Patrius Health

BLUE ADVANTAGE

Resources for Providers

Blue Advantage
A Medicare Approved PPO

PRV20621PAT-2402

Blue Advantage® PPO is provided by Patrius Health, a Blue Cross and Blue Shield organization that strives for the highest quality care and relationships with patients and network providers in Mississippi. The materials in this booklet cover important topics including incentives available to you, wellness exams for your patients, coding tips and more..

We look forward to working with you to strengthen healthcare in The Magnolia State.

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Steps to a Successful Start

Here are some steps you can take to get your **Blue Advantage® (PPO)** patients on a path to receiving quality health services from you.

Review Online Resources

Log in to ***my*Blue Provider**, and then click "Blue Advantage Resources" to get answers about Blue Advantage. On our website you can find:

- Pre-Service Review Information
- Medical Policies
- Incentives for You and Your Patients
- Pharmacy Resources
- Coding Guides
- List of Attributed Patients
- Provider Manual

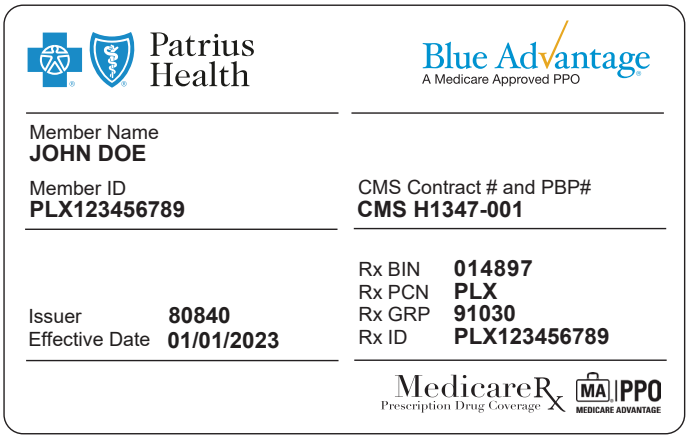
Schedule Annual Wellness Exams

Annual Wellness Visits (AWVs) and annual physical exams are **available at no cost to your Blue Advantage patients**. It's a good opportunity to create a care plan by discussing your patients' overall health, as well as addressing any chronic conditions and gaps in care. During these visits, you can begin talks about advanced care planning.

Earn Health Risk 360 (HR360) Incentives

We are rewarding you for performing comprehensive health risk assessments for your Blue Advantage patients. **You can earn $150 for each completed and accepted HR360 form** you submit based on your patient encounters. You can easily complete the HR360 during your patients' AWVs or annual physical exams! Our provider website has all the details.

Sample Member ID Card



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2024 Blue Advantage Rewards & Wellness Program

Get rewarded for making your health a priority when you enroll in the Blue Advantage® Rewards & Wellness Program. Blue Advantage (PPO) members can enjoy this program at no cost, and may be able to earn up to $45 in Walmart gift cards[1] in 2024!

How to Enroll

- Log in or register for your *my*BlueCross account at **PatriusHealth.com/BlueAdvantageRewards**.
- From *my*BlueCross, click on Blue Advantage Rewards & Wellness on the right side of the page.
- Follow the prompts on the screen to enroll.
- Continue to access Blue Advantage Rewards & Wellness through *my*BlueCross. You'll also find online wellness resources including:
  - A health assessment that recommends healthy habits to improve your health.
  - Videos and articles on topics like nutrition and health conditions.
  - Programs that help you set goals and create healthy habits.

Enroll Today!

Questions or prefer to enroll by phone?
Call **1-877-386-1352** (**TTY:711**)

How to Earn Rewards

Earn rewards by completing the following activities:

Enroll in Blue Advantage Rewards & Wellness	$10[2]
Annual wellness visit	$25
Flu shot (received August 1 to December 31, 2024)	$10

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[1] All rewards will be mailed in the form of a Walmart gift card, which may be used in store or online at Walmart.com. Gift card may NOT be used for Alcohol, Tobacco, Firearms or Lottery. After completing an activity, it may take approximately 8-12 weeks to receive the gift card.

[2] Only for new reward program enrollees.

Our hours are from 7 a.m. to 9 p.m. Central time Monday - Friday. On weekends and holidays you may be required to leave a message. Calls will be returned the next business day. Blackhawk Network is an independent company providing rewards (Walmart gift cards) to Blue Advantage (PPO) members on behalf of Patrius Health. Blue Advantage is a PPO with a Medicare contract. Enrollment in Blue Advantage (PPO) depends on contract renewal. Patrius Health is an independent licensee of the Blue Cross and Blue Shield Association.

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ANNUAL WELLNESS VISIT AND ROUTINE PHYSICAL EXAM GUIDE

Members can receive an Annual Wellness Visit (AWV) and routine physical exam at any time during the calendar year. The routine physical exam can be done during the same time as the AWV. During the wellness visit and physical exam, the provider will develop a personalized prevention plan, complete the Health Risk 360 (HR360), perform a physical examination and a comprehensive review of systems. A physician or advanced practice provider can complete these visits.

These visits will include the following components:

- A comprehensive history and physical examination
- A review of any chronic conditions
- Ordering of laboratory and radiology services
- Any ordering of preventive screenings
- Counseling for risk-factor interventions

The member will not have a copay, coinsurance or deductible for the routine physical exam and AWV.

