09/22/2022

2022 Medicare Advantage Incentive: Mass Claims Adjustment Process

Agenda

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- Osteoporosis Management in Women who had a Fracture (removal of erroneous diagnosis codes).

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What is a Claims Adjustment?

- The claims adjustment process is a recognized method for submitting additional services or information necessary to process a claim for payment.
- The *Mass Claims Adjustment* process works as a claim adjustment and can be used to report quality performance measures to Highmark for services rendered to our Medicare Advantage members.
- If it is realized that a claim previously submitted to Highmark did not contain all services rendered, or reportable data related to that visit (such as current diagnosis for that member or all quality performance metrics available for reporting) providers can submit a claims adjustment form to reflect additional appropriate content.

****The key to this process is that an E&M claim has already been generated by the REQUESTING practice for that member visit and is on file with Highmark.**

What is the Mass Claims Adjustment Process?

The mass claims adjustment process is an Excel spreadsheet that contains the elements required to "include data onto" an existing claim that was previously submitted by the same provider.

Note: A practice can only request data adjustment to claims that have been generated under their practice ID. If a claim for the billing provider reported on the Mass Claims Adjustment form can not be found, or does not match the information provided, the adjustment will not occur, and the practice will not receive credit for compliance on that patient.

Note: It is also important to call out that if the DOS of the visit does not match the requirements for that specific measure as directed by HEDIS, then the practice will not receive credit for compliance.

What is the Mass Claims Adjustment Process?

This year, the process will include 9 MA Incentive measures:

- Eye Exam for Patients with Diabetes
- HbA1c
- Medication Reconciliation Post-Discharge
- Statin Use in Persons with Diabetes (exclusions)
- Statin for Cardiovascular Disease (exclusions)
- Controlling High Blood Pressure
- Falls Risk
- Frailty Diagnosis (ICD10 Diagnosis Coding Only)
- Osteoporosis Management in Women who had a Fracture (removal of erroneous diagnosis codes)

There is the opportunity to capture frailty diagnosis codes on members for whom medical record documentation exists but may have not been submitted via claims. Frailty diagnosis must be representative of the 2022 measurement year.

Additionally, there is an opportunity to remove ICD 10 codes from claims that erroneously pull members into the Osteoporosis gap. Note: if it is the only code on a claim, an additional code will need provided.

- **Data is captured in such a way to be considered as administrative claims and will enable inclusion of this data in all P4V programs that monitor these measures for the Medicare Advantage members.**

- **Highmark requires a completed request and attestation form to be submitted with the adjustment Excel forms.**

Request and Attestation Form

The following information should be placed on the requesting practice/entity letterhead, signed and attached to the email:
(A template letter is located on the MA Share point site to share with the provider.)

To Whom It May Concern:

I am enclosing an Excel document with this letter, requesting that the Health Plan adjust the indicated claims to incorporate the data listed herein. This is an effort to document that our Highmark patients, your members, have received the appropriate care and that the Health Plan has all the necessary information regarding the services we have provided.

I have reviewed all data contained on the spreadsheet and attest that the data is documented in the patient's medical records. Therefore, please supplement the previously submitted claims data to incorporate the information contained on the enclosed Excel document.

Measure Specifics & Requirements

Gap Closure Requirements: Eye Exam for Patients with Diabetes

For the Eye Exam for Patients with Diabetes, an exam in the current year, or a negative exam in the prior year (no evidence of retinopathy) may indicate that a member is at low risk for retinopathy and does not require an exam in the current measurement year.

CPTII code **2022F**(with evidence of retinopathy) **or 2023F** (without evidence of retinopathy) can be submitted to adjust an E&M claim with a DOS in 2022 to indicate that an eye exam has been completed in this measurement year. This can be used if a member did not use Highmark insurance to receive this test. The eye exam report must be secured and maintained in the provider medical record.

The mass claims adjustment form can also be used to adjust an E&M claim with DOS in 2022 to indicate that a DRE was performed, and results were negative in 2021 by using CPTII code **3072F.**

C13: Eye Exam for Pts with Diabetes		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**CPTII Quality Codes to Report Eye Exam Completion**
(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	(2022F/2023F for eye exam completed in 2022 or 3072F for negative eye exams in 2021)

Gap Closure Requirements: HbA1c

The final HbA1c lab value in the measurement year must demonstrate control: less than or equal (< or =) to 9%.

