Florida Blue
Your local Blue Cross Blue Shield

MEDICARE

Medicare Stars
HEDIS Best Practices Guide for Providers

Measurement Year 2023

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The information contained in this document is not intended to be used as a tool for diagnosis.

Measures Covered

- PCP Year-round Best Practices
- Breast Cancer Screening (BCS)
- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Osteoporosis Management in Women with Fractures (OMW)
- Antidepressant Medication Management (AMM)
- Eye Exam for Patients with Diabetes (EED)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Kidney Health Evaluation for Adults with Diabetes (KED)
- Care for Older Adults (COA)
- Transitions of Care – Medication Reconciliation Post-Discharge (TRC)
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
- Plan All-Cause Readmissions (PCR)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Use in Persons with Diabetes (SUPD)
- Medication Therapy Management (MTM)
- Medication Adherence

PCP Year-Round Best Practices

- Use Provider Link™ to retrieve Florida Blue Medicare communications and reports to assist with PCP office practices.
- Complete an annual wellness visit (AWV) either at the beginning of the year or around the patient's birthday.
- Create a process to pull your new-patient member roster monthly to reach out and schedule new patients within 30 days of enrollment.
- Schedule a post-inpatient hospitalization follow-up visit within seven to 14 days after discharge.
- Schedule all patients for in-office or telehealth visit at least once every six months.
- Provide an after-visit summary to ensure patients understand what they need to do and what was discussed during their visit.
- Review Care Gaps Report and plan chart reviews twice a year. Submit compliant medical records to close gaps using the Stars/HEDIS supplemental data submission (SDS) process within the Provider Link platform.
- Submit claims timely and include the appropriate codes for diagnosis, health conditions and the services provided.

Breast Cancer Screening (BCS)

The percentage of women between the ages of 50 and 74 who had mammogram screening for breast cancer: One or more mammograms anytime on or between October 1, two years prior to the measurement year, and December 31 of the measurement year.

- Educate female patients about the importance of early detection and encourage testing.
- Discuss possible fears with the patient and inform women that available testing methods are less uncomfortable and require less radiation.
- Use the Care Gaps Report to reach out to patients and use three-way calling with the patient to reach out to diagnostic center and help the patient schedule mammogram.
- Document in the medical record if the patient has had bilateral mastectomy and include appropriate ICD-10 and CPT codes when submitting claims.
- Submit medical records with bilateral mastectomy documentation to Florida Blue Medicare through the Stars/HEDIS SDS process within the Provider Link platform.

Colorectal Cancer Screening (COL)

The percentage of members between the ages of 45 and 75 who had appropriate screening for colorectal cancer.

- Use the Care Gaps Report to identify patients with open gaps.
- Use standing orders to empower clinic staff to reach out to the patient to encourage a fecal immunochemical test (FIT) or Cologuard® screening.
- Reach out to patients on the FIT Kit mailing list and create follow-up tracking to ensure the patients return the kit.
- Clearly document and update patient history yearly to include colon cancer screening, colostomy, ileostomies, and history of colon cancer.
- Submit the most recent colorectal screening to Florida Blue through the Stars/HEDIS SDS process within the Provider Link platform.

Controlling High Blood Pressure (CBP)

The percentage of members between the ages of 18 and 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.

- Calibrate the office sphygmomanometer annually.
- Select the appropriately sized blood pressure cuff when taking patient BP.
- For patient-reported BP, document in the medical record the date and time of call.
- Do not count BP taken by the patient using a non-digital device such as a manual blood pressure cuff and a stethoscope.
- Create in-office treatment plan and recheck process for elevated and abnormal BP in office.
- Review treatment plan for any out-of-control reading and schedule nurse visit for follow-up testing.
- Document all systolic and diastolic readings if multiple BP taken on the same date.
- Use CPT II codes to document the lowest systolic and diastolic readings taken during each visit.

