The Advantasure® Remote CDI program™

Blue Cross Blue Shield of Michigan
In State & Out-of-Area

03/22

The Remote CDI program is important in caring for your patients.

Providers and health plans play a vital role in coordinating and improving the delivery and cost of health care. We're also held accountable for the quality and efficiency of the care we deliver.

Blue Cross Blue Shield of Michigan is working with Advantasure on their Remote Clinical Documentation Improvement program. This program helps providers make complete and accurate diagnoses of our Medicare Advantage PPO members.

Complete and accurate diagnosis coding helps us identify patients who may benefit from disease and medical management programs. It also gives the Centers for Medicare & Medicaid Services the most accurate patient illness burden and health status.

The Advantasure Remote CDI Program assists providers in:

- Capturing chronic conditions of their patients
- Documenting more specifically in the patient's medical record
- Addressing their patient's gaps identified by the CMS Star Ratings program

The Remote CDI Program works to ensure that all patients' conditions are addressed every year and that the diagnosis code data is documented and reported by primary health care providers.

The Remote CDI Program helps with diagnosis closure by focusing on patients' previously reported and suspected conditions, which should be reported in the patient's medical record at least once every calendar year.

Better documentation results in better care for patients.

The Remote CDI program uses the *CDI Alert* as a one-page guide to aid providers in closing and addressing gaps during a face-to-face or audio and visual virtual patient visit. A *CDI Alert* is created for each of Blue Cross' Medicare Advantage PPO patients and will list their potential conditions.

The diagnosis gaps identified by Advantasure help providers confirm and validate patients' conditions. Confirming these conditions allows us to maintain the most accurate patient data possible and have the resources available to treat them.

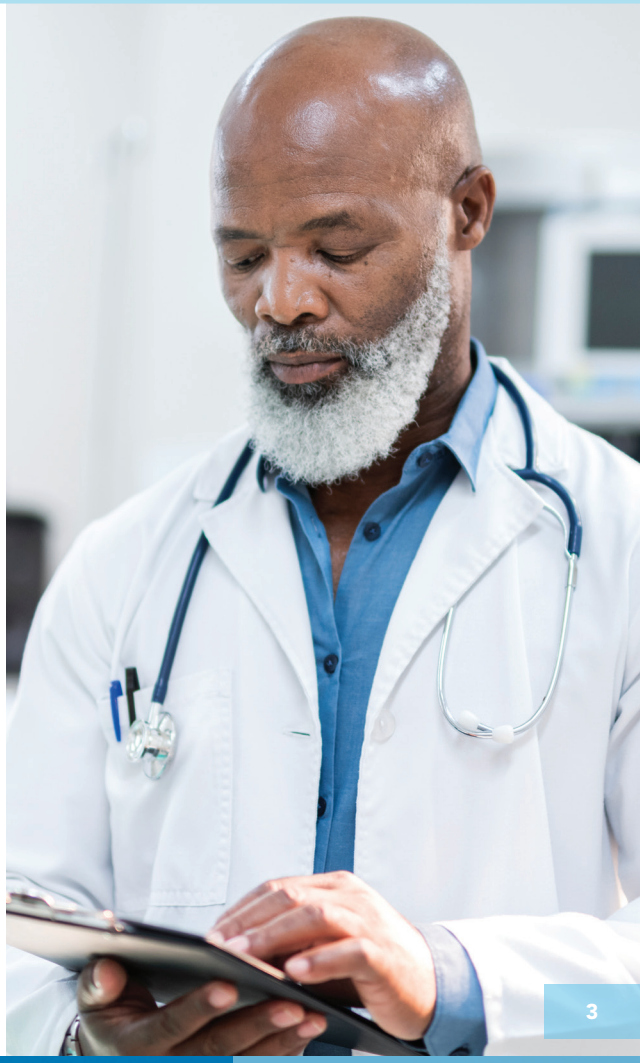
Having all of a patient's chronic conditions and diagnosis codes addressed and documented every year leads to improved quality of care and benefits for our members.

Incentives for participation.

Providers who close out 100% of the identified open historical and suspected gaps for each eligible member will earn $100 per attributed member.

Requirements:

1. Patients must have coverage through the Medicare Advantage plan from Blue Cross Blue Shield of Michigan or other Blue Cross plan and be assigned to the provider through the plan.
2. Patients must have at least one open diagnosis gap identified during the period of January 1 through September 30.
3. All open diagnosis gaps for patients are appropriately addressed before December 31 during a face-to-face or audio and visual virtual visit.
4. All *CDI Alerts* are completed and returned within 14 days of the visit.
5. Any queries or exceptions are completed and returned within seven days of receipt.



