of Tennessee

QUALITY+
MEDICARE ADVANTAGE

Opportunities to Connect with Our Medicare Advantage Members Using Telehealth

A Guide for Our Provider Community

Updated February 2022

Dear Provider,

The past two years have been challenging for all of us, but especially for you and the patients you provide care for. The COVID-19 national public health emergency has required you to pivot quickly and adapt to a new way of patient care that's quickly becoming a new norm. A simple "Thank you" doesn't seem like nearly enough to recognize the work you've done.

While we never expected we'd be dealing with a pandemic, we've learned some valuable lessons about alternative, effective ways members can continue to access needed care and services. Telehealth is a useful and alternative way to connect with BlueCross Medicare Advantage (MA) plan members and maintain routine and preventive care that's critical to their overall health when they're unable to come to the office or are concerned about coming into the office.

We've been working behind the scenes to develop policies and information concerning telehealth services that we hope have given you some peace of mind while you focus on your patients.

We've put this guide together to highlight opportunities for telephonic and virtual evaluation and management (E/M) services. In addition to providing another channel to deliver care to your BlueCross MA plan patients, telehealth services may also help you improve your Star ratings through better patient compliance with your plan of care and needed preventive services.

We hope you find the information helpful. Please contact your BlueCross Medicare Advantage Provider Quality Representative if you have questions.

Sincerely,

Angeline Brunetto MD

Angeline Brunetto, MD, MBA, CPE
Interim Vice President and Chief Medical Officer, Senior Products

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BlueCross Telehealth Coverage for Medicare Advantage

During the COVID-19 national public health emergency and in this guide, we use the term telehealth to refer to real-time telephone or audiovisual consultations that take place between one of our MA plan members and their in-network provider, and, in certain circumstances, provider-to-provider consultations as described below.

Covered services provided to our MA plan members via telehealth during the COVID-19 national public health emergency for primary care, behavioral health and specialist office appointments will be reimbursed consistent with the member's covered services and Original Medicare telehealth coverage guidelines that were effective when the service was rendered. This also applies to covered services that previously required an in-person visit in settings like outpatient clinics, hospitals, emergency rooms and therapist offices. Codes listed within this guide can be billed with place of service (POS) 02, 10 or the POS where the service would typically be provided with a modifier 95 to indicate the service was performed using telehealth. Payments for telehealth will be consistent with your standard BlueCross fee schedule for the equivalent face-to-face service.

Please note: The Centers for Medicare & Medicaid Services (CMS) has published a series of frequently asked questions related to Medicare Fee-for-Service billing during the COVID-19 public health emergency. Please refer to CMS publications for information about telehealth services and any temporary changes to CMS coverage requirements. Also, to view the most up-to-date information and learn more about covered services and billing guidelines, please visit the Provider FAQ section of BCBSTupdates.com. As always, you can also contact your Network Manager for assistance.

Using Telehealth to Complete Transitional Care Management Services for the Transitions of Care (TRC) Measure

As part of the Transitions of Care (TRC) measure, patient engagement and medication reconciliation is important for your patients who are BlueCross MA plan members and have recently been discharged from a facility. Not only are these components part of a CMS Star measure, they're good ways to check in with your patients and take the first steps to reduce readmissions.

Patient Engagement After Inpatient Discharge

Telehealth services may be used for the Patient Engagement After Inpatient Discharge component of the TRC measure. In addition to an outpatient visit, any of the following will meet the criteria:

- 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 the provider)

Use the following codes for Telephone Visits, E-Visits and Virtual Check-Ins with POS 02 or 10. Transitional Care Management codes are listed further down.

Telephone Visits CPT®:

98966, 98967, 98968, 99441, 99442, 99443

E-Visits or Virtual Check-Ins CPT®:

98969, 98970, 97971, 98972, 99421, 99422, 99423, 99444, 99457

HCPCS:

G0071, G2010, G2012, G2061, G2062, G2063

Medication Reconciliation Post-Discharge

A registered nurse, nurse practitioner, physician assistant, clinical pharmacist or physician can complete a medication reconciliation, which must be done within 30 days of discharge. However, nurses and pharmacists performing this service can only bill with CPT® code 1111F as noted below. Use the applicable codes listed below for Transitional Care Management Services and/or Medication Reconciliation Post-Discharge.

The following requirements must be met to bill with CPT® code 99495:

- You must make initial contact with the member within two business days of discharge.
- The service requires **moderate** medical decision-making complexity.
- A provider (a medical doctor, doctor of osteopathic medicine, nurse practitioner or physician assistant) **must** complete this service.

The following requirements must be met to bill with CPT® code 99496:

- You must make initial contact with the member within two business days of discharge, and have a face-to-face or telehealth visit within seven days of discharge. Please note that telehealth has only been approved by CMS during the COVID-19 emergency.
- The service requires **high** medical decision-making complexity.
- A provider (a medical doctor, doctor of osteopathic medicine, nurse practitioner or physician assistant) **must** complete the service.