Routine Physical Exam	
CPT	**Description**
99385-99387 *No modifier needed*	Annual Routine Physical Exam – New Patient
99395-99397 *No modifier needed*	Annual Routine Physical Exam – Established Patient

Welcome to Medicare	
HCPCS	**Description**
G0402	Initial Preventive Physical Examination (IPPE) – first 12 months of enrollment into Medicare Part B

Annual Wellness Visit (AWV), Exams and Screenings	
HCPCS	**Description**
G0438	**Annual Wellness Visit (AWV), Initial** – Includes a personalized prevention plan of service (PPS) – after the first 12 months of enrollment
G0439	**Annual Wellness Visit (AWV), Subsequent** – Includes a personalized plan of service (PPS)
Depression Screening*	
G0444	Annual Depression Screening – fifteen minutes
*A depression screening is a required element of the initial AWV. However, the depression screening code, G0444, is not separately payable when the initial AWV code, G0438, is billed. It is appropriate to bill both codes if a depression screening is completed at the time of a subsequent AWV (HCPCS code G0439).	

Routine Physical Exam and Annual Wellness Visit Diagnoses	
ICD-10	**Description**
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings

HCPCS CODES G0402 (WELCOME TO MEDICARE) AND G0438 (INITIAL EXAM)

Welcome to Medicare is only covered once per lifetime.

Included in visit:

- Completion of an HR360
- List of providers involved in patient's medical care
- Medical/family history
- Screening of cognitive impairments, mental risk factors, level of safety and functioning abilities
- Review of patient's mental risk factors, functional ability and level of safety
- Establishment of a personalized prevention plan
- Health advice, health education, referrals or preventive counseling service to help reduce any risk factors
- Advanced care planning services at patient's discretion

HCPCS CODE G0439 (SUBSEQUENT AWVs)

This code is to be used once per calendar year after the patient's initial visit.

Included in visit (update all as needed):

- Completion of an HR360
- List of providers involved in patient's medical care
- Medical/family history
- Screening of cognitive impairments, mental risk factors, level of safety and functioning abilities
- Establishment of a personalized prevention plan
- Health advice, health education, referrals or preventive counseling service to help reduce any risk factors
- Advanced care planning services at patient's discretion

Be sure to include on the claim the appropriate ICD-10 codes (Z00.00 or Z00.01) as well as ALL other active diagnoses considered during the visit.

AWV AND ANNUAL PHYSICAL CLAIMS FILING REQUIREMENTS

In-Person Visit

Include the BMI ICD-10 code and blood pressure CPT II codes on the claim. If the BMI diagnosis or blood pressure result codes are omitted from the claim, the claim will reject on your audit report.

You should also report the results if coding Hemoglobin A1C lab (CPT code 83036) or home test (CPT code 83037). If performing an A1C test in the office, file the appropriate CPT II code 83036 or 83037 with the Category II code result code on the claim.

Telehealth Visit (Audio and Video)

Include the required place-of-service code:

- 02 – In a place other than the patient's home
- 10 – In the patient's home

Note: *The Welcome to Medicare IPPE cannot be performed through telehealth.*

For more information, visit MLN6775421 – Medicare Wellness Visits (cms.gov).

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Documentation & Coding Guidance

KEY POINTS:

- Any condition that is taken into account or affects patient care, treatment or management at the time of the encounter should be documented and coded. The condition must be documented as current to capture in coding.
- Documentation must support the code used.
- It's important to document and code the patient's diagnosis to the highest level of specificity.
- Some medical conditions never go away; however, coding from past medical history without current support for the condition is not acceptable. Be sure to review and update the past medical history, current problem list, and medication list at every visit.
- Diagnosed conditions must be expressly stated. Avoid terms such as probable, suspected, rule out or working diagnosis.
- All conditions should be documented at least annually.

The importance of consistent, complete documentation in a medical record cannot be overemphasized. Without it, accurate coding cannot be achieved and audit findings cannot be validated.

The federal government reimburses Medicare Advantage plans based on the health of their patients. This reimbursement is determined through a method used by CMS called risk adjustment.

Providers play an important role in the risk adjustment process because data from patient claims is used to indicate the complete picture of health for plan members.

This same data also enables Patrius Health to analyze and design programs to help manage patients' chronic conditions.

Documentation and coding must mirror one another in order to accurately capture the patient's complete picture of health.

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Thoroughly reviewing documentation and coding practices through internal auditing procedures ensures that the data has been reported correctly and that the appropriate reimbursement is received.

Best Medical Record

For a patient record to be considered a Best Medical Record by CMS, it should include:

- ☑ The provider's signature, credentials and date
- ☑ The patient's name and date of service on each page of the chart
- ☑ The medical record must support all diagnoses coded for the date of service submitted
- ☑ The record must be complete, legible, and able to stand alone
- ☑ One of the following designations should precede the practitioner's name for electronic records: *electronically signed by, authenticated by, signed by, approved by, validated by*

Best Practices

- Thoroughly reviewing documentation and coding practices through internal auditing procedures ensures that the data has been reported correctly and that the appropriate reimbursement is received.
- Telehealth visits need to state that the encounter was completed via audio *and* video in order to capture risk.
- Significant conditions such as transplant status, current ostomies, amputations, dialysis status, long-term insulin use, and asymptomatic HIV infection are frequently overlooked.

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2024 COMMON HCC ICD-10 CODES

When documenting chronic conditions, remember: 1) Coding is based on clear documentation that includes a diagnostic statement and ongoing treatment plan. Any condition that is taken into account or affects patient care, treatment or management at the time of the encounter should be documented and coded. 2) The encounter note should be a face-to-face visit and be complete, legible, concise, and contain the provider signature with credentials. 3) Avoid the use of uncertain diagnoses such as "suggestive of," "suspected," "consistent with" or "probable," and code to the highest level of certainty for the encounter/visit.