The *Clinical Documentation Improvement Alert*

The *CDI Alert* is a comprehensive list of your patients' potential diagnoses. Providers address patients' conditions by marking a response to each one of the conditions listed on the alert.

CDI Alerts are populated based on:

- Physician and certified coder medical record reviews
- Suspected diagnosis data
- Prior Hierarchical Condition Categories information to encourage reaffirmation of prior chronic conditions

CDI Alerts will be distributed to your office up to three times a year.

Use the most recent alert by checking the date listed in the bottom left corner of the alert.

If this date is more than four months old, check to see if we sent you an updated alert.

Please note that the alert may not include all conditions or quality measures that exist for the patient.

ADVANTASURE™
Fueling Accelerated Performance

Clinical Documentation Improvement Alert

Blue Cross Blue Shield of Michigan
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

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

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

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

Location: _____ **Provider Name:** _____

Member Name: _____ **Member DOB:** _____ **Member ID:** _____ **Appointment Date:** _____

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

_ Yes _ No _ Not Addressed I700 Atherosclerosis of aorta
_ Yes _ No _ Not Addressed F3342 Major depressive disorder, recurrent, in full remission

_ Yes _ No _ Not Addressed E1122 DM type 2 with diabetic chronic kidney disease

---

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

_ Yes _ No _ Not Addressed Obstructive sleep apnea (OSA) noted; please consider screening echocardiogram for pulmonary hypertension given documented risk factor

_ Yes _ No _ Not Addressed The following criteria for morbid obesity were noted: BMI >35 with comorbidities of HTN and DM; please assess for morbid obesity and document if appropriate

_ Yes _ No _ Not Addressed Patient has chronic asthma, on inhalers; please consider screening with PFT for asthma with chronic obstruction

---

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

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

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

Provider Tax ID: _____ **Contact Name:** _____

06/18/2021 **Provider Signature:** _____ **Date:** _____

Sections in the *CDI Alert*

Confirmation of conditions

These diagnoses have been submitted for the patient in prior claims or supplemental data to Blue Cross. For those conditions under your active management or treatment, mark "Yes" and document this diagnosis in the patient's medical record.

Clinical documentation improvement opportunities

Based on medical record review of clinical indicators, clinical documentation opportunities were identified. If you agree, mark "Yes," evaluate and document it in the patient's medical record.

Star measure gap closure (when applicable)

The CMS Star Ratings section of the alert contains gaps in the quality measures that are reported annually to CMS. The CMS rules for these measures vary. Some require screening tests each year, others every two years. Some measures, such as medication adherence, aren't related to a screening.

The provider marks **one** response to the action indicated to each of the Star Ratings measure gaps listed on the alert. Marking the response on the *CDI Alert* by itself won't close a Star Ratings measure gap.

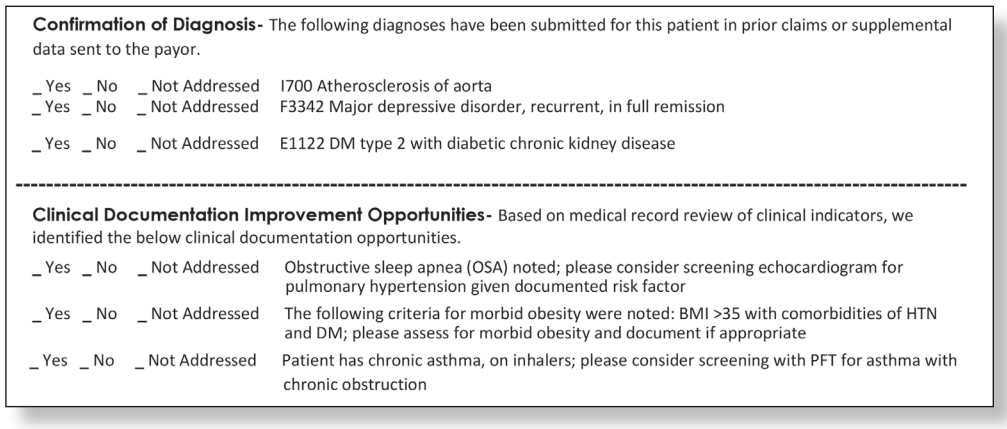
Star Ratings measure gaps typically will populate on the CDI Alerts in the second half of the year for any identified open Star Ratings measure gaps.