The measure is resulted based on the final lab claim result for the measurement year. For example, if Highmark receives a claim from a lab provider without a result after the PCP practice submitted a claim with a CPTII code **(3044F, 3051F or 3052F)** demonstrating control; the final submission from the lab provider will override the PCP practice's prior reporting. Tests performed that are not resulted will be determined, by HEDIS specifications, as non-compliant.

Note: HEDIS requires that all claims are eligible for evaluation and resulting, including hospital claims.

Reminder: An E&M claim submitted by the Practice requesting an adjustment must already exist to adjust for additional information. **The E&M claim to be adjusted must be on the same date as the lab draw or after.** If a lab draw has a date more than 7 days after the E&M claim with a CPTII code result it will be considered a new and later test, which may result in non-compliance, if there is no associated result demonstrating control.

C15: HbA1c		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**HbA1C CPT II Code**
(There must be an E&M claim with a 2022 DOS and the DOS must be on or after the lab draw date)	(Claim on or after the date of lab draw)	("CPT II code" demonstrating controlled HbA1C) (only controlled last value of measurement year closes gap)

Gap Closure Requirements: Medication Reconciliation Post Discharge

Medication Reconciliation is required within 30 days of an inpatient discharge.

The mass claims adjustment form can be used to adjust a Practice's E&M claim in 2022 to indicate a medication reconciliation was completed within 30 days of an inpatient visit and is documented in the outpatient medical record within those 30 days.

Use CPTII code **1111F** – Discharge medications reconciled with the current medication list in outpatient medical record, to adjust the E&M claim indicating that the medication reconciliation occurred. The DOS of the E&M claim and the medication reconciliation must be within 30 days of the member's inpatient discharge.

C20 :Medication Reconciliation Post Discharge		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**Medication Reconciliation Conducted**
(DOS of E&M visit must be within 30 days of inpatient discharge for 2022)	(Claim with E&M in which medication reconciliation occurred)	("CPT II Code" demonstrating medication reconciliation completed and documented appropriately in the outpatient medical record)

Gap Closure Requirements: Medication Reconciliation Post Discharge

Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria:

- Documentation 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.
- Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Requires documentation indicating that the provider was aware of the member's recent hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Denominator Exclusion Criteria: Statin Use in Persons with Diabetes

Members can be excluded from the denominator for ESRD, Pre-Diabetes, Pregnancy, Cirrhosis, Polycystic Ovarian Syndrome, Myopathy, and Rhabdomyolysis.

The mass claims adjustment form can be used to adjust a 2022 E&M claim to capture an above exclusion diagnosis that was not listed on the original submitted claim. The exclusion diagnosis can be added if the exclusion was discussed during the measurement year. Please see the mass claims form for specific diagnosis codes that will meet for exclusion compliance.

D14: Statin Use in Persons with Diabetes		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**RA Diagnosis Code**
(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	(ICD10 diagnosis code exclusion)

Denominator Exclusion Criteria: Statin Therapy for Cardiovascular Disease

Members can be excluded from the denominator for ESRD, Cirrhosis, or Myalgias, Myositis, Myopathy, and Rhabdomyolysis.

The mass claims adjustment form can be used to adjust a 2022 E&M claim to capture an exclusion diagnosis that was not listed on an original claim. The exclusion diagnosis can be added if the exclusion was discussed during the measurement year. Please see the mass claims form for specific diagnosis codes that will meet for exclusion compliance.

DMC17: Statin Therapy for Cardiovascular		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**CVD Diagnosis Code**
(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	(Exclusion ICD10 diagnosis code)

Gap Closure Requirements: Controlling High Blood Pressure

The mass claims adjustment form can be used to adjust an E&M claim with DOS in 2022 to indicate that a representative systolic BP and a diastolic BP was performed during the most recent outpatient visit and results were <140 and < 90 using the below CPTII codes.

Most recent Systolic: Most recent Diastolic:
3074F :<130 mm Hg 3078F: <80 mm Hg
3075F: 130-139 mm Hg 3079F: 80-89 mm Hg

- *Please use one code per line. Each member will therefore have two lines on the form.*

Note: The visit must be the most recent BP reading during the measurement year (as long as it occurred after the second diagnosis of hypertension).