Diabetes Mellitus (DM)	TYPE 1	TYPE 2
Diabetes mellitus without complications	E10.9	E11.9
Combination Codes: Utilize combination codes that link the complications of a disease. If there are multiple complications of diabetes mellitus then be sure to code each of the diabetes mellitus combination codes.		
D84.81: Immunodeficiency due to conditions classified elsewhere **Notes:** Don't forget to consider immunodeficiency for your patients with Type 1 DM. If they are immunocompromised, document and code D84.81.		
Diabetes mellitus with hyperglycemia	E10.65	E11.65
Hyperglycemia: When hyperglycemia, poorly controlled, inadequately controlled or out of control is documented, diabetes mellitus with hyperglycemia should be coded. The word uncontrolled can mean either hypo- or hyperglycemia; therefore, it is insufficient documentation to code E10.65/E11.65.		
Diabetes mellitus with diabetic neuropathy, unspecified	E10.40	E11.40
Diabetes mellitus with polyneuropathy	E10.42	E11.42

Diabetes Mellitus with Kidney Complications	TYPE 1	TYPE 2
Diabetes mellitus with diabetic chronic kidney disease	E10.22	E11.22
Diabetes mellitus with diabetic nephropathy	E10.21	E11.21
Diabetic chronic kidney disease (CKD) and nephropathy: When diabetic nephropathy and CKD are documented, code diabetic CKD, not nephropathy.		
Use additional code to also to identify stage of CKD.	N18.1- N18.6	N18.1- N18.6

Diabetes Mellitus with Ophthalmic Complications	TYPE 1	TYPE 2
Diabetes mellitus with unspecified diabetic retinopathy	E10.31	E11.31
Ophthalmic complications: If adequately documented, code specifically as to type and designate right, left, bilateral or unspecified eye.	E10.3-	E11.3-

Diabetes Mellitus with Circulatory Complications	TYPE 1	TYPE 2
Diabetic peripheral angiopathy without gangrene	E10.51	E11.51
Diabetic peripheral angiopathy with gangrene	E10.52	E11.52
Diabetes mellitus with foot ulcer	E10.621	E11.621
Use additional code to identify site of ulcer.	L97.4- , L97.5-	L97.4- , L97.5-

Endocrine, Nutritional and Metabolic Disorders	CODE
Morbid (severe) obesity due to excess calories	E66.01
Evaluate for morbid obesity in patients with BMI > or = to 40. Also evaluate for morbid obesity for patients with comorbidities affected by weight.	

Mental, Behavioral and Neurodevelopmental	CODE
Dementia, unspecified without behavioral disturbance	F03.90-
Dementia, unspecified with behavioral disturbance	F03.91-
Major Depressive Disorder, single episode, mild	F32.0
Major Depressive Disorder, single episode, moderate	F32.1
Major Depressive Disorder, single episode, severe, without psychotic features	F32.2
Major Depressive Disorder, single episode, severe, with psychotic features	F32.3
Major Depressive Disorder, single episode, in partial remission	F32.4
Major Depressive Disorder, single episode, in full remission	F32.5
Major Depressive Disorder, recurrent, mild	F33.0
Major Depressive Disorder, recurrent, moderate	F33.1
Major Depressive Disorder, recurrent, severe, without psychotic features	F33.2
Major Depressive Disorder, recurrent, severe, with psychotic features	F33.3
Major Depressive Disorder, recurrent, in remission, unspecified	F33.40
Major Depressive Disorder, recurrent, in partial remission	F33.41
Major Depressive Disorder, recurrent, in full remission	F33.42
Other Recurrent Depressive Disorders	F33.8
Major Depressive Disorder, recurrent, unspecified	F33.9
Document the following components of depression: **1.** Degree (mild, moderate, severe); **2.** Episode (single or recurrent); **3.** Status (partial or full remission); **4.** Presence or absence of psychotic features.	
Anorexia nervosa, unspecified	F50.00
Anorexia nervosa, restricting type	F50.01
Anorexia nervosa, binge eating/purging type	F50.02
Bulimia nervosa	F50.2
Alzheimer's disease unspecified	G30.9
Alzheimer's disease: Must be specifically confirmed by the physician to code. It is essential that the Alzheimer's code be paired with the additional **F02.8-** codes as a manifestation of Alzheimer's. The physician does not have to mention dementia to code it.	
Epilepsy, unspecified, not intractable, without status epilepticus	G40.909
Unspecified convulsions	R56.9
Do not assign R56.9 when a patient has had a seizure disorder or recurrent seizures. When a seizure disorder or recurrent seizures are present utilize appropriate code from Category G40.	

Circulatory Conditions	CODE
Hypertensive heart disease with heart failure	I11.0
Use additional code to identify type of heart failure.	I50.-
Hypertensive heart disease without heart failure	I11.9
Hypertensive heart disease without heart failure can be coded when there is a hypertension diagnosis and a heart disease code from the range I51.4-I51.7; I51.89; I51.9. No additional code is needed other than I11.9.	
Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease	I12.0
Use additional code to identify stage of CKD.	N18.5-N18.6
Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I12.9
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I13.0
Use additional code to identify heart failure type and stage of CKD.	I50.-, N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease	I13.10
Use additional code to identify stage of CKD.	N18.1-N18.4, N18.9
Hypertensive heart and chronic kidney disease without heart failure and with stage 5 chronic kidney disease or end stage renal disease	I13.11
Use additional code to identify stage of CKD.	N18.5, N18.6
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease or end stage kidney disease	I13.2
Use additional code to identify the type of heart failure and stage of CKD.	I50.-, N18.5, N18.6
Atherosclerosis of native arteries of extremities with rest pain, right leg	I70.221
Atherosclerosis of native arteries of extremities with rest pain, left leg	I70.222
Atherosclerosis of native arteries of extremities with rest pain, bilateral legs	I70.223

Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, right leg	I70.321
Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain, left leg	I70.322
Paroxysmal atrial fibrillation	I48.0
Longstanding persistent atrial fibrillation	I48.11
Defined as persistent and continuous lasting longer than a year.	
Other persistent atrial fibrillation	I48.19
Code I48.19 when documented as chronic persistent AF.	
Chronic atrial fibrillation, unspecified	I48.20
Only code chronic AF when documented by the provider.	
Permanent atrial fibrillation	I48.21
Not to be confused with persistent; assign only when permanent AF is documented.	
Unspecified atrial fibrillation	I48.91
Unspecified atrial flutter	I48.92
Sick sinus syndrome	I49.5
Left ventricular failure, unspecified	I50.1
End stage heart failure	I50.84
Use additional code to identify the type of heart failure as systolic, diastolic or combined, if known (I50.2-I50.43).	
Heart failure, unspecified	I50.9