Completing the *CDI Alert*

How to mark responses on the *CDI Alert*

Confirmation of diagnosis and improvement opportunities sections

- Mark "Yes" if the diagnosis listed on the alert is being addressed with the patient during the current face-to-face or audio and visual virtual visit. "Yes" responses need to be supported by medical record documentation.
- Mark "No" if the diagnosis doesn't exist. A gap shouldn't be marked "No" solely for the reason that you're not actively treating the condition.
- Mark "Not Addressed"
  If you're unsure if the diagnosis exists or if the diagnosis is valid and you're not addressing it during the current visit. Conditions or opportunities marked "Not Addressed" will repopulate on future alerts.



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

_ Yes _ No _ Not Addressed I700 Atherosclerosis of aorta
_ Yes _ No _ Not Addressed F3342 Major depressive disorder, recurrent, in full remission

_ Yes _ No _ Not Addressed E1122 DM type 2 with diabetic chronic kidney disease

---

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

_ Yes _ No _ Not Addressed Obstructive sleep apnea (OSA) noted; please consider screening echocardiogram for pulmonary hypertension given documented risk factor

_ Yes _ No _ Not Addressed The following criteria for morbid obesity were noted: BMI >35 with comorbidities of HTN and DM; please assess for morbid obesity and document if appropriate

_ Yes _ No _ Not Addressed Patient has chronic asthma, on inhalers; please consider screening with PFT for asthma with chronic obstruction

The Health e-Blue℠ portal isn't an option to close historical and suspected gaps when completing the *CDI Alert*. The *CDI Alert* must be completed at the time of the patient visit with all diagnoses checked Yes or No. Historical and suspected gaps closed in HeB won't count toward the Remote CDI incentive.

Use your professional judgment when using the *CDI Alert*

When responding to the *CDI Alert*, exercise your professional, independent judgment. The fact that a question is asked doesn't imply that any particular answer is desired or expected.

The *CDI Alert* objective is to support the goal of accurate and CMS-compliant documentation. When you submit the alert, you **must** send the office visit note. Handwritten notes on *CDI Alerts* won't replace the office visit notes.

The CDI Alert is not part of the permanent medical record. All documentation relative to the patient's diagnoses, assessment, management and referrals should be done in the office visit note. Providers are only expected to mark their responses on the alert, and sign and date it.

Star Ratings measure gap closure section

The provider is asked to take the action indicated and check the response describing whether any action was taken. Checking the response on the *CDI Alert* by itself won't close a Star Ratings measure gap.

The action taken and the results should be documented in the medical record. Return the results by submitting the *CDI Alert* to Advantasure or on a claim to Blue Cross. Mark only **one** response to the action taken in this section.

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

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

Checklist for submission of *CDI Alerts*:

- ☑ Make sure all items that were addressed during the face-to-face or audio and visual virtual visit were marked.
- ☑ **Include medical record documentation** for each response marked on the alert.
- ☑ If "Yes" is marked, provide supporting documentation in the patient's office visit note from the current visit, showing the condition was addressed during the visit.
- ☑ Submit office visit notes with the *CDI Alert* within 14 days of the visit.
- ☑ **Fax** the completed *CDI Alert* with the corresponding medical record office visit note to **1-844-576-2527**.

Exception Notices and *Query Requests*

An ***Exception Notice*** will be sent to your office when we can't assign diagnosis codes from the *CDI Alert* or office visit note because some of the information is missing or illegible. In order to process the alert, fax the requested information. Examples of an exception include:

- The alert or office visit note is missing signatures
- The office visit note submitted with the alert is missing pages
- The patient's identifiers in the alert or office visit note don't match or are missing
- The documentation in the office visit note is illegible

If your office receives an *Exception Notice*, correct and fax the requested information listed in the notice within seven days to 1-844-576-2527.

A ***Query Request*** will be sent to the provider requesting to add missing or incomplete information.

Queries are part of Advantasure's real-time record review process and give providers an opportunity to clarify disconnections with coding and documentation in the medical record.

Query requests are most often sent for two reasons:

- **There's missing documentation in the office visit note.** For example, if "Yes" was marked on the *CDI Alert* and no supporting documentation is found in the office visit note to show the condition was addressed during the visit.
- **More specificity is required in the documentation to report the appropriate diagnosis code.** For example, if the documentation is incomplete or not specific enough to meet CMS guidelines for reporting a condition.

