Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

March 2018

Update! *Frequently Asked Questions:*

HEDIS Clincal Quality Validation

(previously named HEDIS Attestations)

HEDIS and Stars: A Florida Blue Health Care Quality Program

1. **What is HEDIS? (Healthcare Effectiveness Data and Information Set)**
   HEDIS® stands for Healthcare Effectiveness Data and Information Set which is a widely used set of performance measures in the managed care industry. HEDIS was developed and maintained by the National Committee for Quality Assurance (NCQA). It has become more than a set of performance measures – it has evolved into an integral system for establishing accountability in managed care.

   HEDIS reporting is mandated by NCQA and the Centers for Medicare & Medicaid Services (CMS) for accreditation and regulatory compliance. It is important that health care providers and staff become familiar with HEDIS to understand what health plans are required to report to improve the quality of patient care.

2. **What are the Stars measures?**
   CMS uses a five-star system to measure Medicare members' care and experiences with the health care system; with one as the lowest rating and five as the highest rating. CMS Star ratings apply to Medicare Advantage (MA) plans which include: Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and Private Fee-For-Service (PFFS) plans.

3. **Who is required to comply with HEDIS and HEDIS Stars requirements?**
   All Florida Blue participating providers are required to comply with HEDIS requirements and complete/submit the requested forms and documentation.

4. **Is there documentation that needs to be completed for the HEDIS Stars program?**
   Yes. Florida Blue provides the Clinical Quality Validation (formerly HEDIS Attestation form) to be used for each identified Florida Blue member with an open care gap as indicated on the validation. The Clinical Quality Validation is provided in the Clinical Quality Validation portal in Availity®[1], Payer Spaces.

5. **What is the purpose of the Clinical Quality Validation?**
   The Clinical Quality Validation is an easy-to-navigate web-based form that provides physicians with pre-populated care gaps identified from claims data relating to care and/or quality measures. The validation documents the assessment and care provided by the provider and attests that the information provided is true, accurate and complete.

6. **Will I need to complete and submit a "new" validation in the Clinical Quality Validation work queue for the same member if I already completed and submitted a Clinical Quality Validation for this year?**
   The provider needs to complete and submit another validation for the same member if:
   - More than one care gap was not addressed on the submitted validation
   - Additional care gaps become open during the year
   - The patient changes health plans or product lines during the year

7. **Is it a Florida Blue requirement that I attach a medical attachment in order for the Clinical Quality Validation to be submitted?**
   Yes, medical attachment(s) to include progress notes, consultations, diagnostic/operative reports and/or labs are required in order to submit the validation form.

8. **What are the size and type requirements for medical attachments?**
   File attachments should relate to the sections completed on the Clinical Quality Validation. You can upload up to five medical file attachments for a maximum size of 10 MB for the care gaps that you are closing. Each file **must** be a PDF, TIF or JPG file, otherwise we can't open them.

9. **Will Florida Blue fax/mail the Clinical Quality Validation to me?**
   No. The Clinical Quality Valdiation is only available electronically at availity.com.

10. **What are the benefits of the Clincial Quality Validation?**
    - Ensures diagnoses and quality measures documented in medical records are captured for submission to CMS, performance reporting and prospective initiatives
    - Improves health outcomes for our members
    - Improves coordination of care from both Florida Blue and their providers
    - Assures member care gap status is accurately reflected in provider or member outreach
    - Enhances provider engagement with our members
    - Provides an easy completion process and improves quality of information collected, while assuring document integrity and security
    - Decreases the number of medical records requests sent to provider offices during the HEDIS seasonal project

11. **How can I access the Clinical Quality Validation?**
    You must have the proper permissions as an Availity user to access the Clinical Quality Valdiation. To gain access, contact your Primary Access Administrator (PAA).

12. **How can I edit information on the Clincial Quality Validation once the validation is submitted?**
    Editing the Clincial Quality Validation after it is submitted is not possible at this time. Ensure that the information documented on the validation is accurate and correct before submitting.

13. What is the logic that aligns a patient to a physician?

Depending on the product in which the member is enrolled, Florida Blue either assigns a PCP based on member selection/system assignment or a member is attributed to a physician.

- Patients who are in an HMO product have an assigned PCP. It is possible for the member to be on your panel roster and not been seen by you, if the HMO member is assigned to you.
- For patients in a plan other than HMO, Florida Blue uses attribution logic to attribute the patient to a provider, based on claims data and the number of visits.