Note: As defined by HEDIS, TOC visits are not able to be used in reporting values for blood pressure measurement so please do not include these for claims adjustments as they will not meet for compliance. Also please make sure these visits are outpatient PCP visits as some specialist visits do not use E&M coding therefore are not acceptable per HEDIS for gap closure compliance.

C16: Controlling Blood Pressure		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**CBP CPT II Code**
(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	("CPT II code" demonstrating CBP <140/90) (only last value of measurement year closes gap)

Gap Closure Requirements: Falls Risk

Discussion documented in the medical record that a fall risk was completed at least once during the measurement year.

The mass claims adjustment form can be used to adjust a Practice's E&M claim in 2022 to indicate those having a screening for fall risk using CPTII **1100F** to indicate documentation of two or more falls in the past year, or any fall with injury in the past year, OR CPTII **1101F** to indicate documentation of no falls in the past year or only one fall without injury. CPTII **3288F,** falls risk assessment documented, is also numerator compliant. Exclusions can also be submitted by using CTPTII 1100F-1P; 1101F-1P–Patient not screened for future fall risk for medical reasons (i.e., patient is not ambulatory).

Note: A fall is defined as a sudden, unintentional change in position causing and individual to land at a lower level, on an object, the floor, the ground, other than because of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

HOS1:Fall Risk		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**CBP CPT II Code**
(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	("CPT II code" demonstrating fall discussion occured)

Gap Closure Requirements: Frailty

Members can be excluded at 66–80 years of age during the measurement year with frailty and advanced illness if they meet both criteria, OR members 81 years of age and older during the measurement year with frailty only.

The mass claims adjustment form can be used to adjust a Practice's E&M claim in 2022 to indicate that a member was seen and did have a frailty diagnosis exclusion during the measurement year.

NOTE: Mass claims can only be used for Frailty Diagnosis with ICD10 coding. Advanced Illness should be reported and captured via normal claims cycle.

Frailty DOS		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**Code**
(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	(ICD10 Coding to show Frailty for the member)

The below measures allow for Frailty exclusions:

- CBP: looks at 81 and older for frailty; 66-80 for frailty AND advanced illness
- BCS: 66 and older for frailty AND advanced illness
- COL: 66 and older for frailty AND advanced illness
- CDC: (HbA1c, Eye, Nephropathy): 66 and older for frailty AND advanced illness
- SPC: 66 and older for frailty AND advanced illness
- ART: looks at 81 and older for frailty; 66-80 for frailty AND advanced illness
- OMW: looks at 81 and older for frailty; 66-80 for frailty AND advanced illness

** * Once a member is excluded from a measure using Advanced Illness & Frailty, they will be excluded from all measures listed above***

Gap Closure Requirements: Osteoporosis for Women who Fractured

The mass claims adjustment form can be used to adjust an E&M claim with DOS from 7/1/2021 through 6/30/2022 (included in the 2022 denominator).

Mass claims can be used to remove a diagnosis from a claim that was erroneously coded.

Proper coding is essential in correctly identifying members who have recently suffered a fracture. Recent or new fractures are fractures that are not yet healed and should be coded as such.

However, if a fracture is healed, coding should indicate that the member has a history of fracture.

C12: Osteoporosis		
Date of Claim to be Adjusted	**Previous Highmark Claim Number**	**Code**
(This must be an E&M claim with a 2021/2022 DOS)	(Submitting practice's claim # to be adjusted)	(ICD10 Coding to be **removed** for claims correction)

Mass Claims Forms and Submission Guidelines

Mass Claims Form

The practice ID/NPI must be the same ID to match what was submitted on the claim.

All Columns must be completed, or the form will not be accepted.

Diabetes Management - Retinal Eye Exam Claims Adjustment Request Form

Submission Date:
*Entity/Practice Name:
*Billing NPI or BSID:

Notes:
All requests must be received no later than January 14th, 2023.
Email requests to MA CTC.
Ensure data itemized below is documented in the patient's medical records.

