. The provider should document in the measurement year that the patient has myalgia or muscle cramps when taking statins as a reason for not being on them.
- Attestations for statins received through cash pay, VA or patient assistance programs and SPC measure exclusions can also be made in the Quality Care Rewards application located in Availity®.

Statin Use in Persons with Diabetes

- Review records of non-compliant members for diagnoses that qualify for exclusion from this measure.
- Document statin intolerance in the patient's medical record and include appropriate ICD-10 code(s) on claims for diagnoses of rhabdomyolysis or myopathy; pregnancy, lactation, or fertility; cirrhosis; pre-diabetes; and polycystic ovary syndrome (PCOS).
- The diagnosis code for the applicable condition must be submitted on a claim to exclude the patient. The condition the diagnosis code refers to doesn't have to necessarily occur in the same year the diagnosis code was submitted. The member's medical chart should reflect a "history of" the condition if the condition isn't acute. These diagnosis codes are intended to close Star measure gaps and don't apply to payment or reimbursement. Only the diagnosis codes for the conditions above will exclude the member from the SUPD measure. Patients must be excluded each measurement year.

BlueAdvantage Freedom (PPO)SM

A Plan Designed with Veterans in Mind and Members Who Don't Need a Prescription Drug Plan

Our BlueAdvantage Freedom plan is a Medicare Advantage plan with extra everyday benefits to care for the total member. It doesn't include Part D prescription drug coverage. This plan is for members who don't want or need a prescription drug plan.

Eligibility

- The member must sign up specifically for this plan.
- The member must live in Tennessee.
- The member must be enrolled in Medicare Parts A and B.
- This plan is offered at the same time of the year and with the same restrictions as other Medicare Advantage plans.

Network

- No referrals are required.
- Members with the Freedom plan will use the same network providers as our other PPO plans.

Cost

- $0 monthly plan premiums.
- $3,200 maximum annual out-of-pocket for in-network care.

Things to Keep in Mind

- Members can't enroll in a standalone Part D prescription plan while enrolled in BlueAdvantage Freedom. Doing so will automatically disenroll them from the Freedom plan.
- Members may face a future late enrollment penalty if they go for a period of time without creditable drug coverage and later enroll in a Medicare Part D plan.
- An example of creditable coverage would be coverage a member might have through the VA.
- The same rules apply for authorization of services as with our other MA PPO plans.
- You will **not** need to set up mail order prescriptions for your patients that are enrolled in the Freedom plan as they won't have prescription drug coverage through this plan.
- Diabetic supplies, therapeutic shoes and continuous glucose monitors (CGMs) are available through Durable Medical Equipment (DME) providers.

Benefit Highlights

The BlueAdvantage Freedom plan offers extra benefits, including but not limited to:

- **Primary Care** ($0 copay)
- **Telehealth** for Certain Services
- **Fitness Program** ($0 all year)
- **Hearing Aid Coverage** as low as $199 copay
- **14 Free Meals** following inpatient stay
- **Part B Premium Reduction** (up to $40)
- **Over-the-Counter Items** ($100 allowance per quarter with no carry-over to the next quarter)
- **Eyewear** ($225 Annual Allowance)
- **Dental Care** ($2,500 Annual Allowance)

Advanced Illness and Frailty Exclusions

The National Committee for Quality Assurance (NCQA) has established specifications that impact Centers for Medicare & Medicaid (CMS) Star measures for patients with advanced illness and frailty diagnoses. Additional exclusions to these measures were made because the services recommended in the original definition may not benefit older adults with advanced illness limiting their ability to receive certain treatments.

Advanced illness codes must be submitted in the current (measurement) year or the prior year to exclude the patient from the impacted Star measures. **Frailty codes must be submitted in the current (measurement) year** in order to exclude the patient from the impacted Star measures. Please see the table below for specific measures impacted by these diagnoses.