Osteoporosis Management in Women with Fractures (OMW)

The percentage of women between the ages of 67 and 85 who suffered a fracture and had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

- Order a BMD test on all women with a diagnosis of fracture within six months of the fracture,

  Or

- Prescribe medication to prevent osteoporosis (bisphosphates) within six months of the fracture.
- Review the medical record for BMD screening done 24 months prior to the fracture diagnosis.
- Submit the BMD report to Florida Blue Medicare through the Stars/HEDIS SDS process within the Provider Link platform.
- Educate your patients on the importance of identifying if they are at risk for osteoporosis to help prevent future fractures/injuries.

Antidepressant Medication Management (AMM)

The percentage of members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment. Two rates are reported:

- Acute Treatment Phase: 84 days (12 weeks)
- Continuation Treatment Phase:180 days (six months)

- Closely monitor medication prescriptions and dispensing dates to avoid gaps in treatment.
- Include a depression screening assessment with each patient encounter and educate patients on the importance of taking medication as prescribed to receive the maximum benefits from treatment.
- Use Lucet Behavioral Health Network and Case Management services as needed:
  - Florida Blue Member services: Use the phone number on the member ID card.
  - Lucet Behavioral Health Member services: Members can call Monday through Friday, 8 a.m. – 8 p.m. ET, to receive behavioral healthcare coordination and referrals at **866-287-9569**.
  - Lucet Behavioral Health Physician and Case Management services: For help locating a behavioral health professional or coordinating care for a patient, call **866-350-2280** Monday through Friday, 7:30 a.m. – 5:30 p.m. ET**.**

Eye Exam for Patients with Diabetes (EED)

The percentage of members between the ages of 18 and 75 with diabetes (type 1 and type 2) who had a retinal eye exam.

- Educate patients about the difference between an eye exam for new glasses and a comprehensive diabetic eye exam.
- Submit CPT II codes to report eye exam outcomes.
- Submit the CPT II code 3072F in the current measurement year to capture negative for retinopathy eye exams from the prior year.
- Documentation of hypertensive retinopathy is considered as positive for diabetic retinopathy.
- Work with a local ophthalmologist or optometrist to establish dilated retinal exam referral contacts/relationships.
- Work with Florida Blue Medicare or iCare for Retinal Exam event options.
- Submit a Retinal Exam report to Florida Blue Medicare to close gaps using the Stars/HEDIS SDS process within the Provider Link platform.

Hemoglobin A1c Control for Patients With Diabetes (HBD)

The percentage of members between the ages of 18 and 75 with a diagnosis of diabetes (type 1 and type 2) and hemoglobin A1c (HbA1c) at the following levels:

- HbA1c control (<8.0%)
- HbA1c poor control (>9.0%)

- Follow up with patients to monitor changes and schedule follow-up testing.
- Frequency of visits should depend on level of A1c control: patients with values >9% need to be seen more frequently and target <9% A1c goal.
- For point-of-care HbA1c testing, document the date of the in-office test and include the result in your claims submission, using CPT II codes. Must submit the CPT code for the test performed and CPT II codes to report A1c result value.

Kidney Health Evaluation for Adults With Diabetes (KED)

The percentage of members enrolled between the ages of 18 and 85 with diabetes (type 1 and type 2) who have received an annual kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during the measurement year.

- Estimated glomerular filtration rate (eGFR) is a blood test to assess kidney function by testing for waste products (creatinine) in the blood.
- Urine albumin-creatinine ratio (uACR) is a urine test to assess kidney damage by testing for proteins (albumin) in the urine. Use a spot urine albumin-to-creatinine ratio. Both tests should be completed with service dates four or less days apart.
- KED is an administrative only measure. Submit claims and encounter data in a timely manner.