Vascular Disorders	CODE
Peripheral vascular disease, unspecified	I73.9
Disorder of arteries and arterioles, unspecified	I77.9
Use this code when Carotid Artery Disease is documented and is not specified as due to occlusion or stenosis.	
Aortic aneurysm of unspecified site, without rupture	I71.9
Aneurysm of unspecified site	I72.9
Aortic ectasia, unspecified site	I77.819

Diseases of the Respiratory System	CODE
Unspecified chronic bronchitis	J42
Emphysema, unspecified	J43.9
Chronic obstructive pulmonary disease with (acute) lower respiratory infection	J44.0
Use additional code to identify the infection.	
Chronic obstructive pulmonary disease with (acute) exacerbation	J44.1
If COPD with acute exacerbation and COPD with lower respiratory infection are present: document and code both.	
Chronic obstructive pulmonary disease, unspecified	J44.9
Severe persistent asthma, uncomplicated	J45.50
Severe persistent asthma with (acute) exacerbation	J45.51
Severe persistent asthma with status asthmaticus	J45.52
Respiratory failure	J96.1-J96.92

Diseases of the Digestive System	CODE
Crohn's Disease, unspecified	K50.9-
Ulcerative colitis, unspecified	K51.9-

Diseases of the Musculoskeletal System and Connective Tissue	CODE
Rheumatoid arthritis, unspecified	M06.9
Rheumatoid arthritis: If known, code specifically regarding with or without rheumatoid factor. Also code specific site as documented.	M05-M06.8A
Systemic lupus erythematosus, unspecified	M32.9
Systemic lupus erythematosus (SLE): Documentation must confirm and specify Lupus as systemic to assign a code from category M32.	M32.0-M32.9
Sicca syndrome (Sjogren), unspecified	M35.00

Genitourinary Conditions	CODE
Two separate eGFR values are required to change the CKD stage. When both acute kidney failure and CKD are present, code both conditions.	
Acute kidney failure, unspecified	N17.9
Chronic kidney disease, stage 1	N18.1
Chronic kidney disease, stage 2 (mild)	N18.2
Chronic kidney disease, stage 3 unspecified	N18.30
Chronic kidney disease, stage 3a	N18.31
Chronic kidney disease, stage 3b	N18.32
Chronic kidney disease, stage 4 (severe)	N18.4
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6
Use additional code to identify dialysis status in end stage renal disease.	Z99.2

Factors Influencing Health Status	CODE
Body mass index (BMI)	Z68.1-Z68.45
BMI: Reported BMI >40 requires a weight diagnosis to be documented and coded, such as "Morbid Obesity" to rise to an HCC.	
Long-term (current) use of insulin	Z79.4
If the patient is treated with both oral hypoglycemic drugs and insulin, code both Z79.84 and Z79.4.	
Personal history of malignant neoplasm (code specific history of cancer code)	Z85.-
Differentiating between "active" and "history of" cancer: When determining active versus history of cancer, look for active treatment, such as chemotherapy, radiation, hormone therapy, watchful waiting, or patient refusal of treatment. Remember, when coding active cancer, document specific primary sites and metastasis (secondary), if present.	
Personal history of transient ischemic attack (TIA)/cerebrovascular accident (CVA) without residual effects	Z86.73
TIA/CVA: Use history of codes unless patient is having active symptoms of TIA or CVA during the visit. If the patient has residual of a CVA, code the residual symptoms or sequelae to the highest level of specificity I69.3- (i.e., monoplegia, hemiplegia, hemiparesis, etc.).	
Acquired absence of toe(s), foot and ankle	Z89.4-Z89.449
Acquired absence of leg below knee	Z89.5-Z89.519
Acquired absence of leg above knee	Z89.6-Z89.619
Tracheostomy status	Z93.0
Gastrostomy status	Z93.1
Ileostomy status	Z93.2
Colostomy status	Z93.3
Cystostomy status	Z93.5- Z93.59
Artificial opening status, unspecified	Z93.9
Heart transplant status	Z94.1
Lung transplant status	Z94.2
Heart and lung transplant status	Z94.3
Liver transplant status	Z94.4
Bone marrow transplant status	Z94.81
When your patient is immunocompromised while taking anti-rejection medication, consider documenting and coding D84.821 "Immunodeficiency due to drugs."	
Dependence on renal dialysis	Z99.2

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

For more coding and documentation tips, visit Providers.PatriusHealth.com.

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Health Risk 360

An Important Patient Exam With an Incentive for You

Receive $150 for each completed and submitted Health Risk 360 (HR360) assessment of your Blue Advantage® patients.

How can you get started?

- Complete the HR360 form during an Annual Wellness Visit (AWV) or annual routine physical exam.
- Remind your patients: AWVs and annual physical exams are available at no cost to them.
- Use this assessment to capture your patients' full picture of health, including chronic conditions and medications.

Which providers can earn this incentive?