Patients age 66 and older can be excluded if they have both advanced illness and frailty	Patients age 81 and older can be excluded with frailty alone
• Breast Cancer Screening (BCS) • Colorectal Cancer Screening (COL) • Controlling Blood Pressure (CBP) • Hemoglobin A1c Control for Patients With Diabetes (HBD) • Eye Exam for Patients With Diabetes (EED) • Kidney Health Evaluation for Patients With Diabetes (KED) • Osteoporosis Management in Women Who Had a Fracture (OMW) • Statin Therapy for Patients with Cardiovascular Disease (SPC)	• Controlling Blood Pressure (CBP) • Kidney Health Evaluation for Patients With Diabetes (KED) • Osteoporosis Management in Women Who Had a Fracture (OMW)

Helpful Tip

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

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

To qualify for frailty exclusion, the patient must have at least two claims with a frailty diagnosis or treatment code with different dates of service during the measurement year.

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. Please refer to the "Best Practices" section on page 108 of this guide for additional helpful tips with the Advanced Illness and Frailty exclusions.

Medicare Advantage Inter-Plan Care Management Program

All BlueCross Medicare Advantage Plans (including BlueCross BlueShield of Tennessee) are a part of the Inter-Plan Medicare Advantage Care Management Program created by the Blue Cross Blue Shield Association.

This 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 collaborative model is intended to lessen confusion when patients have out-of-state BlueCross BlueShield membership cards and provide a more seamless process for care among all BlueCross members. Additionally, this model helps improve Star scores, ensure appropriate risk adjustment, and increase the effectiveness of members' care management from the home Blues plan.

The Care Management program helps out-of-state Blues plans coordinate with providers to close gaps in care and risk adjustment diagnosis capture.

What You Should Know

- Providers are responsible for ensuring that documentation of needed screenings, tests and services are completed the same way they would be for BlueCross BlueShield of Tennessee MA 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 as soon as we receive the list from the out-of-state Blues plan.

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)℠ plans ONLY.

Dual Special Needs Plan (D-SNP)

D-SNP is a Medicare Advantage special needs plan serving people who are dual-eligible for Medicare and Medicaid. BlueCare Plus Tennessee offers three D-SNP plans, BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-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 is required for network providers, ICT members, and BlueCare Plus staff
- Network providers that complete the Model of Care training by March 31 each year could see an increase in reimbursement rate.

This information applies to BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-SNP)℠ ONLY.

2024 High-Level Benefit Compare
BlueCare Plus Tennessee

Benefit Description	2024 BlueCare Plus H3259 - 001	2024 BlueCare Plus Choice H3259 - 002	2024 BlueCare Plus Select H3259 - 003
Chiropractic Routine Services Supplemental Benefit	20 routine visits per year	20 routine visits per year	20 routine visits per year
Podiatry Services (Routine Foot Care)	6 visits per year	6 visits per year	6 visits per year
Meals	28 meals following discharge	56 meals following discharge	56 meals following discharge
Transportation	$0 150 one-way trips/every yr.	$0 60 one-way trips/every yr.	$0 60 one-way trips/every yr.
OTC / Food Wellness	$300 allowance/monthly	$280 Allowance/monthly	$300.00 per month combined Healthy Food OTC & Housing utilities
Housing Utilities	this amount is included in the $300 per month OTC/Food & utilities amount	$100/monthly	this amount is included in the $300 per month OTC/Food & utilities amount
Dental Services			
2 routine exams, cleanings and x-rays	$0 copay (included in plan)	Not Included	Not Included
Routine and Preventive Services	Combined Flex Card $3,900 Yearly		
Hearing Services			
Routine Hearing Exams	Combined Flex Card $3,900 Yearly	Combined Flex Card $3,300 Yearly	Combined Flex Card $3,000 Yearly
Hearing Aid/Evaluation/Fitting			
Vision Services			
Routine Eye Exams	Combined Flex Card $3,900 Yearly	Combined Flex Card $3,300 Yearly	Combined Flex Card $3,000 Yearly
Glasses / Frames / Contacts			
Pharmacy Services (Preferred and Standard)	30 / 60 / 90 Day Supply	30 / 60 / 90 Day Supply	30 / 60 / 90 Day Supply
RX Out-Of-Pocket max	$8,000	$8,000	$8,000
Initial coverage Limit	$5,030	$5,030	$5,030
1. Deductible Stage	$0	$0	$0
Tier 1: Preferred Generic	$0/$0/$0	$0/$1.55/$4.50	$0/$0/$0
Tier 1: Brand	$0/$0/$0	$0/$4.60/$11.20	$0/$0/$0
Gap Coverage	$0	$0	$0

This information applies to BlueCare Plus (HMO D-SNP)℠, BlueCare Plus Choice (HMO D-SNP)℠ and BlueCare Plus Select (HMO D-SNP)℠ ONLY.

