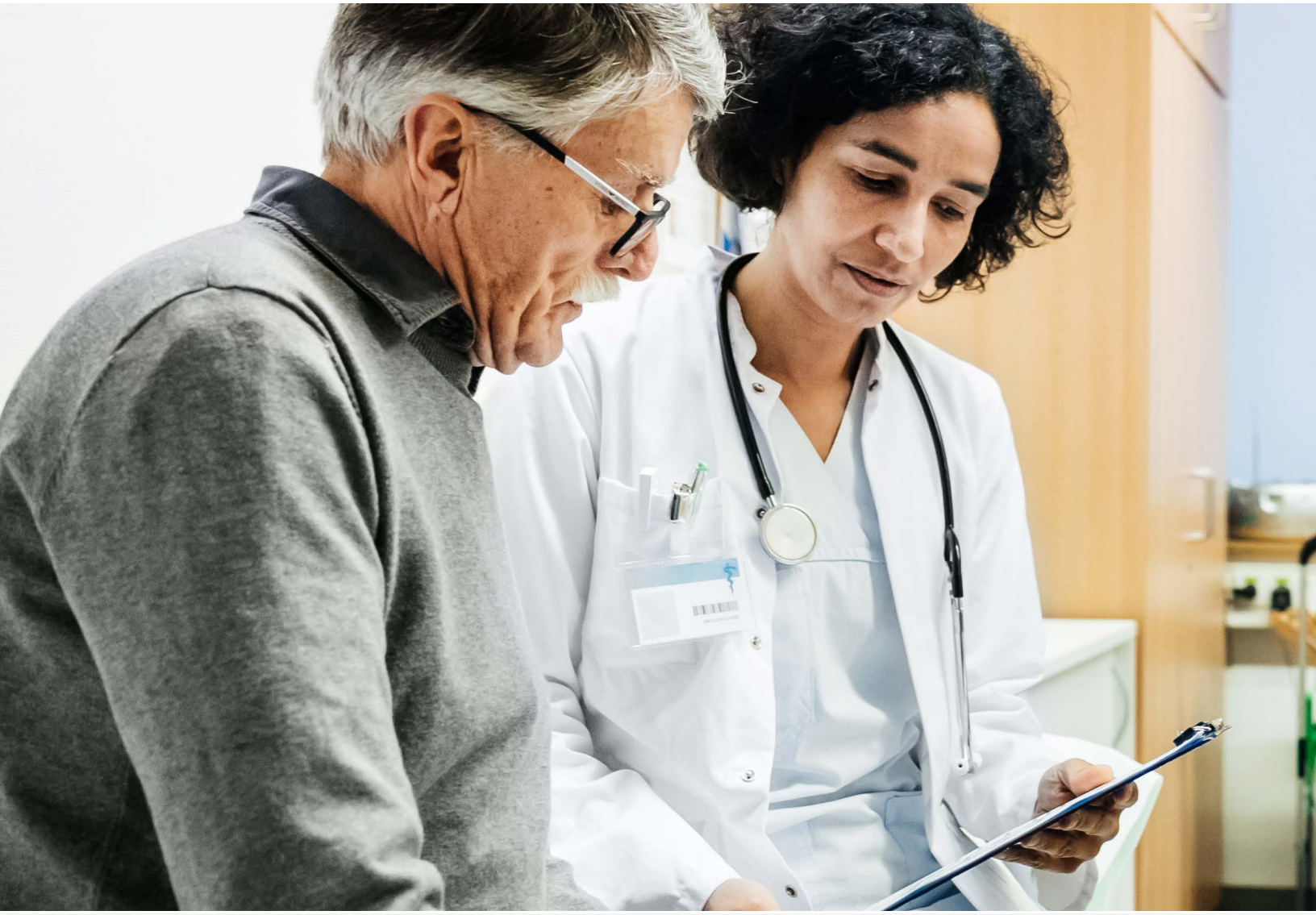
BlueCross BlueShield of Montana



2024-2025 Medicare Advantage Annual Wellness Visit Guide

2024-2025 Medicare Advantage Annual Wellness Visit Guide

How do Annual Wellness Visits benefit patients and providers?

Wellness visits provide opportunities to screen for new problems and manage chronic ones. Depending on your contract, completion of a wellness visit may result in an incentive payment.