Blue Advantage-participating providers, including physicians, nurse practitioners and physician assistants, in the following specialties are eligible:

- Family Practice
- General Practice
- Geriatrics
- Internal Medicine
- OB-GYN

Your HR360 quick guide:

- The encounter associated with completion of the HR360 form must be either in person or performed via telehealth using both audio and video technology (patient physical exam codes may not be performed via telehealth).
- The incentive is available once per practice (based on NPI/Tax Identification Number combination) for each HR360 submitted per eligible patient.
- **COMING IN EARLY 2024:** You can use our new interactive AutoHR360 tool for easier submission. Log in to ***my*Blue Provider** and click Blue Advantage Resources. You will find the HR360 link under Provider Tools at the top of the webpage.
- The AutoHR360 tool pre-populates the HR360 form based on patient demographics and clinical data on file. It allows you to input additional information and submit the form directly through this web application.
- The AutoHR360 tool will eventually replace the current upload process for submitting HR360s. You also have the option to print a blank or pre-populated form and upload it through the AutoHR360 tool if that works best with your workflow. Review the Patrius Health provider website for details.

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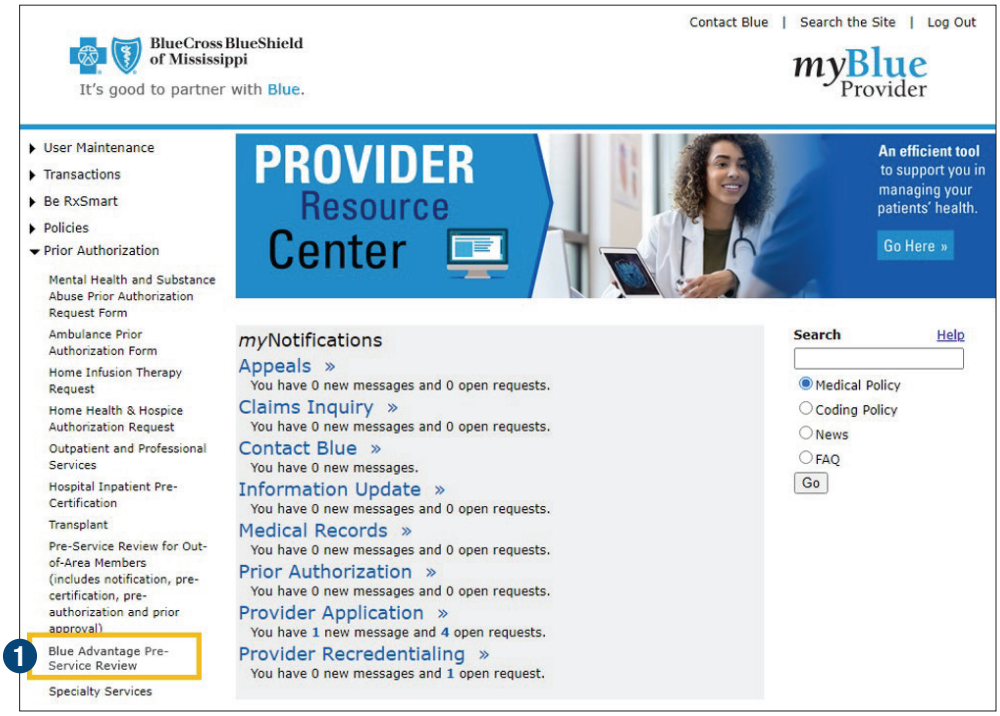
Use the following steps to complete the pre-service review process, which includes precertification, prior authorization and predetermination for certain medical services for your Blue Advantage® patients. You can also use this process to request a continued stay review.

1. Start the Pre-Service Review process on ***my*Blue Provider**, Blue Cross & Blue Shield of Mississippi's provider website. Under **Prior Authorization** in the left menu, select **Blue Advantage Pre-Service Review**. You will be directed to the Blue Advantage Pre-Service Review portal for Patrius Health.

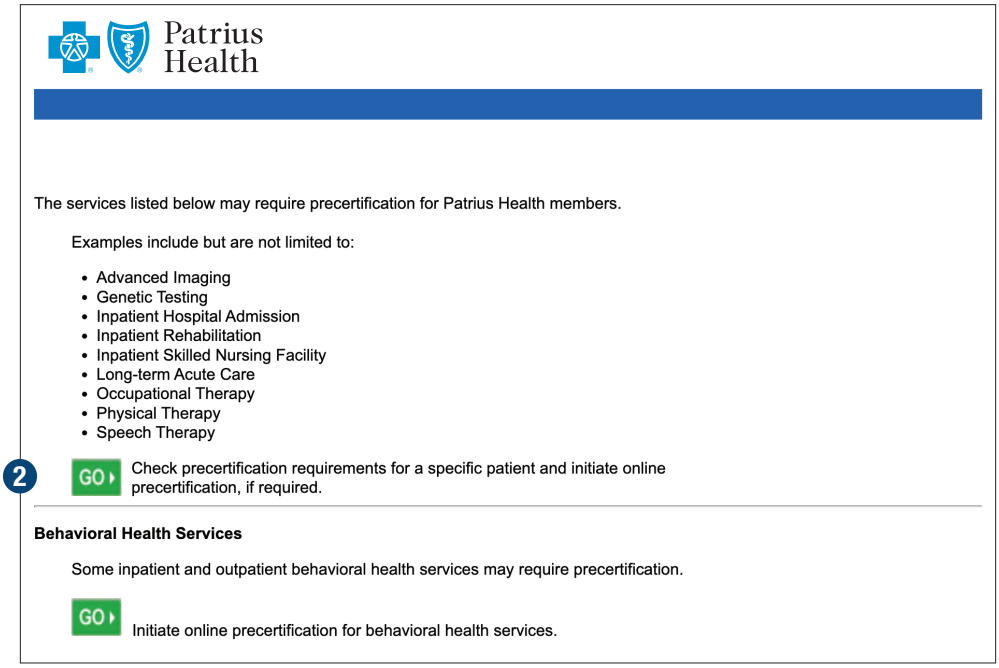
   Note: Make sure to deactivate any pop-up blockers on your web browser.