BlueCare Plus Tennessee (HMO D-SNP)℠ 2024 Quality+ Partnerships

Your Partner in Quality Care

BlueCare Plus 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 reimbursement is 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 applicable screenings.

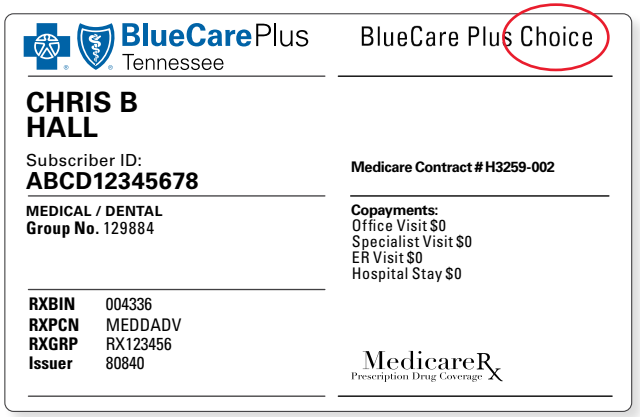
Measure Name	Member Reward Available
Annual Wellness Visit (AWV)	$50
Annual Health Needs Assessment (HNA)	$25
Breast Cancer Screening (BCS)	$25
Colorectal Cancer Screening (COL)	$50 (Colonoscopy or Flexible Sigmoidoscopy) $15 (FOBT in home kit or FIT DNA)
Comprehensive Diabetes Care (CDC) Retinal Eye Exam	$15 (BCBST Vendor Partner) $50 (Optometrist or Ophthalmologist)

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.

Fully Integrated Dual Eligible (FIDE)

BlueCare Plus Tennessee

A FIDE SNP is a type of special needs plan that covers all of the core benefits under original Medicare and optional or mandatory supplemental benefits included with BlueCare Plus Choice. 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.


BlueCare Plus Tennessee

BlueCare Plus Choice

CHRIS B HALL

Subscriber ID:
ABCD12345678

MEDICAL / DENTAL
Group No. 129884

Medicare Contract # H3259-002

Copayments:
Office Visit $0
Specialist Visit $0
ER Visit $0
Hospital Stay $0

RXBIN	004336
RXPCN	MEDDADV
RXGRP	RX123456
Issuer	80840

MedicareRx
Prescription Drug Coverage

CHOICES Services by Group

What's Covered	Group 1	Group 2	Group 3
Nursing facility care	✓	Short-term only (up to 90 days)	Short-term only (up to 90 days)
Community-based residential living		✓	(Specified CBRA services and levels of reimbursement only. See below)[1]
Personal care visits (up to 2 visits per day at intervals of no less than 4 hours between visits)		✓	✓
Attendant care (up to 1080 hours per calendar year; up to 1400 hours per full calendar year only for persons who require covered assistance with household chores or errands in addition to hands-on assistance with self-care tasks)		✓	✓
Mom's Meals (up to 1 meal per day)		✓	✓
Personal Emergency Response Systems (PERS)		✓	✓
Adult day care (up to 2080 hours per calendar year)		✓	✓
In-home respite care (up to 216 hours per calendar year)		✓	✓
In-patient respite care (up to 9 days per calendar year)		✓	✓
Assistive technology (up to $900 per calendar year)		✓	✓
Minor home modifications (up to $6,000 per project; $10,000 per calendar year; and $20,000 per lifetime)		✓	✓
Pest Control (up to 9 units per calendar year)		✓	✓

[1] CBRAs for which Group 3 members are eligible include only: Assisted Care Living Facility services, Community Living Supports 1 (CLS1), and Community Living Supports-Family Model 1 (CLS-FM1)

12 | Welcome to BlueCare Plus Choice. 1-800-332-5762 (TTY: 711)

This information applies to BlueCare Plus Choice (HMO D-SNP)℠ ONLY

Additional Information / Frequently Asked Questions

Q: What is 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.