CMS guidelines allow providers to change their documentation in the medical record up to 30 days from the date of the face-to-face or audio and visual virtual visit. Providers will not be asked to make any changes to their documentation outside of the 30-day timeframe.

When you receive a query:

Amend the office visit note with the requested clinical documentation.

Fax the amended office visit note and the *CDI Alert* back within seven days to 1-844-576-2527.

Documentation tips

MEAT and coding

The acronym MEAT is used to describe the types of documentation in the medical record that support the assignment and reporting of ICD-10-CM diagnosis codes according to the CMS and ICD-10 official coding guidelines. In addition to the diagnosis itself, the documentation must include whatever action the provider took during a visit relative to the management of the diagnosis.

MEAT:

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

Documentation of a patient's diagnosis without the clinical significance, current status or plan of care isn't considered sufficient documentation to submit the corresponding ICD-10-CM code on the claim for that visit.

A gap shouldn't be closed solely for the reason that you're not actively treating the condition. A diagnosis gap should only be closed during the office visit by one of three ways:

- Addressing the condition
- Determining that the patient no longer has the condition
- Suspected condition doesn't exist

Monitoring

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

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

Evaluation

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

MEAT

Assessment

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

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

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

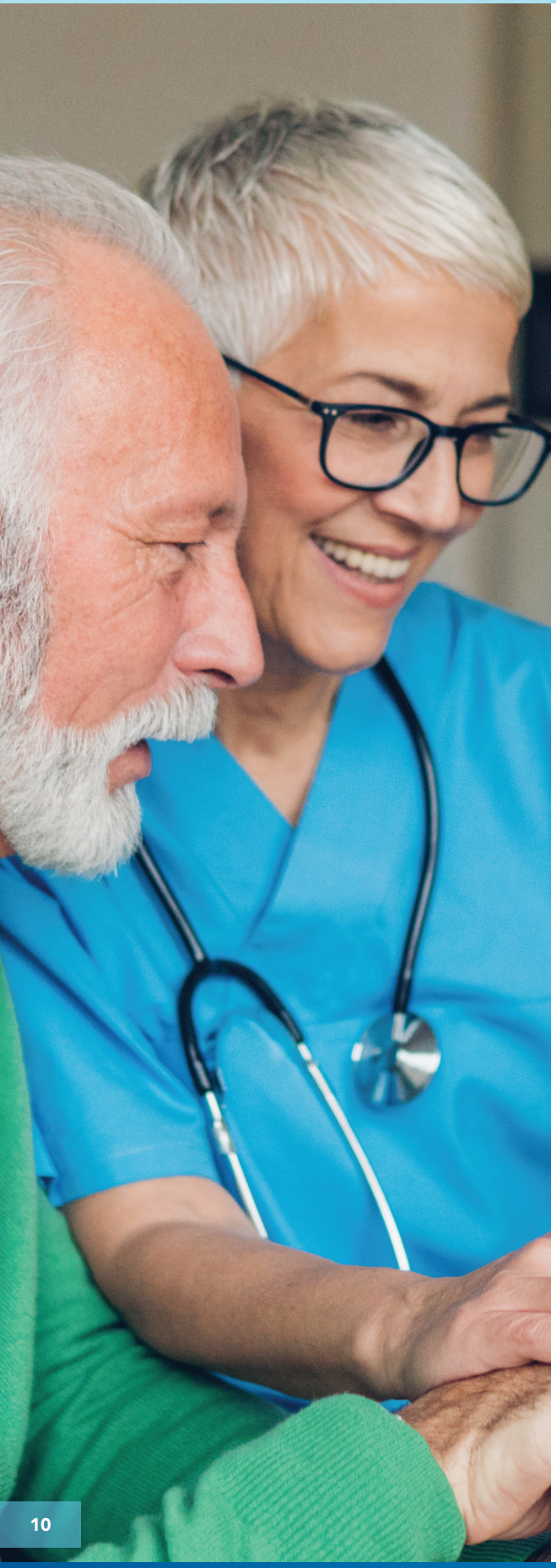
Treatment

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

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

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

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



How to participate in the Remote CDI program

Included in this welcome packet is the *Participation and Fax Validation* form. Simply complete the *Participation and Fax Validation* form and fax it to Advantasure at 1-844-576-2527 to start your participation in the program.

When you complete the form, be sure to include your office's primary and secondary contact so they can be reached regarding any questions or updates about the Remote CDI program.