Medicare covers wellness visits every 12 months. The Centers for Medicare and Medicaid Services requires that providers make a good-faith effort to perform an initial health assessment for all new members within 90 days of enrollment. You can do this by performing the once-in-a-lifetime wellness visit known as the **Initial Preventive Physical Examination**.[1]

Members are eligible for the IPPE during the first 12 months of enrollment in Medicare. After 12 months, members may receive either the initial once-in-a-lifetime **Annual Wellness Visit**[2] or if already performed, the subsequent AWV.[3] Bill no more than one visit per calendar year (IPPE, initial AWV or subsequent AWV).

If, during a wellness visit, you perform additional screening or address another medical problem, you can submit an additional claim.[4] The wellness visits and most of the recommended preventive tests have both the copay and deductible waived. To remove barriers to completion, several preventive services and certain wellness visits[5] can be completed via telehealth in the member's home or a doctor's office.

Annual Wellness Visit Form

We've developed a **Medicare Advantage Annual Wellness Visit Form** to make the process easier for you. It's available in the Education and Reference section of our website under Forms. This form is designed as a resource for documentation and coding. It doesn't need to be returned.

Contents

[1] G0402
[2] G0438
[3] G0439
[4] Patient co-pay/deductible may apply to the additional E/M portion
[5] AWV, Initial (G0438) and AWV, Subsequent (G0439)

Wellness Visit Checklist

Each item in the checklist is explained more fully in this manual.

Done	Task	Notes
☐	Select the correct Wellness Visit code (G-code)	Wellness visits and preventive services are allowed every 12 months. As part of our efforts to increase scheduling flexibility, these codes can be used anytime within the calendar year, regardless of the 12 month/365 day rule often applied. To determine the date the member had their last preventive service: • Go to the CMS HIPAA Eligibility Transaction System or • Medicare Administrative Contractor
☐	Satisfy General Coding Requirements	• Member's name on each page • Date all entries • **MEAT** • See appendix for coding resources • Submit claim with ICD-10, Current Procedural Terminology (CPT®) and CPT II codes • Signature • Credentials • Documentation to support why a screening was not performed
☐	Satisfy specific, minimum coding requirements for a particular wellness visit code	• IPPE (G0402)[6] • AWV, Initial (G0438)[7] or • AWV, Subsequent (G0439)[8] Note: Federally Qualified Health Center visit, IPPE or AWV use code G0468.
☐	Code for other E/M services if performed (e.g., 99213-25) and inform patient of responsibility for additional deductible/ copay according to their plan	
☐	Consider performing Other Preventive Services and Screenings	View eligibility and documentation requirements of services/screenings before performing to ensure: • Coverage criteria applies • Frequency limits are maintained • Total time spent or start/stop times are documented for timed services • Document billed services in the medical record
☐	Consider performing relevant Healthcare Effectiveness Data and Information Set (HEDIS®) measures to close care gaps	
☐	Consider referral for disease management, case management or behavioral health	We have many medical and behavioral health programs to help coordinate care.
☐	Submit completed claim within 60 days of the original date of service	

Send any questions about this form, Annual Wellness Visit program, partnership opportunities around risk adjustment coding, quality or other related topics to **RiskAdjustment@bcbsil.com**

[6] https://www.ecfr.gov/cgi-bin/text-idx?SID=af9f9e26dd0a5e796df373f4887296ff&mc=true&node=pt42.2.410&rgn=div5; See section §410.16
[7] Ibid.; See section §410.15
[8] Ibid.; See section §410.15

Coding for Wellness Visit

The following are preventive services, so members are not responsible for a copayment or deductible:

G0402 – IPPE

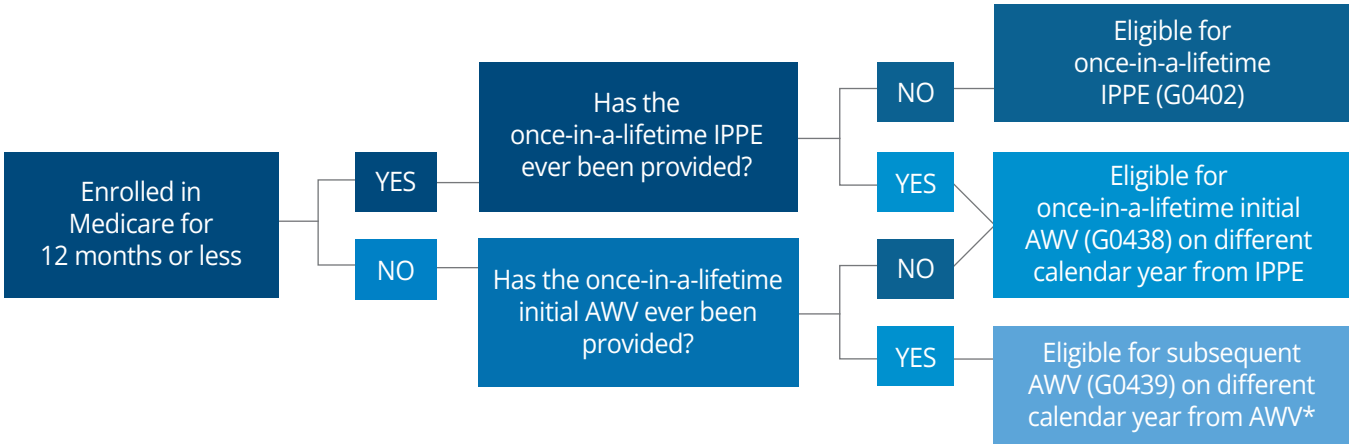
- Limited to a new Medicare member during the first 12 months of Medicare enrollment
- Used once in a lifetime

