Blue Cross Blue Shield Blue Care Network of Michigan

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Star Measure Guide for CDI Alerts

2022 CDI Alerts

Use this guide as a reference when completing the Star Measure Gap Closure section of the CDI Alert. This guide includes:

- How to complete the Star Measure Gap Closure section
- Star Measure Guide for CDI Alerts
- Date ranges per measure for the **2022 measurement year**

To complete the Star Measure Gap Closure section of the CDI Alert:

1. Check the date on the bottom left corner to make sure you're using the most recent alert.
2. During a face-to-face or audio-visual telehealth visit with your patient, check one answer that relates to each of the Star Measure gaps listed in the alert.
3. Fill in your provider tax ID, date and sign the alert.
4. Fax the completed alert with the office visit notes and supporting medical record documentation (lab or procedure reports) to **Advantasure® at 1-844-576-2527**.
5. You can use this guide as a reference for the information about Star Measures and the necessary documentation that needs to be submitted with the completed alert.

Example of the Star Measure Gap Closure section on the CDI Alert

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 X 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	X 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.

Provider Tax ID: 123456 **Contact Name:** John Williams

Provider Signature: Dr. Jane Smith **Date:** July 14, 2022

06/25/2022

Provider signature, credentials and date must be on the CDI Alert and medical record documentation. Please also include the patient's first name, last name and date of birth. Medical record documentation related to the date of service must be submitted with the alert.

This isn't a comprehensive guide on Star Measures, but it can be used as a reference tool when filling out the Star Measure Gap Closure section of the CDI Alert.

Star Measure	If service not rendered	If service rendered - what documentation is needed to be submitted with the medical record and CDI Alert
Hemoglobin A1c Control for Patients with Diabetes	Perform an HbA1c test in office or refer patient to a lab. If test is performed in the office, bill both CPT codes for the test AND result (below): • CPT codes: 83036 or 83037 (HbA1c test) • CPT Category II code – 3044F (HbA1c Level <7) • CPT Category II code – 3046F (HbA1c Level >9) • CPT Category II code – 3051F (HbA1c Level ≥ 7% – < 8%) • CPT Category II code – 3052F (HbA1c Level ≥ 8% – ≤ 9%) HbA1c tests should be done two to four times per year to ensure patient is in the compliant range. Note: to be compliant, the patient must have an HbA1c Level ≤ 9% on the last test of the measurement year.	**Lab Report** • The latest HbA1c lab report in the measurement year with date collected and result Or **Office Visit Note** • Portion of the medical record with the latest HbA1c date of service and result
Eye Exam for Patients with Diabetes	Refer patient to an eye care professional (ophthalmologist or optometrist) to have diabetic eye exam by end of the measurement year. When an eye exam report is received/reviewed, place it in the medical record and submit a claim with the appropriate CPT code: • 2022F – Dilated retinal exam interpretation by an ophthalmologist or optometrist and reviewed, with evidence of retinopathy or • 2023F – Dilated retinal exam interpretation by ophthalmologist or optometrist and reviewed, without evidence of retinopathy • 92229 – Automated eye exam	**Eye Exam Report or letter from eye care professional** • Letter must include the date of service and that an eye exam was performed (e.g., retinal eye exam), the result of the exam, the eye care professional's name, specialty or credentials Or **Office Visit Note** • Document in the health maintenance section of the record: Eye exam date, results and eye care professionals name, or that the eye exam was completed by an optometrist or ophthalmologist
Breast Cancer Screening	Ensure the patient has mammogram every two years or bill the appropriate exclusion ICD-10 code on a claim: • Z90.13 Acquired absence of bilateral breasts and nipples • Z90.12 Acquired absence of left breast and nipple • Z90.11 Acquired absence of right breast and nipple	**Mammogram Report** • Mammogram report between October 1 two years prior to measurement year and December 31 of the measurement year with date mammogram completed and results Or **Office Visit Note** • Submit documentation that a mammogram was performed (with the date of service) on or between October 1 two years prior to the measurement year and December 31 of the measurement year Or • Portion of medical record that substantiates any exclusions (i.e., member with a bilateral mastectomy or two unilateral mastectomies) with the date of service