Faxing the form to Advantasure confirms your fax number and that your office can receive and send *CDI Alerts*, exceptions, queries and office visit notes and any other corresponding documentation by fax.

If you have questions, call:

- Clinical consultant, Tom Rybarczyk at 313-378-8259
- Senior analyst, Denise McMillian at 313-983-2998

Reference Tool

A copy of the Advantasure's *Reference Tool* is provided on the next page. The *Reference Tool* is a list of common diagnoses encountered during primary care visits. It also includes information to assist providers in properly documenting these diagnoses and assigning the appropriate diagnosis codes to the patient's chronic conditions. The *Reference Tool* can be used when filling out your patient's *CDI Alert* or when documenting in their medical record

CDI Alert Reference Tool

Tips on documenting chronic conditions for your patients:

- Coding is based upon clear medical record documentation. Each diagnosis must be **Monitored, Evaluated, Assessed or Treated** at least once a year.
- Each note must be **complete, legible, concise, and contain your signature with credentials.** Only code symptoms if a definitive diagnosis cannot be determined.
- Avoid use of indecisive adjectives such as "history of," "consistent with," "suggestive of," "suspect," etc.

NOTE: The actual ICD-10 code used is dependent upon provider documentation. For a complete list of codes please consult your ICD-10 coding manual.

Respiratory

When clinically indicated, perform yearly spirometry for all patients with COPD. Screen symptomatic patients who have risk factors, e.g., hx of smoking or evidence of COPD on imaging. FEV1/FVC<0.7 at baseline is indicative of airway obstruction. This confirms COPD (emphysema or chronic bronchitis) in the appropriate clinical setting. For asthmatics showing the same results, asthma with chronic obstruction should be documented.

	ICD-10
Asthma with Chronic Obstruction	J44.9
Chronic Bronchitis	J42
Smoker's Cough	J41.0
COPD	J44.9
COPD with Acute Exacerbation	J44.1
Chronic Respiratory Failure	J96.10
Emphysema	J43.9
Obesity/Hypoventilation Syndrome	E66.2

Mental Disorders

Patients treated for major depression, with medications, psychotherapy or both, should have the recurrence (single episode or recurrent) and severity (mild, moderate, or severe) of their depression documented. Patients who are asymptomatic as a result of treatment are considered "in remission". Alcohol dependence and drug dependence are lifelong diagnoses. Even after patients quit, they still carry the diagnosis of dependence, and the documentation should reflect that they are "in remission". When withdrawal symptoms occur, whether or not as part of a detoxification process, they should be documented in the record.

Depression or Depressive Disorder	F32.A
Major Depressive Disorder	F32.0 - F32.9, F33.0-F33.5
Episodic Mood Disorder	F39
Bipolar Disorder	F31.0 - F31.9
Schizophrenia	F20.0 - F20.9
Sedative Dependence	F13.9 - F13.99
Alcohol Dependence	F10.2 - F10.239
Opioid Dependence	F11.1 - F11.19

Neurology

Codes for acute cerebrovascular accidents (CVA), whether ischemic or hemorrhagic, should not be used in an office setting unless the CVA is diagnosed acutely in the office. Otherwise, late effects of the CVA, e.g., hemiplegia, hemiparesis, should be documented. Epilepsy and Parkinson's disease are chronic diseases that should be evaluated and documented yearly.

Late Effects of CVA with Hemiparesis/Hemiplegia	I69.059 - I69.959
Parkinson's Disease	G20 - G21.4
Epilepsy	G40.401 - G40.419
Seizure or Convulsions	R56.9

Digestive

Cirrhosis of the liver should be documented yearly along with any complications, e.g., portal hypertension, esophageal varices, hepatic failure and whether the patient had a liver transplant. The underlying cause of cirrhosis should also be documented, e.g., alcohol, chronic hepatitis C and primary biliary cirrhosis.

Alcoholic Liver Cirrhosis	K70.2 - K70.31
Chronic Viral Hepatitis	B18.0 - B18.9
Esophageal Varices without Bleeding	I85.00
Portal Hypertension	K76.6
Liver Transplant Status	Z94.4

Cardiovascular System

CHF, aortic and peripheral atherosclerosis, and arrhythmias are chronic illnesses that should be evaluated and documented on an annual basis, whether symptomatic or asymptomatic. Pharmacological treatment(s) should be documented regardless of whether there have been changes made to the regimen.