G0438 – Initial AWV

- Limited to a Medicare member after the first 12 months of Medicare enrollment, including new or established patients
- Used once in a lifetime

G0439 – Subsequent AWV

- Used the following calendar year after any wellness visit (IPPE, initial AWV or subsequent AWV)



***Initial or Subsequent AWV**

Use the IPPE and initial AWV no more than once during the member's lifetime. Member is eligible for the IPPE only during the first 12 months of Medicare enrollment. HCSC allows one IPPE or AWV* per calendar year.

Note: FQHC visit, IPPE or AWV use code G0468.

General Coding Requirements

- Patient's name must appear on every page of the medical record
- All entries/encounters must be dated
- Ensure documentation complies with hierarchical condition category coding by **documenting MEAT** (monitoring, evaluating, assessing and treatment) in the medical record:
  - Monitoring signs, symptoms, disease progression, disease regression
    - New diagnoses, chronic conditions or suspected conditions
  - Evaluating results of tests, medication effectiveness, response to treatment
  - Assessing by ordering tests, discussion with the member, reviewing records, counseling
  - Treatment with medications, therapies, other interventions
- See appendix for disease-specific coding information
- Submit claim to plan with all active ICD-10, CPT and CPTII codes
- Code all documented conditions that require or affect treatment or management
- Document whenever a screening is not indicated, contraindicated or patient refuses or is noncompliant to explain why the quality measure was not met
- Include physician's signature and credentials on each patient encounter. An electronic signature requires authentication by the responsible provider

Specific Minimum Coding Requirements

Initial Preventive Physical Examination (G0402)

All the following must be performed by a qualified provider[9] to an eligible member:

1) Review medical, family and social history with attention to modifiable risk factors for disease:
- Medical history:
  - Past medical history (illnesses, hospital stays, operations, injuries and treatments)
  - Past surgical history
  - Allergies
  - Medications
  - Supplements (including calcium and vitamins)
- Family medical history
  - Medical events in member's family
  - Hereditary disease
- Social history:
  - History of alcohol, tobacco and illicit drug use
  - Diet
  - Physical activities

2) Review risk factors for depression or anxiety with an appropriate screening instrument like the PHQ-9 or GAD-7, respectively. This includes current or past experiences with depression or other mood disorders.

3) Review functional ability and level of safety:
- Hearing impairment
- Activities of daily living
- Fall risk
- Home safety

4) Examination should include:
- Height
- Weight
- BMI
- Blood pressure
- Visual acuity screen
- Other factors as deemed appropriate based on medical and family history

5) End-of-life planning, verbal or written information regarding:
- Individual's ability to prepare an advance directive in case an injury or illness causes the individual to be unable to make health care decisions
- Whether the physician is willing to follow the individual's wishes in an advance directive

6) Education, counseling, and referral provided to the individual for obtaining the appropriate screenings:
- Electrocardiogram
- Other screening and preventive services covered as separate Medicare Part B benefits.[10]

[9] Qualified provider means a physician who is a doctor of medicine or osteopathy, physician assistant, nurse practitioner or clinical nurse specialist, or medical professional working under the direct supervision of a physician.