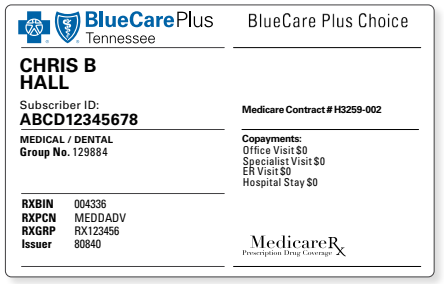
Q: Who's eligible?

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 BlueCare Plus Choice members get a new identification card?

A: They'll get one subscriber ID and membership card that can be used for all Medicare, Medicaid and pharmacy services. Here is a sample ID card:



Front

Back

Member PCP Selection

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

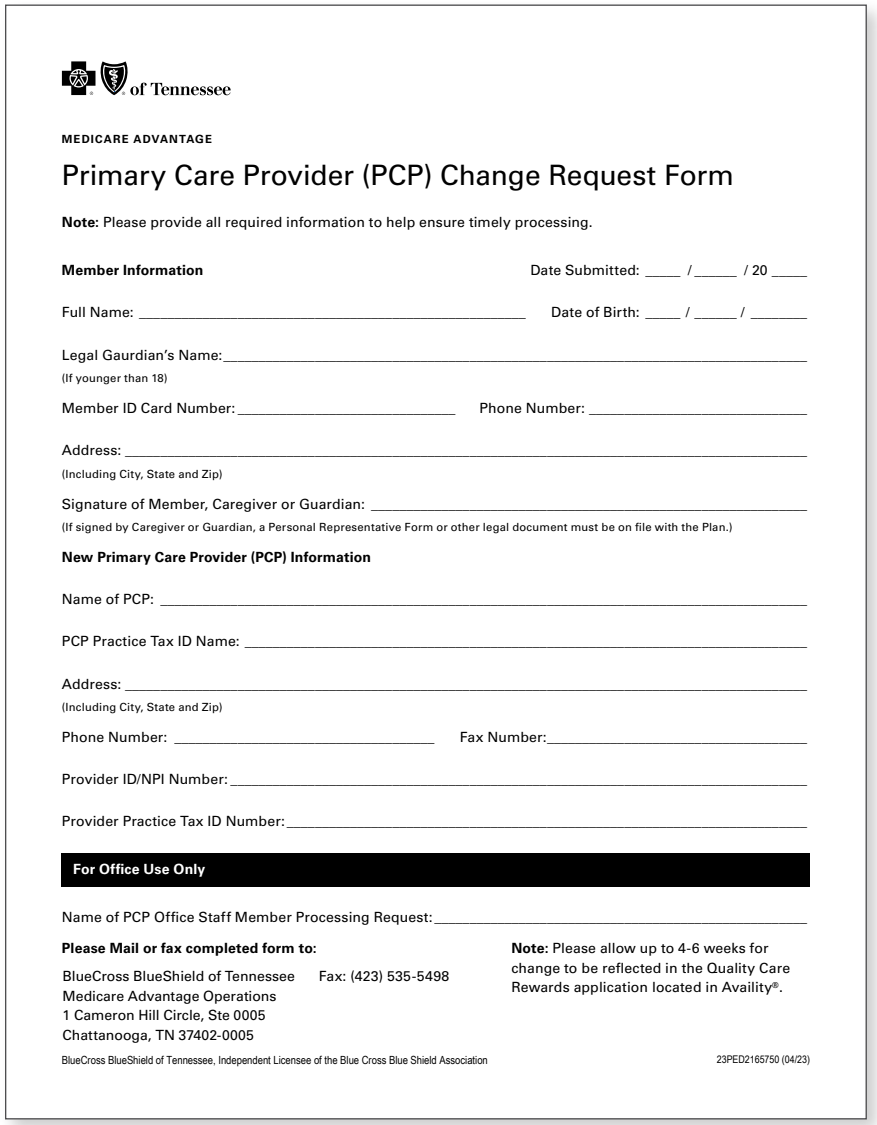
If a member visits a mobile clinic or is visited by a home-care vendor, the member can tell them which PCP they selected.