Care for Older Adults (COA)

The percentage of adults age 66 and older who are in a Special Needs Plan and had each of the following during the measurement year:

- Medication review
- Functional status assessment
- Pain assessment

- Schedule visit early in the year to complete services.
- Medication review must be conducted annually by a prescribing practitioner or clinical pharmacist, and the medication list must be dated and signed in the same medical record.
- Perform annual pain assessment. Documentation must include positive or negative findings or the result of a standardized pain assessment tool.
- Perform functional status assessment annually. Document the patient activities of daily living (ADL), or instrumental activities of daily living (IADL), or the result of a standardized functional status assessment tool.
- Audit medical record to identify compliance and submit CPT II codes to report completed services.
- Refer members to Florida Blue Medicare case management for Dual-Eligible Special Needs Plans (D-SNPs). Toll-free number: 866-780-4240; fax: 904-301-1931; email: dsnp@FloridaBlue.com.

Transitions of Care – Medication Reconciliation Post-Discharge (TRC)

The percentage of discharges from acute inpatient or sub-acute inpatient facility stays between January 1 – December 1 of the measurement year for patients age 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

- Access daily discharge reports from Provider Link.
- Registered nurse to review and reconcile discharge medications with current medication list telephonically and schedule follow up within seven days of discharge.
- Prior to the visit, flag the chart with a Medication Reconciliation reminder for the provider and office staff.
- Documentation in the outpatient medical records must include the current medication list, any new medications or changes to medication related to the hospitalization and a review.
- Confirm a CPT II code 1111F was submitted as part of your billing for the medication reconciliation.
- Clearly document the reason for the visit as “follow-up visit after hospitalization.”

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

The percentage of emergency department (ED) visits between January 1 and December 24 of the measurement year for members 18 years and older who have multiple high-risk chronic conditions and who had a follow-up service within seven days of the ED visit (eight days total).

- Schedule post ED follow-up visit within three to five days after discharge.
- Encourage patients to have regular office visits to monitor and manage chronic disease conditions.
- Provide a visit summary with what was discussed during the PCP visit with clear instructions on changes that need immediate attention.
- Encourage patients to call PCP's office/after-hours line when condition changes.
- Create a daily process to schedule patients that have been discharged from the ED or an inpatient stay.
- Establish relationships with area hospitals to develop a notification process for ED visits.
- Submit claims timely and include the appropriate codes for diagnosis, health conditions and the services provided.

Plan All-Cause Readmissions (PCR)

Percentage of the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission for members 18 years of age and older.

- Monitor admission, discharge and emergency department visit reports
- Obtain hospital discharge summary and use to schedule post-discharge appointments within three to seven days.
- Document in office notes and code any conditions found during hospital admission.
- Perform medication reconciliation soon after discharge to prevent medication related readmissions.
- Consider telehealth or home health visits for discharged patients when appropriate.
- Complete patient risk assessments to manage potential admissions and provide extensive ongoing member outreach.
- Validate patients understand instructions on changes that require immediate attention and to call the office.
- Develop a coordinated transition-of-care process.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

The percentage of males between the ages of 21 and 75 and females between 40 and 75 during the measurement year who were identified as having atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year.

- Review patients with cardiovascular disease and ensure the patient is on a medium- to high-intensity statin.
- Consider prescribing a low-cost generic statin medication to ensure patients do not incur excessive out-of-pocket costs.
- Remind your patients to use their insurance card to fill their prescriptions.
- Statin use should always accompany lifestyle modifications focused on diet and weight loss to lower the patient's risk of developing complications from cardiovascular disease.

Statin Therapy for Persons With Diabetes (SUPD)

The percentage of members between the ages of 40 and 75 who were dispensed at least two diabetes medication (oral hypoglycemic or insulin) fills and who also received a statin medication fill during the measurement year. This is a Pharmacy Quality Alliance measure for members enrolled in Part D.

- Prescribe a statin for all diabetic patients as appropriate.
- Submit exclusion codes for members with diagnosis of end-stage kidney disease, Rhabdomyolysis or Myopathy, Pre-diabetes, Polycystic ovary syndrome, Pregnancy, Lactation, or Fertility, or members in Hospice.
- Remind your patients to use their insurance card when they fill their prescriptions.
- Consider prescribing a low-cost generic statin medication to ensure patients do not incur excessive out-of-pocket costs.
- Statin use should always be accompanied by lifestyle modifications focused on diet and weight loss to lower the member's risk of developing complications from diabetes.