14. Why do I sometimes have duplicate validations for the same patient?

Florida Blue is always striving to help you have the most updated information on our members. When matching the member information with the provider ID number and tax ID number, if either ID number has been updated based on new claims received and a pending validation already exists, you will receive a duplicate validation with the most updated information we have for that member. We do not remove existing 'pending' validations based on these updates so as not to remove work that may have already been completed by our providers.

15. What steps do I need to complete to fulfill HEDIS Stars requirements?

a) Contact patients who have been identified as part of the program to schedule an appointment or service.

b) Conduct an assessment of the member to determine/assess what care gaps need to be addressed when completing the Clinical Quality Validation. Verify the pre-populated data and document, as appropriate, in the validation from the medical record.

c) Complete the Clinical Quality Validation in its entirety, addressing the open care gaps captured in the "Care Gaps Identified" section.

d) Electronically attach the medical record(s) (office visit, labs, reports, consults) pertinent to the open care gap being addressed and include the date of service used.

e) Electronically enter the name of the office contact and the contact phone number in the Clinical Quality Validation.

f) Electronically submit the Clinical Quality Valiation. The validation stays open in the work queue until the provider completes/submits the validation or the validation is archived after the calendar year.

16. Is there a timeframe to see new members assigned to my panel who also have an Clinical Quality Validation assigned in the Clinical Quality Validation work queue?

The provider is strongly encouraged to initiate an office visit to address the open care gaps in a Clinical Quality Validation within 90 days of the member's assignment to the primary care physician.

17. What is the best approach when a member has a Clinical Quality Validation assigned in the Clinical Quality Validation work queue and is a new (not established/active) member assigned to a member panel?

The best approach is to contact (phone, email, mail) the member to establish the member with your practice, and document the contact in the EMR system. If you're unable to reach the member, or don't receive a response, attempt contact a total of three times and document the attempts in EMR. Per CMS guidelines, Florida Blue does not remove patients from the member panel that are not established, nor does Florida Blue do member outreach to establish a member. The member may contact Member Services to change the PCP.
Note: the member may be an "attributed" member on the member roster.

18. Is the Clinical Quality Valdation the only way to close a HEDIS care gap for a member?

No. An additional way to close a care gap is:

- Completeting the needed test/procedure; and
- Electronic submission of associated claims as long as the claims are coded correctly, accurately and timely

19. How do I provide additional supplemental ICD-10 & Category II codes that occurred during the original E&B service?

Submit a second, original claim, and use procedure code 99080.

- Florida Blue can accept either a zero charge or a penny charge on this created line. Check your software to determine if a zero charge can be billed.
- If the claim is electronic, use frequency Code "0". This procedure code will deny as incidental to the procedure code submitted on the primary claim therefore no payment will apply. (The advantage of billing with a zero charge is that there is no reconciliation on the outstanding balance of a penny for providers.)
- There is a claims lag period of up to 90 days.

Do NOT submit a corrected claim (Frequency Type 7). A corrected claim tells us the original claim was wrong and we will recover on the original claim with valid charges and pay the penny claim instead.

Please ensure that claims data being submitted to clearinghouses or through an electronic medical record (EMR) system are not inadvertently removing or excluding diagnosis codes prior to being submitted to Florida Blue.

Florida Blue has the ability to key/enter all diagnosis codes billed for up to 25 billed diagnosis codes.

To a degree, coding has an order of importance. The first diagnosis code is the primary reason for the visit. With ICD-10, diagnosis codes are required to be sequenced by the etiology and then any manifestations as applicable.

The timeframe for submitting claims is generally a 180-day timely filing limitation but also depends on the provider's contract, the line of business and any group ERISA language. Check

your contract or contact your Florida Blue Network Manager for the applicable timeframe for submission of claims.

Complete and accurate code submission is vital to ensure you are getting proper credit for this program and/or complying with contractual requirements.