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.

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 bluecareplus.bcbst.com. Member services can be reached at **1-800-332-5762** to change their PCP at any time via phone.



of Tennessee

MEDICARE ADVANTAGE

Primary Care Provider (PCP) Change Request Form

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

Member Information Date Submitted: ____ /____ / 20 ____

Full Name: _____ Date of Birth: ____ / ____ / _____

Legal Gaurdian's Name: _____
(If younger than 18)

Member ID Card Number: _____ Phone Number: _____

Address: _____
(Including City, State and Zip)

Signature of Member, Caregiver or Guardian: _____
(If signed by Caregiver or Guardian, a Personal Representative Form or other legal document must be on file with the Plan.)

New Primary Care Provider (PCP) Information

Name of PCP: _____

PCP Practice Tax ID Name: _____

Address: _____
(Including City, State and Zip)

Phone Number: _____ Fax Number: _____

Provider ID/NPI Number: _____

Provider Practice Tax ID Number: _____

For Office Use Only

Name of PCP Office Staff Member Processing Request: _____

Please Mail or fax completed form to:

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

Fax: (423) 535-5498

Note: Please allow up to 4-6 weeks for change to be reflected in the Quality Care Rewards application located in Availity®.

BlueCross BlueShield of Tennessee, Independent Licensee of the Blue Cross Blue Shield Association

23PED2165750 (04/23)

Annual Wellness Visit Facts

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

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

Welcome to Medicare Exams

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

Service	Codes	Coverage Notes
Initial Preventive Physical Examination (IPPE)	G0402	Members are covered for comprehensive preventive medicine evaluation and management, including: - Appropriate history, age and gender - Examination - Counseling and anticipatory guidance - Risk factor reduction interventions
Initial Preventive Physical Examination (IPPE) w/ EKG	G0402 with G0403, G0404 or G0405	

Annual Preventive Exam

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

Service	Codes	Coverage Notes
Annual Wellness Visit (AWV)	G0438 (Initial), G0439 (Subsequent)	Members are covered for comprehensive preventive medicine evaluation and management, including: - Appropriate history, age and gender - Examination - Counseling and anticipatory guidance - Risk factor reduction interventions
Annual Preventive Physical Exam	99385-99387 (New Patient), 99395-99397 (Established Patient)	This is a BlueCare Plus D-SNP 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.

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.

Service	Codes	Coverage Notes	Reimbursement Amount
Patient Assessment & Care Planning Form (PACF)	96160, 96161	This is a BlueCare Plus D-SNP 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.	$155.00
Interdisciplinary Care Team (ICT)	99366-99368	This is a BlueCare Plus D-SNP 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.	$54.00

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

Annual Patient Assessment & Care Planning Form Interdisciplinary Care Team Guide

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

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

Immediate and Future Benefits to You

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

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

BlueCare Plus encourages our members to complete an Annual Wellness Visit (AWV) 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.

Code	Description	Amount
99366-99368	Interdisciplinary Care Team	$54.00
96160, 96161	Administration of PACF	$155.00

The completion of the PACF and ICT may be done in conjunction with the Welcome to Medicare or Medicare Annual Wellness Visit. Member rewards for getting necessary preventive screenings are triggered by the codes billed for the annual wellness visit or comprehensive preventive medicine evaluation and management.

Important PACF Details

Submit annually, ideally during the patient's 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 don't 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 you can 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 isn't required to be considered complete.
- **Practitioner Attestation/Signature/Date of Service**

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

PACF Completion Options

You have three options for completing and submitting PACFs:

- Online via secure Availity® portal: availity.com
- Submit your BlueCare Plus Tennessee approved non-standard PACF from your medical records by upload in the QCR application or by fax to **423-591-9504**
- Access the writable PACF at the BlueCare Plus website: bluecareplus.bcbst.com
  Upload to the QCR or fax the completed form to **423-591-9504**