[10] See sections 1861(s)(10), (jj), (nn), (oo), (pp), (qq)(1), (rr), (uu), (vv), (xx)(1), (yy), (bbb), and (ddd)

Annual Wellness Visit (G0438, G0439)

Initial AWV (G0438) - complete every section
Subsequent AWV (G0439) - skip sections 6 and 7

All the following must be performed by a qualified provider to an eligible member:

1) Review and administer, if needed, a **health risk assessment** that meets the following criteria:
- Collects self-reported information about the member
- Can be administered by the member independently or by a health professional prior to or as part of the AWV
- Accommodates communication needs of underserved populations, persons with limited English proficiency and persons with health literacy needs
- Takes no more than 20 minutes to complete
- Address the following topics:
  - Demographic data (age, gender, race, ethnicity, etc.)
  - Self-assessment of health status, frailty and physical functioning
  - Psychosocial risks (depression/life satisfaction, stress, anger, loneliness/social isolation, pain, fatigue, etc.)
  - Behavioral risks (tobacco use, physical activity, nutrition, oral health, alcohol consumption, sexual health, motor vehicle safety – seat belt use, home safety, etc.)
  - Activities of daily living (dressing, feeding, toileting, grooming, physical ambulation – balance/risk of falls, bathing, etc.)
  - Instrumental activities of daily living (shopping, food preparation, using telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, ability to handle finances, etc.)

2) Establishment of an individual's **medical, family and social history**
- Medical history:
  - Past medical history (illnesses, hospital stays, operations, injuries and treatments)
  - Past surgical history
  - Allergies
  - Medications
  - Supplements (including calcium and vitamins)
- Family medical history
  - Medical events in member's family
  - Hereditary disease
- Social history:
  - History of alcohol, tobacco and illicit drug use
  - Diet
  - Physical activities

3) List member's **current providers and suppliers** that frequently provide medical care

4) Examination should include:
- Height
- Weight
- BMI
- Blood pressure
- Other factors as deemed appropriate based on medical and family history

5) Detection of any **cognitive impairment** by direct observation, patient reports, concerns raised by family members, friends, caretakers or others

6) Review risk factors for **depression** or **anxiety** with an appropriate screening instrument like the PHQ-9 or GAD-7. This includes current or past experiences with depression or other mood disorders.

7) Review **functional ability** and level of safety (based on direct observation or screening questions or questionnaire recognized by national professional medical organizations):
- Hearing impairment
- Activities of daily living
- Fall risk
- Home safety

8) Establish the following:
- Written screening schedule, such as checklist, for next five to 10 years based on:
  - U.S. Preventive Services Task Force
  - Advisory Committee on Immunization Practices
  - Age-appropriate preventive services covered by Medicare
  - Member's health risk assessment, health status and screening history
- List:
  - Risk factors and conditions (including any mental health conditions or conditions identified on the IPPE) which have a recommended primary, secondary or tertiary preventive intervention (or recommended intervention is currently underway)
  - Treatment options
  - Associated risks/benefits

9) Provide the member with **personalized health advice** and, if appropriate, a referral to reduce risk factors, improve self-management and wellness to any of the following:
- Health education or preventive counseling services or programs
- Community-based lifestyle interventions

10) Furnish **advance care planning services**, at member's discretion, to discuss:
- Future care decisions that may need to be made
- How member can inform others about care preferences
- Explanation of advance directives which may require completion of standard forms

11) Other elements determined appropriate through the national coverage determination process

Coding for Other Evaluation and Management Services

If you need to render an E/M service (e.g., 99213), including lab tests or other diagnostic services, in addition to a preventive service (G0402, G0438 or G0439):
- Inform member of their potential responsibility to pay for the deductible/copay for the E/M portion of the service
- Submit the CPT code with modifier -25 along with the "G" code as part of the claims encounter submission (e.g., G0438 and 99213-25)

Other Preventive Services or Screenings

Medicare Advantage plans cover standard Medicare preventive services. To be eligible for coverage, each preventive service must comply with:

1) Unique coverage criteria (e.g., prostate screening for 50 and older)

2) Frequency limits of testing (e.g., diabetes screening for members diagnosed with pre-diabetes every six months)

3) Documentation requirements for timed services must include either total time spent or start/stop times

View the Medicare coding rules when billing these services to ensure eligibility. If eligible, **the deductible and copay of most services are waived** by Medicare(*). Some services may be provided by telehealth([TH]) including the AWV (initial or subsequent). Other services that take longer than the typical service time may be billed with the Prolonged Preventive Service code([P]).