Aortic Atherosclerosis Aneurysm	I70.0
Abdominal Aortic Aneurysm	I71.9
Aortic Ectasia or Dilated Aorta	I77.819
PAD/PVD	I73.89
Leg Varicosity with Ulcer and Inflammation	I83.20 - I83.229
Angina Pectoris	I20.8 - I25.799
Cardiomyopathy	I42.9
Congestive Heart Failure	I50.20 - I50.9
Atrial Fibrillation	I48.0 - I48.91
Paroxysmal Supraventricular Tachycardia	I47.1
Pulmonary Hypertension	I27.20

Diabetes

Diabetes should be evaluated and documented yearly. Combination codes that link diabetes with its complications should be used when certain conditions caused by diabetes are also present. These include diabetic neuropathy, CKD, retinopathy and peripheral vascular disease. Uncontrolled diabetes must be further specified as diabetes with hyperglycemia or with hypoglycemia.

	ICD-10
Type 2 Diabetes without Complications	E11.9
Type 2 Diabetes with Chronic Kidney Disease (CKD)	E11.22
CKD (Stage 3) unspecified GFR 30-59	N18.30
CDK (Stage 3a)	N18.31
CDK (Stage 3b)	N18.32
CKD (Stage 4) GFR 15 - 29	N18.4
CKD (Stage 5) GFR<15	N18.5
ESRD	N18.6
Type 2 Diabetes with Ophthalmic Complications	E11.311 - E11.39
Diabetic Retinopathy	E11.319
Type 2 Diabetes with Neurological Complications	E11.40 - E11.49
Diabetic Neuropathy	E11.40
Type 2 Diabetes with Peripheral Circulatory Complications	E11.51 - E11.59
Type 2 Diabetes with Gangrene	E11.52
Type 2 Diabetes with Periperial Vascular Disease	E11.51
Type 2 Diabetes with Other Complications	E11.6 -E11.8
Type 2 Diabetes with Ulcer of Lower	E11.621
Limb Type 2 Diabetes with Dermatitis	E11.620
Type 2 Diabetes, Poorly Controlled (Out of Control, Inadequate Control)	E11.65

Endocrine Disorders

Hyperparathyroidism should be suspected in patients with elevated calcium levels. Patients with CKD are particularly at risk and should be screened with an intact PTH level. Hyperparathyroidism should be documented when the PTH level is high. A low PTH level denotes hypoparathyroidism.

Hyperparathyroidism	E21.3
Hyperparathyroidism of Renal Origin (Due to CKD)	N25.81
Hypoparathyroidism	E20.9

Malnutrition

Patients with a low BMI<19 or with unintentional weight loss >10% of body weight within one year should be evaluated for protein-calorie malnutrition. Poor oral intake and a low serum albumin are additional indicators. Cachexia usually occurs in patients with terminal illness, e.g., malignancy, end stage COPD or CHF, and should be documented in cases of severe weight loss with muscle wasting.

Protein Calorie Malnutrition	E44.0, E44.1, E46
Cachexia	R64

Morbid Obesity

Patients with BMI >35 and comorbidities such as DM, heart disease, obstructive sleep apnea, GERD, osteoarthritis and HTN meet the diagnostic criteria for morbid obesity. Patients with BMI ≥40, regardless of comorbid conditions, also meet the criteria.

Morbid (Severe) Obesity	E66.01
BMI>40.0	Z68.41- Z68.45

Malignancy

Malignancies should be documented as active only while the patient is receiving active treatment. This includes surgery, chemotherapy, radiation and long term adjuvant therapy. Once treatment is completed, malignancies should be documented and coded as "personal history of." Hematologic malignancies, however, can be coded as "in remission" after treatment is completed.

Leukemia, Unspecified, Active	C95.00
Multiple Myeloma, Active	C90.00
Breast Cancer (In Active Treatment)	C50.911 - C50.919
Prostate Cancer (In Active Treatment)	C61
Leukemia,Unspecified, in Remission	C95.91
Multiple Myeloma, in Remission	C90.01
Personal History of Prostate Cancer	Z85.46

Secondary/Metastatic Malignancy

Any lymph node involvement and/or distant metastases should be included in the documentation of malignancies.

Secondary/Metastatic Malignant Neoplasm of Lymph Node	C77.9
Secondary/Metastatic Malignant Neoplasm of Unspecified Site	C79.9

Blue Cross
Blue Shield
Blue Care Network
of Michigan

Advantasure is an independent company that provides health care technology solutions and services for Blue Cross Blue Shield of Michigan and Blue Care Network. Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

W007094