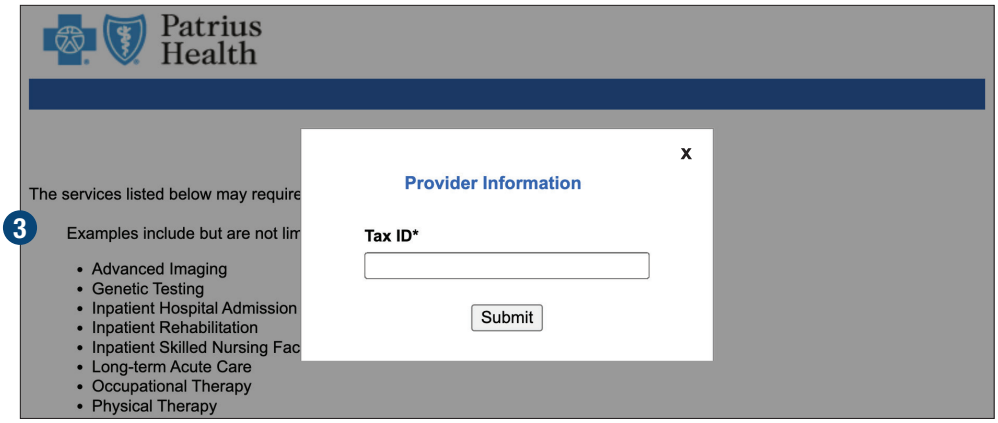
2. On the Pre-Service Review landing page, initiate the precertification process by selecting the bottom **GO** button for behavioral health services and the top button for all other services.

   Note: Reviews of behavioral health services involve a separate process with Lucet, a partner of Patrius Health. Under the Behavioral Health Services heading, initiate the review process by using the **GO** button. This process is available only to institutional providers.

   If you have questions after initiating the behavioral review process, contact Lucet at 1-855-339-9812.

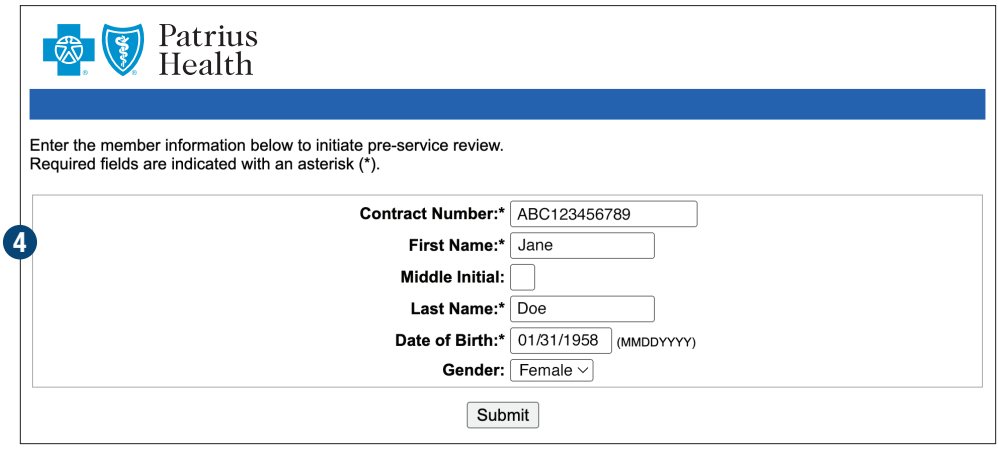


3 Enter your provider tax ID in the pop-up box that appears and click **Submit**.



4 Next, enter your patient's information and click **Submit**.

Note: Include the prefix with the contract number (subscriber ID).

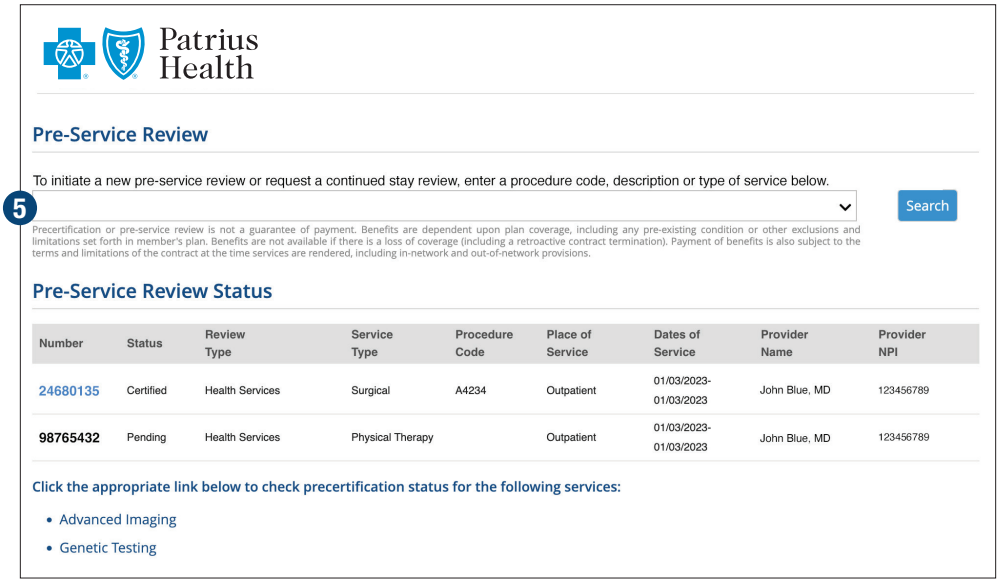


5 Enter a procedure code, description or type of service in the search box to see if pre-service review is required.

Also on this page is a list of previously submitted requests for this specific patient. Return to this page to find submitted requests and status updates, including the related correspondence.