The following are **preventive services that are covered by Medicare** and can be billed separately:

Task	Notes
Advance care planning* (99497 and 99498)	Every 12 months, waived when part of either initial or subsequent AWV
Alcohol misuse screening and counseling*[TH]	Screening every 12 months; counseling four times per year if criteria met
AWV*[TH,P]	Every 12 months, initial or subsequent
Bone mass measurements*[P]	Every 24 months or more often if medically necessary
Cardiovascular disease screening tests*	Every 60 months
Colorectal cancer screening	Deductible waived, copay may or may not be; frequency depends on risk stratification and method; PPS for flex-sig and colonoscopy
Counseling to prevent tobacco use*[TH]	Two cessation attempts per 12 months with up to four intermediate or intensive sessions per attempt
Depression screening*[TH]	Primary care setting and staff requirements, every 12 months
Diabetes screening*	Every 12 months; if pre-diabetic then every six months
Diabetes self management training[TH]	Can't also bill Medical Nutrition Therapy on same date of service
Glaucoma screening	Every 12 months
Hepatitis B virus screening,* vaccine and administration*	Screen once unless high risk and unvaccinated or pregnant; vaccine and administration not covered if low risk
Hepatitis C virus screening*	High risk, born between 1945 and 1965, or blood transfusion before 1992
HIV screening*	Coverage and frequency depend on age and risk
Initial preventive physical exam*[P]	Once in a lifetime; first 12 months of enrollment
Intensive behavioral therapy for cardiovascular disease*[TH]	In primary care setting with primary care provider, every 12 months
Intensive behavioral therapy for obesity*[TH]	BMI >= 30 and multiple other conditions
Lung cancer screening*[P]	Every 12 months with conditions; counseling by telehealth
Medical nutrition therapy*[TH]	Cannot also bill DSMT on same date of service; diabetic or renal disease
Medicare Diabetes Prevention Program*	Multiple coverage conditions
Prolonged preventive services*[TH]	Beyond typical service time of the primary procedure; the AWVs (G0438 and G0439) and IPPE (G0402) can be used with this service; the IPPE (G0402) can't be used with telehealth
Prostate cancer screening	Only PSA test is waived, every 12 months
Screening for sexually transmitted infections and high intensity behavioral counseling for prevention*[TH]	Covered when at increased risk; requires primary care referral, provider and setting
Screening mammography*[P]	Use special modifier if screening mammography turned into a diagnostic mammography; age 35 to 39 once, age 40 and older every 12 months
Screening pap test	Every 23 months, more often if high risk; PPS may be used with Q0091,* HPV test (every 60 months; done with pap)* and pelvic exam (every 23 months, more often if high risk)*[P]
Ultrasound screening for abdominal aortic aneurysm*[P]	Authorization and referral requirement; once in a lifetime
Vaccines and their administration	Influenza (once per influenza season),* Pneumococcal (once if never received, up to twice with conditions)* and Hepatitis B*

Closing Care Gaps

The National Committee for Quality Assurance collects HEDIS measurements. These measurements are collected from our providers, but not necessarily at the same time as the wellness visit.

Wellness visits satisfy one HEDIS measure: Adults' Access to Preventive/Ambulatory Health Services. You can close care gaps by performing other relevant HEDIS measures and collect HEDIS data at the wellness visit.

The following HEDIS measurements are applicable to most Medicare members. Several are covered by Medicare as a preventive service*. Other specific HEDIS measures are listed in the appendix.

Consider performing the following HEDIS measures at regular intervals. Medical standard of care may require more frequent testing or other tests.

1) BMI and weight **every two years** for members 18 to 74 years old

2) Controlling High Blood Pressure for members 18 to 85 years old who have been diagnosed with hypertension

3) Comprehensive Diabetes Care* for members 18 to 75 years old with diabetes

4) Breast Cancer Screening* for members 50 to 74 years old with screening mammography **every two years**

5) Colorectal Cancer Screening* for members 45 to 75 years old with one of the following:

- Annual FOBT
- Stool DNA every three years
- Flexible-sigmoidoscopy or CT colonography every five years
- Colonoscopy every 10 years

6) Cervical Cancer Screening* for members 21 to 64 years old who were screened for cervical cancer within the last 3 years

7) Care for Older Adults for members 66 years and older, consider each of the following **annually**:

- Advance care planning*
- Medication review
- Functional status assessment
- Pain assessment

8) Osteoporosis Testing and Management* for women 67 to 85 years old who either:

- Received a bone density test to check for osteoporosis in their **lifetime**
- Received either a prescription for a drug to treat osteoporosis or bone mineral density test **within six months** after a fracture

9) Fall Risk Management for members 65 years and older with balance or walking problems or a fall in the **past 12 months** (Falls are the leading cause of death by injury for those 65 and older):

- Discuss the issue with the member
- Administer fall risk intervention

10) Management of Urinary Incontinence for members 65 years and older with urine leakage in the **past six months** (In the U.S., 51% of women and 14% of men experience urinary incontinence):

- Discuss issue with the member
- Discuss treatment options

11) Physical Activity in Older Adults for members 65 years and older with a provider visit in the **past 12 months**:

- Discuss level of exercise or physical activity
- Administer advice to start, increase or maintain level of exercise or physical activity

12) Flu Vaccinations* for members 65 years old and older vaccinated **each year on or after July 1** (Vaccinations can reduce flu-related hospitalizations by 71%)

13) Pneumococcal Vaccinations* for members 65 years and older who received at least one pneumococcal vaccination in their **lifetime**

13) Social Determinants of Health Assessment,* optional evaluation of member's social determinants of health

Appendix

ICD-10 Coding Information

This appendix outlines the required language for ICD-10-CM documentation of some common chronic conditions. Using this type of documentation will minimize requests for medical records and help expedite claim processing, resulting in more timely payment. When possible, we included practical examples of documentation that satisfy reporting requirements.

Contents

Arrhythmias[11] *When documenting arrhythmias, include the following:*
Location
Atrial, ventricular, supraventricular, etc.
Rhythm name
Flutter, fibrillation, Type 1 atrial flutter, Long QT syndrome, sick sinus syndrome, etc.
Acuity
Acute, paroxysmal, chronic, etc.
Cause
Hyperkalemia, hypertension, alcohol consumption, Digoxin, Amiodarone, Verapamil HCl, etc.
Other
Document any other abnormality of heartbeat (palpitations, tachycardia, bradycardia; document if adverse effect of a drug and specify drug)

[11] CMS. ICD-10: Clinical Concepts for Cardiology. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsCardiology1.pdf

Arteriosclerosis (Coronary Artery Disease and Peripheral Arterial Disease) *When documenting arteriosclerotic disease, specify:*
Comorbidities
Alcoholism, diabetes, dyslipidemia, hypertension, obesity
Site (vessel)
Aorta, carotid, cerebral, coronary, extremities, mesenteric, pulmonary, renal, vertebral, etc.
Laterality
Right, left or bilateral
Severity
CAD – with or without angina PVD – manifestations (intermittent claudication, rest pain, ulceration, gangrene) If skin ulcer present, document the type, laterality, site and depth of ulcer
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence History of exposure (second hand, occupational, etc.)
HEDIS measure for Statin Therapy for Patients with Cardiovascular Disease
Males 21 to 75 years old and females 40 to 75 years old with clinical atherosclerotic cardiovascular disease (ASCVD) receiving and adhering to statin therapy

Asthma[12,13] *When documenting asthma, specify:*
Severity
Mild, moderate or severe
Frequency
Intermittent or persistent
Level of exacerbation
Uncomplicated, acute exacerbation or status asthmaticus
Key terms
Allergic, allergic bronchitis, allergic rhinitis with asthma, atopic asthma, chronic obstructive asthma, exercise induced bronchospasm and cough-variant asthma, extrinsic allergic asthma, idiosyncratic asthma, intrinsic non-allergic asthma
Cause
Chemical or particulate cause, cough variant, exercise induced, occupational, smoking. Identify causative agent if known (for example, detergent asthma, miner's asthma, asthma due to dusts)
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence History of exposure (secondhand, occupational, etc.)

[12] CMS. ICD-10: Clinical Concepts for Internal Medicine. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsInternalMedicine1.pdf

[13] CMS. ICD-10: Clinical Concepts for Family Practice. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10FamilyPracticeClinicalConcepts20170324.pdf

Chronic Kidney Disease *Specify the following:*
Underlying cause
Diabetes or hypertension (for example, “diabetic” or “hypertensive”)
If CKD is unrelated to diabetes or hypertension, document the cause, if known
Stage of CKD
Stage 1, stage 2 (mild), stage 3 (moderate), stage 4 (severe), stage 5 or end-stage renal disease
Avoid documenting a range of severity, such as moderate to severe
The diagnosis of CKD can't be coded from diagnostic reports alone. Clearly state a review of the reports and pertinent findings and include the GFR.
Presence of
A/V fistula or shunt for dialysis
Complication due to renal dialysis access device
Implant or graft (such as embolism, hemorrhage, infection, occlusion, pain, stenosis or thrombosis)
Dialysis dependence
Hemodialysis or peritoneal dialysis
Associated diagnoses/conditions
Diabetes with CKD (document stage of CKD)
Hypertension with CKD (document stage of CKD)
Secondary hyperparathyroidism due to CKD (document stage of CKD)
Transplant status
Kidney transplant status (for those patients who still have some form of CKD, document the current stage of the CKD posttransplant)