20. Who can I contact for Health Risk Assessment payments?

For questions regarding payments in support of the 2017 Comprehensive Quality and Risk Program (CQRP), please send payment inquiries to: PRPPaymentInquiries@floridablue.com

21. How do I advise a member that is refusing a colonoscopy? Is Cologuard® a covered service/test?

For Medicare Advantage and Commercial Plans, Cologuard® is covered. Additional screening tests that meet criteria for closing the Colorectal Cancer Screening care gap are:

- Colonoscopy
- Fecal Occult Blood Test or FIT Test
- Flexible Sigmoidoscopy
- CT Colonography

22. How do I attach the medical records to the validation when HIPAA issues arise?

Medical records (attachments) in a PDF format can be password-protected with an established password as follows**:**

How to protect PDF files in Office applications for Windows:

- In an Office application, click the Create PDF button in the Acrobat task ribbon
- Type a file name and select Restrict Editing
- In the resulting Security dialog box, set up a password and permissions as desired
- Click OK, and then click Save
- https://acrobat.adobe.com/us/en/acrobat/how-to/pdf-file-password-permissions.html

To provide password information to the recipient (Florida Blue), contact your Florida Blue Network Manager at **(800) 727-2227** and follow the prompts.

23. What do I do when a deceased patient is a Florida Blue member and is shown on a Clinical Quality Validation?

Contact your Florida Blue Network Manager at **(800) 727-2227** and follow the prompts. If the deceased member has a Medicare Supplement, we will need a copy of the death certificate to submit to the Enrollment Department. If the deceased is a Medicare Advantage member, we can deactivate the member in the system and wait for CMS to send information so we can then advise them that the member is deceased.

24. What happens to the medical record attachment(s) and the HEDIS care gaps validations once submitted?

The Florida Blue Quality Audit Team reviews for compliancy based on the HEDIS measure guidelines**.**

25. I submitted a Clinical Quality Validation form and medical record but the information was not accepted. Why would this be?

This could be due to a number of factors. We want to make sure you are not spending valuable time submitting records to close gaps when information might be missing or incorrect. The following are possible reasons for gaps not closing after you have submitted a medical record in Availity.

a) The medical record is not from the correct year (where applicable)
b) There are not two patient identifiers listed on the medical record. Identifiers we are looking for are last name, first name and date of birth
c) There is not a date of service indicated on the medical record
d) Unable to read handwritten medical records– if they are not legible they will not be used to close the gap
e) Lab values do not have a collected or resulted date and must have D/M/Y – best practice would be to send the actual lab results
f) Diabetic Retinal Exams do not include a result; do not include the provider who performed the exam (first and last name); do not include a date of service (D/M/Y) must have all 3 elements – best practice would be to send the actual exam.
g) Diabetic Retinal Exams that have a diagnosis of Hypertensive Retinopathy are considered non-compliant.
h) Pap smears do not have results or are patient reported
i) When a patient refuses/declines the gap remains open
j) Exclusion for a member must indicate the reason they are excluded and the date they became excluded. See HEDIS and STARS coding gap reference guides for exclusion per measure, HEDIS Documentation and Coding Guide
k) Dates of service are needed for any testing or procedures - D/M/Y for labs, and at least year for all other testing (do not use "up to date" or indicate the "due date" as we need the actual date the test or procedure was performed) – best practice would be to send the actual screening report
l) For BP unless the member is over 60 and not diabetic all BP need to be <140/<90 NOT =140/90
m) Information is not specific. Example- history of hysterectomy. Appropriate documentation – partial or total hysterectomy and date of the procedure (at least the year).

26. I am receiving calls from Availity regarding training on completion of the Clinical Quality Validations. I am already working with a Florida Blue HEDIS nurse. Should I train with Availity also?

No. You can contact your Florida Blue HEDIS nurse, who will reach out to Availity.

27. How do I get access and reports from Florida Blue?

For questions regarding access and reports in the Passport Portal and QERP Tool, contact your Florida Blue Network Manager at (800) 727-2227 and follow the prompts.

28. How do I update provider information in the Availity portal?

The Availity provider self-service portal can be accessed at this link:
https://apps.availity.com/public/apps/provider-self-service-maintenance/#/landing

29. Who do I contact for questions regarding the HEDIS care gap measures?

For questions about Commercial HEDIS care gap measures in the Clinical Quality Validation tool, you can contact your Quality POD nurse, ClinicalQualityValidationFormTraining@bcbsfl.com

30. Who do I contact for questions regarding Availity?

For questions regarding Availity, contact Availity Customer Support:
(800) AVAILITY (282-4548).

[1]Availity, LLC is a multi-payer joint venture company. Visit availity.com to register.