									C13: Retinal Eye Exam				
Individual BCBS Practice Name	**Individual BCBS Practice ID or NPI #**	**Rendering Physician NPI #**	**Physician Name**	**Member ID**	**Patient Last Name**	**Patient First Name**	**MI**	**Patient Date of Birth**	**Date of Claim to be Adjusted**	**Previous Highmark Claim Number**	**CPTII Quality Codes to Report Eye Exam Completion**	**Highmark Internal Use Only- Completed**	**Highmark Internal Use Only- Not Valid**
(The individual practice name if from is being completed from entity level. If individual practice, and the name is the same as above, you may leave blank.)	(The individual practice BSID # or NPI if from is being completed from entity level. If individual practice, and the ID# is the same as above, you may leave blank.)	(The 11 digit NPI assigned to the practitioner who rendered the service.)	(Name of rendering physician)	(Highmark unique member ID is a 12 or 13 digit ID number)	(Patient's Last Name)	(Patient's First Name)	(Middle Initial)	(MM/DD/CCYY)	(This must be an E&M claim with a 2022 DOS)	(Submitting practice's claim # to be adjusted)	(2022F/2023F for eye exam completed in 2022 or 3072F for negative eye exams in 2021)	(Highmark Internal Use Only- Adjustment Completed)	(Highmark Internal Use Only- Adjustment request is Not Valid)

... | DMC17 CVD | CVD Diagnosis Codes | C16 Con Blood Pr | CBP CPT2 Codes | HOS1 Fall Risk | Fall Risk CPT2 Codes | Frailty

The claim number can be located on a Highmark EOB, NaviNet, or your CTC can assist you with obtaining.

Tabs are located at the bottom of the document for each measure. Each measure has two tabs, one for the member detail, and the second for a listing of acceptable codes.

Guidelines for Mass Claim Submission Requests

- A signed request and attestation from the practice must be attached with all adjustment forms. Entity attestation will now be accepted.
- A separate tab of the form must be filled out for each measure submission.
- Multiple billing practices can now submit on the same spreadsheet. Entity submissions for multiple practices should contain the entity number in the top of the form, and each practice should be listed separately with the BSID# and practice name.
- All fields must be filled in appropriately. Incomplete forms will be returned.
- The practice is responsible to submit completed forms by the due date. There will be no extensions passed the due date - **01/14/2023**.

IMPORTANT

An adjustment can only be made if the claim to be adjusted already exists and the request is from the Practice who originally submitted the claim.

Guidelines for Mass Claim Submission Requests (continued)

- All adjustments must be sent via email as an Excel attachment (no handwritten forms will be accepted)
- Attachment must be named with BS# or NPI, Name of the practice or entity, Name of the measure or measures submitting (For example: BSID000011223 Smith Family Medicine HbA1c /Medication Reconciliation Post Discharge /Osteoporosis)
- Use the attachment name in the Subject Line of the email message and send to **your assigned MA CTC. The CTC will then forward your email to the assigned department for completion.**

IMPORTANT

An adjustment can only be made if the claim to be adjusted already exists and the request is from the Practice who originally submitted the claim.

Location & Submission for Providers

Where to find the Excel Form

- NaviNet > Quality Blue > Resources Tab
  or
  NaviNet > Provider Resource Center > Medicare Advantage Stars > Medicare Advantage Member and Provider Programs > under General References & Resources

Forms Submission

- Completed Mass Claims Adjustment forms can be submitted beginning on October 1, 2022 to your assigned MA CTC.

IMPORTANT

The last day for forms to be submitted is January 14, 2023.

Late forms will not be accepted regardless of circumstance.

Claims Adjustment and Return Process

Claims Adjustment Metrics:

- Each of the mass claims adjustment forms contain two Highmark only columns. This allows for tracking of member line input.
- MA Claims personnel will record each member line as either “adjusted” or “not valid”. ******Although the data may have been adjusted, this does not mean the data will meet compliance and will still be subject to HEDIS review and acceptance.*****
- “Not valid” indicates that the adjustment could not occur due to claim not found or missing data.
- Once the MA claims adjustment submissions are reviewed, the completed forms will be sent securely to the SENDER from their assigned Government CTC.

IMPORTANT

Claim forms will be returned as quickly as possible, but the closer to the submission deadline may result in longer wait times and are not guaranteed to be returned by January 31st, 2023.