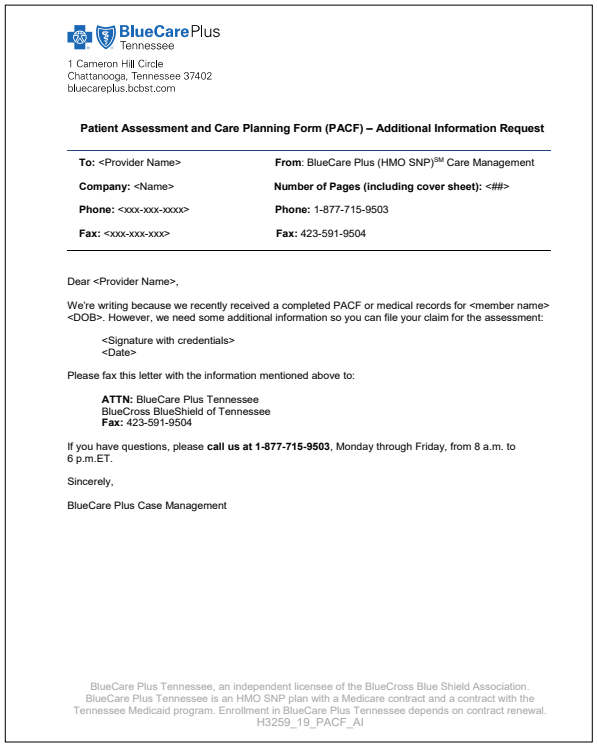
NOTE: For Availity® log-in and registration information and/or Technical Support, contact our eBusiness team at **423-535-5717**, **Option 2** or at **ebusiness_service@bcbst.com**.

Training and Assistance

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

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

NOTE: It's important that the information in the PACF or medical record is complete. If not all information is included you will receive a fax requesting additional information.



BlueCare Plus Tennessee

1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bluecareplus.bcbst.com

Patient Assessment and Care Planning Form (PACF) – Additional Information Request

To: <Provider Name>	**From**: BlueCare Plus (HMO SNP)℠ Care Management
Company: <Name>	**Number of Pages (including cover sheet):** <##>
Phone: <xxx-xxx-xxxx>	**Phone:** 1-877-715-9503
Fax: <xxx-xxx-xxx>	**Fax:** 423-591-9504

Dear <Provider Name>,

We're writing because we recently received a completed PACF or medical records for <member name> <DOB>. However, we need some additional information so you can file your claim for the assessment:

<Signature with credentials>
<Date>

Please fax this letter with the information mentioned above to:

ATTN: BlueCare Plus Tennessee
BlueCross BlueShield of Tennessee
Fax: 423-591-9504

If you have questions, please **call us at 1-877-715-9503**, Monday through Friday, from 8 a.m. to 6 p.m.ET.

Sincerely,

BlueCare Plus Case Management

BlueCare Plus Tennessee, an independent licensee of the BlueCross Blue Shield Association. BlueCare Plus Tennessee is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in BlueCare Plus Tennessee depends on contract renewal. H3259_19_PACF_AI

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 12/13/24".
- **Management** of the problem: If you aren't 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 BlueCare Plus 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 Tennessee members. You also have the opportunity to earn reimbursement 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 don't 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 application or by fax to **423-591-9504**.

Q. How does the PACF close gaps in care?

A. Providers completing the PACF online have the opportunity to attest to gaps in care in the Provider Quality Care Rewards application as they complete the PACF. Faxed and uploaded 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 or uploaded 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) for standard and non-standard PACF
- Submit CPT code 96161 for a PACF completed within or exported from the QCR application in Availity
- Submit the PACF, or your equivalent medical record, via upload to the QCR or fax to **423-591-9504** or online via the **Quality Care Rewards application**

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 D-SNP 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 reimbursement recoupments. You may submit your PACF through the Quality Care Rewards application 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.