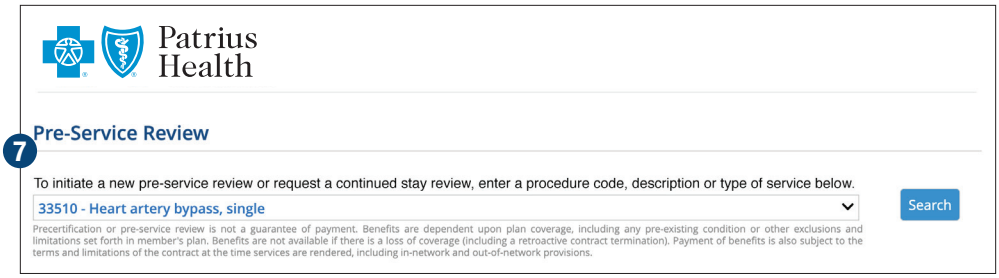
Note: Advanced imaging and genetic testing reviews are conducted by Carelon Medical Benefits Management, a partner of Patrius Health. Part B provider-administered drug reviews are conducted by Magellan Rx Management, a partner of Patrius Health. For additional information about Carelon and Magellan Rx reviews, see the Pre-Service Review webpage. Scan the QR code to access this webpage.

If you have questions after initiating the Carelon review process, contact Carelon at 1-866-803-8002.

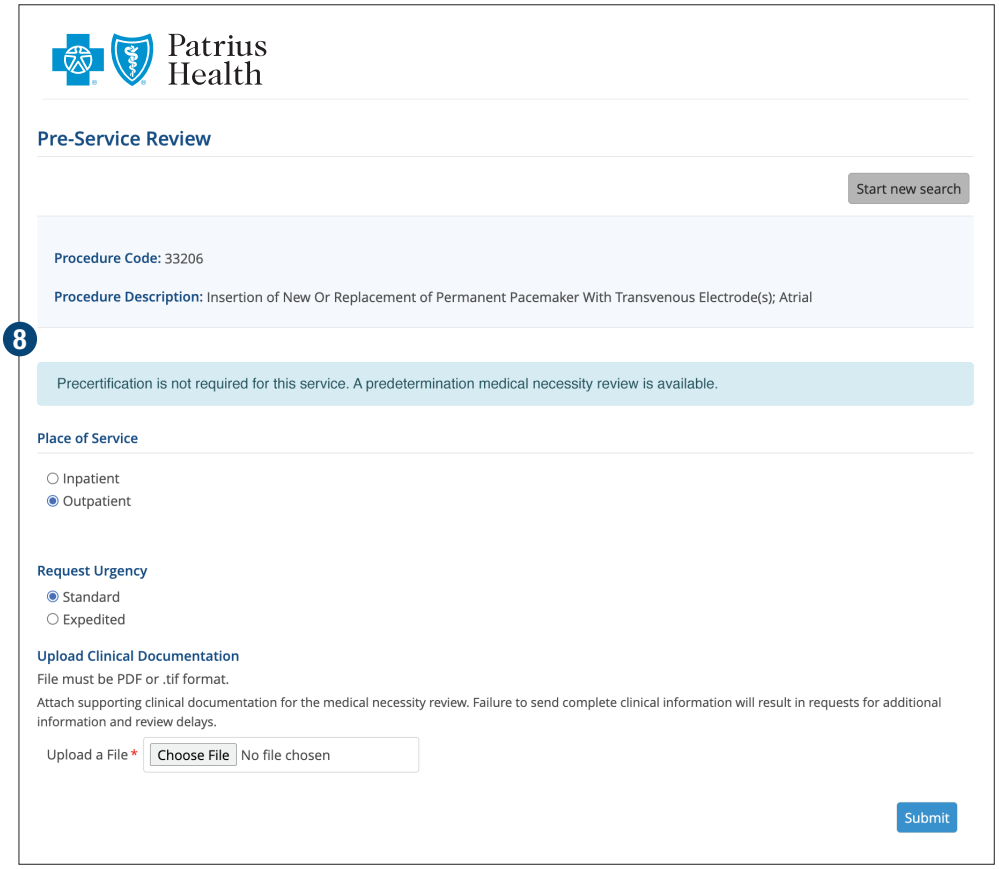


6 Searching for a procedure or service will generate several results that you can review to find a specific code.

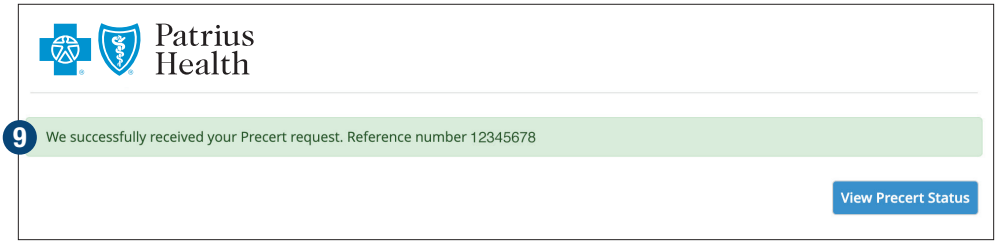
7 Select the specific procedure code or service and click **Search** to advance to the next screen.



8 This screen will indicate whether precertification is required for the selected procedure code or service. Select either inpatient or outpatient, if applicable, for the place of service. Next, select the urgency level (standard or expedited) and upload supporting clinical documents (TIFF and PDF formats are accepted). Click **Submit** to advance.

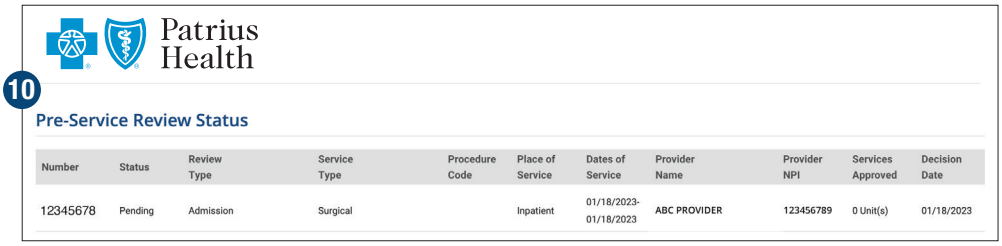


9 The confirmation screen shows that we have received your review request. Next, click **View Precert Status** to view requests that have been submitted for this patient.