Chronic Obstructive Pulmonary Disease *When documenting COPD, specify:*
Type
Asthma with COPD – also document the asthma by severity, frequency and level of exacerbation
Chronic asthmatic bronchitis
Chronic bronchitis with emphysema
Chronic obstructive bronchitis
Chronic obstructive tracheobronchitis
Severity
Acute exacerbation, chronic respiratory failure, hypercapnia, hypoxia
Circumstance
ALS, emphysema, obesity hypoventilation syndrome, respiratory failure, restrictive diseases such as interstitial fibrosis and thoracic deformities, sepsis, shock
Infection
Document any acute lower respiratory infection and the infectious agent, if known

Chronic Obstructive Pulmonary Disease *(continued)*
When documenting COPD, specify:
Cause
Identify any additional lung disease due to external agent and specify agent (for example, organic dust, chemical, gases, fumes, vapors, ventilation system)
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence
History of exposure (secondhand, occupational, etc.)
HEDIS measure for Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Document adults 40 years old and older with a new diagnosis of COPD or recent exacerbation of COPD who received spirometry testing to confirm the diagnosis

Coronary Artery Disease[14]
When documenting atherosclerotic heart disease with angina pectoris, include the following:
Cause
Assumed to be atherosclerosis; document if there is another cause
Stability
Stable angina pectoris
Unstable angina pectoris
If angina equivalent, document the associated symptoms
Vessel
Note which artery (if known) is involved and whether the artery is native or autologous (for example, mammary, radial, etc.)
Chronic total occlusion of coronary artery
Graft involvement
If appropriate, whether a bypass graft was involved in the angina pectoris diagnosis
Note the original location of the graft and whether it is autologous or biologic
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence
History of exposure (secondhand, occupational, etc.)
HEDIS measure for Persistence of Beta-Blocker Treatment After a Heart Attack
Document adults 18 years old and older hospitalized with a diagnosis of acute myocardial infarction who were discharged alive and received persistent beta blocker treatment for at least six months after discharge

[14] CMS. ICD-10: Clinical Concepts for Cardiology. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsCardiology1.pdf

Diabetes[15] ***Note on exclusions:*** *Members are excluded from this HEDIS population if they are taking weight management medications and don't have diabetes. Use proper coding to avoid diabetes diagnoses if the member doesn't have diabetes.* *Specify the following:*
Type of diabetes
Type 1, type 2
Secondary – drug or chemical induced (document first poisoning or adverse effect specific to drug)
Due to underlying condition (document first the underlying condition)
Postprocedural or due to genetic defects
Control status
Controlled
Inadequately controlled
Out of control
Poorly controlled (diabetes, by type, with hyperglycemia)
If uncontrolled, specify as hyperglycemic or hypoglycemic
Complications or any other body systems affected
Diabetic chronic kidney disease – document also the stage of CKD
Diabetic glaucoma – document also the type, stage and affected eye
Diabetic ulcer – document also the ulcer by type, laterality, site and depth
Other diabetic complication – specify the complication (for example, diabetic CAD)
Treatment
Insulin use and/or oral antidiabetic or hypoglycemic drugs
HEDIS measure for Comprehensive Diabetes Care
Document: - the date and value of the Hemoglobin A1C in the progress note - the date and the review of the retinal eye exam and any pertinent positive or negative findings - if the patient had a negative retinal eye exam the prior year - the date and the findings of the nephropathy test and if the nephropathy is evidenced, the order for the prescription to treat - blood pressure control (BP < 140/90 mmHg) - if patient has steroid-induced diabetes as an exclusion under HEDIS/Five-Star Quality for the Diabetes Care measure
HEDIS measure for Statin Therapy for Patients with Diabetes
Document for adults ages 40 to 75 with diabetes but without clinical ASCVD if they received and adhered to statin therapy
HEDIS measure for People with Diabetes and Schizophrenia
Document for adults ages 18 to 64 with diagnosis of diabetes and schizophrenia annual testing of both HbA1C and LDL-C

[15] CMS. ICD-10: Clinical Concepts for Internal Medicine. Centers for Medicare & Medicaid Services. http://www.cms.gov/medicare/coding/icd10/downloads/icd10clinicalconceptsinternalmedicine1.pdf

Heart Failure[16, 17] *When documenting heart failure, specify:*
Underlying cause
Alcohol and illicit drug use, cardiac arrhythmias, cardiomyopathy, chemotherapy, chronic diastolic failure due to hypertension, congenital defects, CAD, diabetes, endocarditis, heart failure due to hypertension with CKD, heart valve disorders, HIV, AIDS, hypertension with chronic diastolic heart failure, thyroid disorders
Comorbidities, examples
Anemia, atrial fibrillation, COPD, diabetes, obstructive sleep apnea, renal insufficiency
Circumstance
Postprocedural
Specific type(s), if known
Biventricular heart failure, combined systolic and diastolic heart failure, diastolic heart failure, end stage heart failure, high output heart failure, left ventricular failure, rheumatic heart failure, right heart failure, systolic heart failure, other heart failure
Severity
Acute, acute-on-chronic, cardiac arrest, chronic
If nothing more specific than "congestive heart failure" is documented then it will be coded to "heart failure, unspecified"