2024 Calendar Year

Dual Special Needs D-SNP Program Measures

Measure Name	Measure Type	Weight	Member Gift Card Available*
Hemoglobin A1C Control for Patients With Diabetes (HBD)	Outcome	3	—
Controlling High Blood Pressure (CBP)	Outcome	3	—
Medication Adherence for Cholesterol (Statins)	Outcome	3	—
Medication Adherence for Hypertension (RASA)	Outcome	3	—
Medication Adherence for Diabetes Medications (OAD)	Outcome	3	—
Plan All-Cause Readmissions (PCR)	Outcome	1	—
Breast Cancer Screening (BCS)	Procedure	1	**$25**
Care for Older Adults (COA) - Medication Review	Procedure	1	—
Care for Older Adults (COA) - Pain Assessment	Procedure	1	—
Colorectal Cancer Screening (COL)	Procedure	1	**$15, $50**
Eye Exam for Patients With Diabetes (EED)	Procedure	1	**$15, $50**
Kidney Health Evaluation for Patients With Diabetes (KED)	Procedure	1	—
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	Procedure	1	—
Osteoporosis Management in Women who had a Fracture (OMW)	Procedure	1	—
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Procedure	1	—
Statin Use in Persons with Diabetes (SUPD)	Procedure	1	—
Transitions of Care (TRC)	Procedure	1	—
Measures for Display/Monitoring Status Only			
Annual Wellness Visit (AWV)	Procedure	0	**$50**
Care for Older Adults (COA) - Functional Status Assessment	Procedure	0	—
Use of Multiple Anticholinergic (ACH) Medications in Older Adults (Poly-ACH)	Outcome	0	—
Use of Multiple Central-Nervous System (CNS)-Active Medications in Older Adults (Poly-CNS)	Outcome	0	—
Member Experience - CAHPS	HMS Mock Member Survey	0	—
Member Experience - HOS	HMS Mock Member Survey	0	—

Please see D-SNP Member Wellness and Rewards table on page 116 for more information.

HMO D-SNP — We're Right Here

BlueCare Plus Tennessee (HMO D-SNP)℠ **1-800-299-1407**

Provider Performance

Tiffany Jackson
Provider Quality Manager
West Region
Phone: (901) 544-2595
Email: tiffany_jackson@bcbst.com

Sam Hatch
Provider Quality Manager
East Region
Phone: (423) 463-4185
Email: sam_hatch@bcbst.com

Member Health Promotion

Rhonda Farriss
Director, Service Operations
Office: (423) 535-4887
Mobile: (423) 309-3664
Email: rhonda_farriss@bcbst.com

Angela Keylon
Manager Health Promotion
Office: (423) 535-4413
Email: angela_keylon@bcbst.com

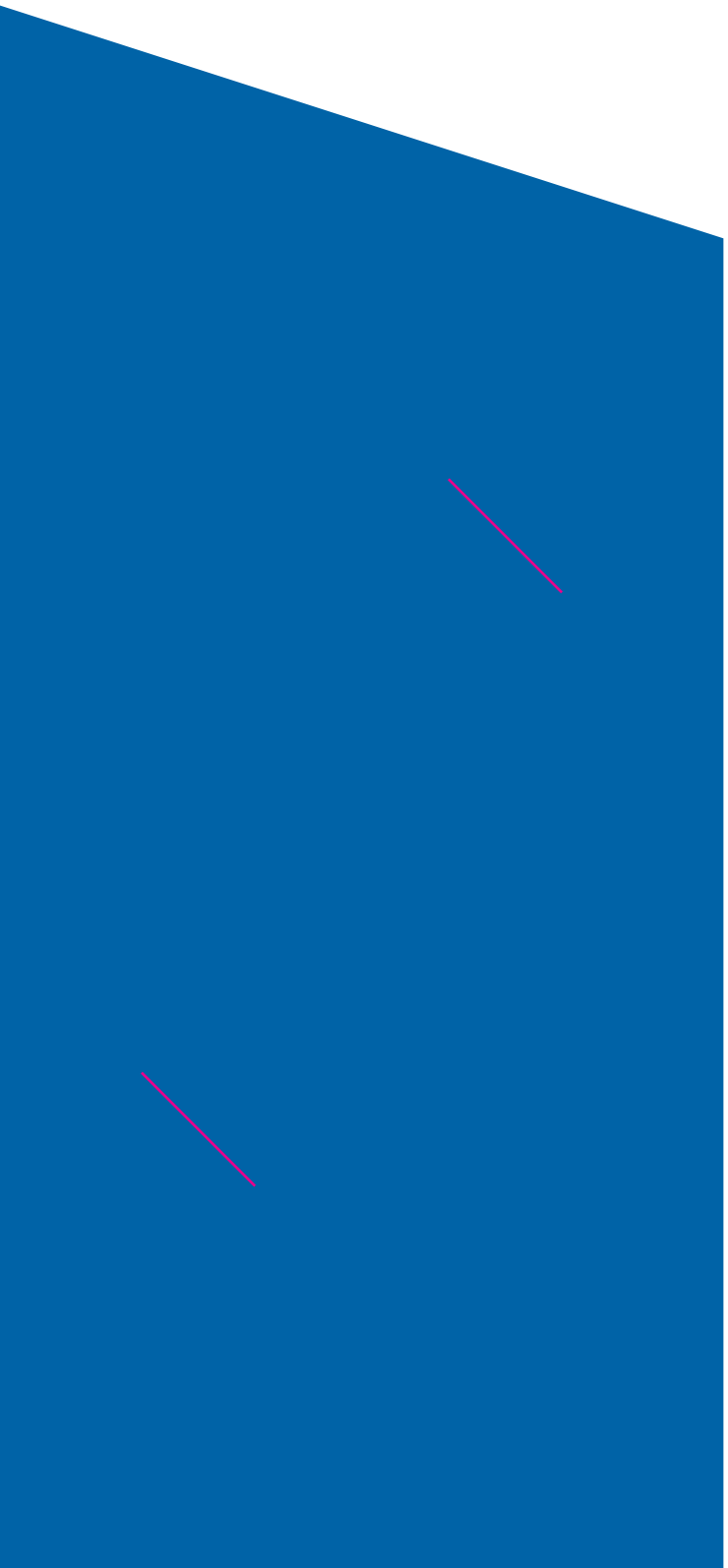
April Russell
Consultant, Member Experience
Mobile: (423) 716-7782
Email: april_russell@bcbst.com