10 You can see the status of submitted requests on this page. Return to this screen to check the review status and locate correspondence related to this request after a status decision is finalized.

Note: Repeat steps 1 to 5 to return to the screen that shows previously submitted requests for this patient.



11 When the status is either "Certified" or "Denied," you can click the request number to view the approval or denial letter. If your request is denied, next steps, including the appeals process, are outlined in the letter.

Note: The submitting provider or rendering provider can view information about a specific request, including the status and correspondence, by entering the patient information as indicated in step 4.

Patrius Health

Pre-Service Review Status

Number	Status	Review Type	Service Type	Procedure Code	Place of Service	Dates of Service	Provider Name	Provider NPI	Services Approved	Decision Date
12345678	Certified	Admission	Surgical		Inpatient	01/18/2023-01/18/2023	ABC PROVIDER	123456789	0 Unit(s)	01/18/2023

11

Patrius Health

January 01, 2023

Jane Doe
123 Main Street
Ocean Springs, MS 39564

Name of Patient: Jane Doe
Date of Birth: 01/31/1958
Contract Number: ABC123456789
Tracking Number:
Initial Date of Service: 01/02/2023
Total Number of Days Certified for this Admission: 7

Dear Jane Doe:

We received your request on 01/01/2023, for authorization of Pacemaker services. Based on the information received, we are able to authorize the requested services. This authorization is for dates of service 01/02/2023 through 01/08/2023. To continue service, please submit additional information beginning 01/09/2023. This information has been provided to Dr. John Blue.

This authorization is not a guarantee of payment. Benefits are dependent upon plan coverage, including any pre-existing condition exclusions or other exclusions and limitations set forth in plan. Benefits are not available if there is a loss of coverage (including a retroactive contract termination). Payment of benefits is also subject to the terms and limitations of the contract at the time services are rendered. This includes in-network and out-of-network provisions.

Thank you for allowing us to serve you.

Sincerely,

Health Management

cc:
Dr. John Blue
BCBSJIVAUM25

Birmingham Service Center P.O. Box 12364 Birmingham, AL 35202-2364

Patrius Health is an independent licensee of the Blue Cross and Blue Shield Association.

Contact us for assistance.

For website support related to a review:
Blue Cross & Blue Shield
of Mississippi EDI at
1-800-826-4068

For other questions related to a review:
Patrius Health provider services at
1-888-949-2352

Patrius Health | Blue Advantage
A Medicare Approved PPO

Initiating a conversation with your patients about advance care planning (ACP) can help them feel comfortable, heard and empowered. Use this guide to begin the ACP process with your patients.

STEP 1	**Identify patients who are appropriate for ACP conversations.** This includes patients who are: • Completing Annual Wellness Visits • Scheduled for surgery • Recently hospitalized with a serious chronic illness • Expressing interest in ACP
STEP 2	**Start the process with these three ACP purposes in mind:** • **Select and prepare a healthcare proxy.** The proxy should be willing to accept the role and understand the patient's preferences for care by being included in conversations. • **Create a personalized plan based on the patient's cultural and spiritual beliefs.** Address the patient's prior experiences with death and their influence on his or her goals of care. • **Discuss goals of care in "outcome-based" situations in preferences for life-sustaining care.** Provide specific examples in order to give more meaning. "If you had less than X% chance of recovery or ability to perform Y, would you want Z intervention?"
STEP 3	**Document ACP conversation findings.** This should include: • Names of participants • Reason for discussion • Voluntary nature of discussion • Topics discussed • Documents discussed and/or completed • Time element

Conversation Tips

In your ACP conversations, keep in mind that your goal is to understand the patient's values and encourage thinking about the future in a non-threatening way. With these ready-to-go messages, you can guide the conversation to meet these goals.

Ask permission to address ACP. Normalize the conversation. Explain that it is part of your process to ensure best care for your patients.

"Now I want to discuss another topic. In order to make sure we meet our patients' needs and give them a voice in their care, I like to ask some questions about how you would want to be cared for if you could not talk to me. Would that be all right?"

When patients are uncertain, slow down and invest in setting up the explanation. Address uncertainties.

"This does not mean I expect anything to happen to you immediately. This is just one of the ways I get to know you so I can give you the best care possible. What questions do you have for me?"

"If you prefer and are more comfortable having a conversation first with your family or members of your faith community, we can provide you with some materials to help you with those conversations. After that, if it is all right with you, I would like to review this topic with you. You can bring the materials back with you to your next visit."

(See helpful resources on the bottom of Page 2.)

When discussing surrogate decision makers, offering multiple choices can help.

"Many of my patients have a hard time picking someone to make decisions for them. They are afraid of putting that burden on a loved one. Does someone come to mind that you feel would be able to speak for you? Spouse, child or religious leader?"

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Frame ACP as hoping for the best while planning ahead to ensure the patient receives the care tailored to his or her goals and values.

"We always hope that we will be able to make decisions for ourselves and be able to express those wishes. But if something were to happen, having your desires already known will give you control over those decisions and relieve others of not knowing what to do."

Present "what if" scenarios to emphasize potential ACP decisions needed for the future and distinguish it from the present.

"What if you were in an accident? Have you ever known anyone who had a stroke and could not speak for themselves? What if this happened to you?"

For additional information on resources related to ACP, visit these websites:

Advance Care Planning

- PrepareForYourCare.org
- TheConversationProject.org
- FiveWishes.org

Advance Directives

- Vimeo.com/198962172
- AdvanceDirectives.com/Mississippi

Physicians Orders for Life Sustaining Treatment (POLST) Information

- POLST.org/Mississippi

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