Hypertension *When documenting hypertension, specify:*
Type
Essential hypertension, hypertension secondary to renal artery stenosis, renovascular hypertension, drug resistant, accelerated
Acuity of hypertension
Hypertensive urgency
Systemic involvement
Hypertension with ventricular hypertrophy
Hypertension with diastolic dysfunction
Hypertension with heart failure – state the type and severity of heart failure (systolic, diastolic, combination, acute, chronic, acute-on-chronic)
Hypertension with CKD – state the stage of CKD
Underlying cause, examples
Underlying renal conditions or hormonal disorders, sedentary lifestyle, excessive amounts of alcohol, stress
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence, history of exposure (secondhand, occupational, etc.)

[16] CMS. ICD-10: Clinical Concepts for Internal Medicine. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsInternalMedicine1.pdf

[17] CMS. ICD-10: Clinical Concepts for Cardiology. Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsCardiology1.pdf

Hypertension *(continued)*
When documenting hypertension, specify:
HEDIS measure for Controlling High Blood Pressure in adult patient with diagnosis of hypertension
Document for adults 18 to 59 years old if BP <140/90 mmHg
Document for adults 60 to 85 years old
- With a diagnosis of diabetes if BP <140/90 mmHg
- Without a diagnosis of diabetes if BP <150/90 mmHg
Document if patient has ESRD or had a kidney transplant

Obesity and BMI
When documenting obesity, specify:
Type
Overweight, obese, morbidly (severely) obese, morbid obesity with alveolar hypoventilation (Pickwickian's), obesity hypoventilation syndrome
Cause
Due to excess calories, drug-induced obesity (specify drug)
Weight and BMI
BMI alone is not enough to satisfy the HEDIS requirement; also include weight
Associated comorbid conditions
Hypertension or diabetes
HEDIS measure for Adult BMI Assessment
Document both the weight and the calculated BMI value
Document any refusal to be weighed as explanation for why HEDIS/Five-Star Quality requirement not met (de facto exclusion)

Peripheral Artery Disease
When documenting PAD, include the following:
Cause
Diabetic, arteriosclerotic/atherosclerotic
Site of disease (vessel)
If native give name of vessel
If bypass graft – autologous, non-autologous biological or nonbiological
Manifestations – intermittent claudication, rest pain, ulceration (specify type, laterality, site, severity), gangrene
Laterality – Right, left, bilateral
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence, history of exposure (secondhand, occupational, etc.)
HEDIS measure for Statin Therapy for Patients with Cardiovascular Disease
Document for males 21 to 75 years old and females 40 to 75 years old with clinical ASCVD receiving and adhering to statin therapy

Stroke and Sequelae of Stroke *When documenting stroke, specify:*
Type
Embolic, hemorrhagic, ischemic, occlusive, stenotic, thrombotic
Site (vessel)
Cerebral – anterior cerebral artery, cerebellar artery, middle cerebral artery, posterior cerebral artery or other artery Precerebral – basilar artery, carotid artery, vertebral artery or other artery
Laterality
Right, left or bilateral
Circumstance
In evolution Intraoperative – whether during cardiac surgery or during other surgery Postprocedural – following cardiac surgery or following other surgery
Residuals of prior stroke (specify deficit)
Cognitive deficit – specify exact type Hemiplegia and hemiparesis Monoplegia of upper or lower limb Speech and language deficit Other paralytic syndrome Other sequela (apraxia, dysphagia – specify type; facial weakness, ataxia, other – specify)
Score
National Institutes of Health Stroke Scale score
Substance use/exposure
Tobacco or illicit drug use, abuse, dependence; history of exposure (secondhand, occupational, etc.)
HEDIS measure for Statin Therapy for Patients with Cardiovascular Disease
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How Can We Help?

Blue Cross and Blue Shield of Montana strives to be collaborative partners for all our providers and members. Everything we do is guided by a straightforward core purpose: **To do everything in our power to stand with our members in sickness and in health®**

For any questions regarding the AWV program and other partnership opportunities around risk adjustment coding, quality or other related topics, please contact: RiskAdjustment@bcbsil.com

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