Health Care Management

Care Management
1-877-715-9503

Utilization Management
1-866-789-6314

PACF Fax
1-423-591-9504



MA PPO — We're Right Here

BlueAdvantage (PPO)℠ **1-800-831-2583**

Provider Engagement and Outreach

Ashley Ward
Director, MA Provider Network Innovation
Office: (865) 588-4628
Mobile: (865) 266-9954
Email: ashley_ward@bcbst.com

Julie Mason, MSSW, LAPSW, CCM
Manager, Provider Engagement and Outreach
Office: (423) 535-6827
Mobile: (423) 618-2562
Email: julie_mason@bcbst.com

Trey Brown
Supervisor, Provider Quality Outreach
East Region
Office: (423) 535-4366
Mobile: (423) 486-8796
Email: treyb_brown@bcbst.com

Natasha Brasher
Supervisor, Provider Quality Outreach
Middle/West Region
Office: (423) 535-8102
Mobile: (731) 693-6364
Email: natasha_brasher@bcbst.com

Pharmacy Quality

Sarah A. Smith, PharmD, BCPS
Quality Pharmacy Director
Office: (423) 535-4566
Mobile: (423) 290-4873
Email: sarah_smith@bcbst.com

Lauren Tunney, PharmD
Manager, Clinical Pharmacy
Mobile: (615) 561-3752
Email: lauren_tunney@bcbst.com

Supplemental Data

Angela Booze, RN, BSN
Clinical Program Manager
Mobile: (901) 356-5967
Email: angela_booze@bcbst.com

Trish Harrell
Provider Quality Outreach Supervisor
Office: (423) 765-7069
Mobile: (423) 765-3614
Email: patricia_harrell@bcbst.com

Member Experience

Carmen Levally, RN, BSN
Manager, Member Experience
Office: (423) 535-8325
Mobile: (423) 888-7663
Email: carmen_levally@bcbst.com

Staci Zink
Member Experience Program Consultant
Office: (901) 544-2351
Mobile: (423) 682-1316
Email: staci_zink@bcbst.com

Brian Oney
Manager, Member Outreach and Retention
Office: (423) 535-6402
Mobile: (423) 255-6351
Email: brian_oney@bcbst.com

of Tennessee

PED-04_ 23PED2405451 (11/23)

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