Medication Therapy Management (MTM)

Pharmacy Quality Alliance measure: Percent of Medicare Part D members 18 years or older enrolled in the MTM program for at least 60 days during the reporting period who received a comprehensive medication review (CMR) during the measurement year.

- Call the patient to schedule a comprehensive medication review (CMR) appointment.
- Contact Florida Blue MTM department to schedule a CMR for your HMO patients; call 833-823-5457.
- At the scheduled appointment time, call your patient and ask them to gather their medications. Advise them that you will be transferring the call to a Florida Blue pharmacist and proceed with the transfer.
- Follow up with your patient to ensure the CMR was completed.

Medication Adherence

Pharmacy Quality Alliance measures: Percent of Medicare Part D members 18 years and older who adhere to their prescribed drug therapy medications for oral diabetic medications, hypertension meds (RAS antagonists), and cholesterol medications (statins).

Eligible Population: The number of patients who were dispensed two or more prescriptions in the drug category listed for the measurement year.

Note: These measures are calculated and benchmarked solely on pharmacy claims. Sample medications cannot be counted towards compliance in the measure.

- Follow the recommendations of the Medication Adherence report for each patient on the list.
- Track patients on an adherence medication and flag patients who are at risk for non-adherence.
- Send updated prescriptions to the pharmacy for medication or dosage changes. Avoid large gaps in time between the first and second fill.
- Consider a 100-day supply for eligible members and switching to generic for improved adherence.
- Suggest PillPack for patients on complex medication regimens. Encourage them to use their Florida Blue Medicare card to generate pharmacy claims and capture patient compliance.
- Encourage use of Florida Blue Medicare mail order program and home delivery options offered by many pharmacies.

CPT II Codes for Closing Certain Care Gaps

The table below lists some common CPT II codes used in the evaluation of some care gaps, including diabetes care, blood pressure, medication reconciliation, functional assessment, and pain assessment.

Advance Care Planning (ACP)		
1123F	CPT II	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
1124F	CPT II	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
1157F	CPT II	Advance care plan or similar legal document present in the medical record
1158F	CPT II	Advance care planning discussion documented in the medical record
Blood Pressure (BP)		
3074F	CPT II	Most recent systolic blood pressure less than 130 mm Hg
3075F	CPT II	Most recent systolic blood pressure 130 – 139 mm Hg
3077F	CPT II	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	CPT II	Most recent diastolic pressure less than 80 mm Hg
3079F	CPT II	Most recent diastolic pressure 80 – 89 mm Hg
3080F	CPT II	Most recent diastolic pressure greater than or equal to 90 mm Hg
Care for Older Adults (COA)		
1159F	CPT II	Medication list documented in the medical record
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
1170F	CPT II	Functional status assessed
1125F	CPT II	Pain severity quantified; pain present
1126F	CPT II	Pain severity quantified; no pain present
Dilated or Retinal Eye Exam (EED)		
2022F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	CPT II	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2025F	CPT II	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	CPT II	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
2033F	CPT II	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	CPT II	Low risk for retinopathy (no evidence of retinopathy in the prior year)
Hemoglobin A1c (HBD)		
3044F	CPT II	Most recent hemoglobin A1c level less than 7.0%
3046F	CPT II	Most recent hemoglobin A1c level greater than 9.0%
3051F	CPT II	Most recent hemoglobin A1c level greater than or equal to 7.0% and less than 8.0%
3052F	CPT II	Most recent hemoglobin A1c level greater than or equal to 8.0% and less than or equal to 9.0%
Transitions of Care (TRC), Medication Reconciliation Post-Discharge (MRP)		
1111F	CPT II	Discharge medications reconciled with current medication list in outpatient medical record

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