The following requirements must be met to bill with CPT® II code 1111F:

- Discharge medications must be reconciled with the current medications in the member's outpatient medical record within 30 days of discharge.
- **This service can be completed by a provider (a medical doctor, doctor of osteopathic medicine, nurse practitioner or physician assistant), a registered nurse or clinical pharmacist.**
  - If the service is completed by a registered nurse, 1111F can be billed with CPT® 99201 or 99211.
  - If the service is completed by a practitioner, consider the problem-focused history and medical decision-making complexity and choose the E/M code that best describes the call.

Medication Reconciliation Documentation Tips

Your patients who are BlueCross MA plan members may have multiple admissions and discharges during the year. These tips can help you address their medication needs after each hospital visit:

- You can find a list of your BlueCross MA plan patients who've been discharged in the Quality Care Rewards application located in Availity®.
- Each discharge to a community setting requires medication reconciliation.
- Medication reconciliation isn't required when members transfer to an acute or non-acute inpatient setting (i.e., a skilled nursing facility or long-term acute care hospital).
- The documented medication reconciliation should be completed and signed by an appropriate provider (registered nurse, pharmacist, medical doctor, doctor of osteopathic medicine, nurse practitioner or physician assistant).
- Your documentation should show that you were aware of the member's hospitalization and discharge. It should also address both the discharge medications and current medications, as well as reconciliation between the two. For example:
  - "Mr. Smith was hospitalized on [date] and discharged on [date]. He was admitted for [diagnosis/condition]. Mr. Smith was seen by telehealth today for a post-hospital follow-up assessment.
    - [Current med list]

    Current and discharge medications have been reconciled."

Addressing Osteoporosis Management in Women Who Had a Fracture

Traditionally, women over the age of 67 who've had a long-bone fracture could visit your office or receive a referral to a testing site for bone densitometry screening within six months of the injury. While these visits may not be possible at this time, we've included other ways you can consider helping your patients who are BlueCross MA plan members prevent another fracture below.

- Contact these members by telephone within six months of the fracture, and assess the benefits of starting a recognized osteoporosis therapy, such as an oral bisphosphonate along with appropriate calcium and vitamin D supplementation.
  - This is a billable service with CPT® codes 99441–99443. These are time-based codes, depending on the length of the conversation.
  - If you choose to use interactive audio and video telecommunication, CPT® codes 99212–99215 may be used.
  - Consider using our mail order service or sending the prescription to a pharmacy that offers delivery or drive-through services for your patients who are BlueCross MA plan members.

If one of your patients who is a BlueCross MA plan member has a fracture, your BlueCross Medicare Advantage Provider Quality Representative may send you a report detailing the fracture date and the last day to close the gap for the **Osteoporosis Management in Women who had a Fracture (OMW)** measure. You may also find this information in the Quality Care Rewards application on the member's page under the OMW measure.

Completing Annual Wellness Visits and Provider Assessment Forms with Telehealth

During the national public health emergency, you can use telehealth to perform both annual wellness visits (AWVs) and provider assessment forms (PAFs). Please see below for additional guidance on completing and billing these services:

- Following CMS guidelines, we require that these be completed in real time with both audio and video interaction with the member.
- This is a great opportunity to document all chronic conditions your patient who is a BlueCross MA plan member may have. The claims are paid with all diagnosis codes reported and not just the ICD-10-CM "Z" code.
- We don't expect that vitals will be taken or a physical exam performed. You can bill for a preventive exam when you bring the member back into the office for a face-to-face exam.
- Please let us know if you're interested in working with us to send in-home screening kits for HbA1c, urine microalbumin and iFOBT/FIT to our MA plan members during this time when you're providing telehealth services.

Additional Resources for Your Practice

Please see the links below for additional information about how to reach us, where to find help using Availity, and state and federal telehealth guidance.

Also, please reach out to your BlueCross Medicare Advantage Provider Quality Representative if you have additional questions about these quality measures or our coverage for telehealth services during the national public health emergency.

- **Provider Service Contact Information**
  https://provider.bcbst.com/contact-us/
- **Availity Assistance**
  Call the eBusiness technical support team at 1-800-924-7141 or send an email to eBusiness_service@bcbst.com.
- **General Telehealth Technical Assistance**
  - National Consortium of Telehealth Resource Centers (https://www.telehealthresourcecenter.org/)
  - Tennessee Regional Telehealth Resource Center
    https://www.telehealthresourcecenter.org/sctrc-2/?Center=SCTRC
  - U.S. Department of Health and Human Services
  - https://www.telehealth.hhs.gov/providers/getting-started/
- **Medicare Telemedicine Provider Fact Sheet**
  https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

We know you're working harder than ever to make sure that your patients get the care and screenings they need in these challenging times. We appreciate you and your commitment to our plan members.

We're Right Here

If you have questions, please contact a member of our Medicare Advantage Provider Outreach Team.

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