Florida Blue

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Blue Cross and Blue Shield Association

March 2018

Medicare Stars
Clinical Documentation Sheet

For your reference, here are some key indicators for select Healthcare Effectiveness Data and Information Set (HEDIS®) Stars measures.

ABA – **Adult BMI Assessment**

- ☐ Use a Z68 series ICD-10 code to indicate BMI was assessed and documented during the measurement year or prior year.
- ☐ Data file transfer of EMR data with BMI and weight will be accepted.

BCS – **Breast Cancer Screening**

- ☐ Mammogram report with date of service occurring within the prior 27 months before December 31 of the measurement year. Alternatively, documentation in the medical record indicating the specific date and result of screening within the 27 months prior to December 31 of the measurement year.
- ☐ Documentation of bilateral mastectomy in medical record.

COL – **Colorectal Cancer Screening**

- ☐ Medical record note with date of colorectal cancer screening, type of test, and signed by PCP. Alternatively a laboratory (e.g., FIT, FIT-DNA) or procedure or pathology report (indicting specimen obtained via a qualifying procedure) documenting colorectal cancer screening within the time frame allotted per the specific test performed.
- ☐ Medical record indicating patient has a history of colorectal cancer. Medical record indicating patient has a total colectomy (*total* must be indicated)

CDC – **Comprehensive Diabetes Care**

1. Diabetes care – blood sugar controlled
   - ☐ Documentation of the *most recent HbA1c* during the measurement year. The patient is compliant if the most recent HbA1c $\leq$ 9%. Documentation must include date of service.
2. Diabetes care – kidney disease monitoring
   - ☐ Documentation of screening for the year, or billing code. A medical record documenting the date of urine test and test findings can also be submitted.
   - ☐ Documentation of a visit to a nephrologist or documentation the patient has stage 4 chronic kidney disease, ESRD or history of kidney transplant.
   - ☐ Prescription claim or medical record indicating patient is on ACE/ARB during the measurement year.

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900-0387-0318

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CDC – **Comprehensive Diabetes Care** ***(continued)***

3. Diabetes care – eye exam
   - ☐ Dilated retinal exam or digital retinal photography report from an eye specialist in the current year. Or, dilated retinal exam or digital retinal photography report on the prior year by an eye specialist with normal findings.
   - ☐ Provider note indicating patient had a dilated retinal exam or digital retinal photography within the measurement year (negative or positive for retinopathy) or the year prior to the measurement year if negative retinopathy documented.

CBP – **Controlling High Blood Pressure**

Supplemental documentation will not be accepted to close this care gap since it applies to only the last visit of the year.

- ☐ CPTII coding or electronic data transmission is encouraged to help Florida Blue assess care opportunities; however HEDIS does not accept CPTII to close this care gap.

ART – **Rheumatoid Arthritis Management**

- ☐ Proof of dispensing a DMARD is required to close this care gap. Medication list documentation in the medical record is not sufficient. Acceptable documentation includes: medical record documentation of DMARD infusion/injection in office; medical record stating sample DMARD was dispensed from provider's office (include medication name, dosage form, quantity dispensed, lot number if available and date sample given to patient).

OMW – **Osteoporosis Management in Women Who Had a Fracture**

- ☐ Bone Mineral Density test (DEXA) results or medical record documentation.
- ☐ Pharmacy claim, medication administration record documenting infusion/injection of osteoporosis treatment within 180 days post-fracture.

MRP – **Medication Reconciliation Post-Discharge**

Medical record documentation will not be accepted or reviewed for closure of MRP care gaps.

- ☐ CPTII code 1111F or transitional care code (99495 and 99496) will close the care gap if performed within 30 days post-discharge and according to the code specifications to the transitional care codes.

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SPC – Statin Therapy in Patients with Cardiovascular Disease

Medical record documentation will not be accepted or reviewed for closure of SPC care gaps.

- ☐ Patients with myalgia, myositis, myopathy or rhabdomyolysis: submit appropriate diagnosis code (ICD-10) along with the visit when this was evaluated during the measurement year. History of myalgia, myositis, myopathy or rhabdomyolysis does not count towards exclusion.

COA – Care of the Older Adult

Applies to Special Needs Plan members only.

1. Medication review:
   - ☐ Medical record that specifies a medication review by a prescribing provider or pharmacist and a medication list were documented during the same visit.
2. Functional status assessment:
   - ☐ Medical record indicating with functional status assessment performed during the measurement year, and including the date performed.
3. Pain assessment:
   - ☐ Medical record documenting a pain assessment and the date it was performed.

Part D – Pharmacy Quality Alliance (PQA) Measure

Care gaps for the following measures will be closed by pharmacy claims only. CMS will not accept proof of prescribing (e.g., medical record) in the absence of a pharmacy claim.

1. Medication Adherence for diabetes medications (oral hypoglycemic agents)
2. Medication Adherence for hypertension (RAS antagonists)
3. Medication Adherence for cholesterol (statins)
4. SUPD (statin use in persons with diabetes) measure

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900-0387-0318