Star Measure	If service not rendered	If service rendered - what documentation is needed to be submitted with the medical record and CDI Alert
Colorectal Cancer Screening	Encourage and refer the patient to have one of the following tests/services completed by the end of the measurement year: • A colonoscopy • A flexible sigmoidoscopy • Fecal Occult Blood Test and submit claim. (stool tests performed by DRE are not compliant) • A sDNA test (stool DNA with FIT test known as Cologuard) • A CT- Colonography Or bill the appropriate exclusion ICD-10 code on a claim: • Z85.038 – Personal history of other malignant neoplasm of large intestine • Z85.048 – Personal history of other malignant neoplasm of rectum, rectosigmoid junction and anus	**Procedure Report/Office Visit Note** • Portion of the medical record documenting a colonoscopy, date of service and result, or a colonoscopy report with date of service within 10 years Or • Portion of the medical record documenting a flexible sigmoidoscopy, date of service and result, or a sigmoidoscopy report, within five years Or • Portion of the medical record documenting a CT-Colonography (virtual colonoscopy), date of service and result, or a CT-Colonography report, within five years Or • Portion of medical record documenting that substantiates an exclusion (i.e. history of colorectal cancer or total colectomy) with date of service Or **Lab Reports** • FOBT with date of service and result within the measurement year Or • Pathology report from a biopsy taken during a colonoscopy procedure with date of service within 10 years Or • sDNA (Cologuard) report with date of service and result within 3 years

Osteoporosis Management in Women who had a Fracture	Order a bone mineral density test and/or prescribe osteoporosis drug therapy for female patients aged 67-85 within six months of a fracture. Screen female patients aged 65-85 with a bone mineral density test. Note: it is payable every two years without cost tot he patient. If patients ag 81-85 have fallen, submit a claim with any of the following ICD-10 codes, when appropriate and the patient will be excluded from the measure: R26.2 Difficulty in walking, NOC R26.89 Other abnormalities fo gait or mobility R26.9 Unspecified abnormalities of gait and mobility R41.81 Age related cognitive decline R53.1 Weakness R53.81 Other Malaise R53.83 Other fatigue R54 Age related physical debility • W01.0XXA-W01.198S Falls on same level • W06.XXXA-W10.9XXS Falls from bed, or other furniture • W18.00XA-W18.39XS Striking against unspecified object, or falls from toilet or shower • W19.XXXA-W19.XXXS Unspecified falls • Z73.6 Limitations of activities due to disability • Z74.09 Other reduced mobility • Z91.81 History of falling	**Procedure Report** Bone mineral density report with date of service (two years before the fracture through six month after the fracture) Or **Office Visit Note** Portion of the medical record that substantiates a bone mineral density test was performed with the date of service (two years before the fracture through six months after the fracture) Or Portion of the medical record indicating patient is receiving or has received osteoporosis drug treatment therapy any time from one year before the fracture date through six months after the fracture date with documented dates of service
Statin Therapy for Patients with Cardiovascular Disease	Prescribe a moderate or high intensity statin medication and encourage compliance. For patients with any of the following conditions in the measurement year, submit a claim with one of the ICD-10 codes below to exclude the patient from the measureL • Myalgia – M79.1, M79.10-M79.12, M79.18 • Myositis – M60.80 – M60.819, M60.821-M60.829, M60.831-M60.839, M60.841 – M60.849, M60.851-M60.859, M60.861-M60.869, M60.871-M60.879; M60.88-M60.9 • Myopathy – G72.0, G72.2, G72.9 • Rhabdomyolysis – M62.82	**Office Visit Note** • If your patient has any of the excluded conditions, (e.g., myalgia, myosistis, myopathy and rhubdomyolysis) submit a claim with one of the exclusion ICD-10 codes

Star Measure	If service not rendered	If service rendered - what documentation is needed to be submitted with the medical record and CDI Alert
Controlling High Blood Pressure	Check the patient's blood pressure at every visit. The last blood pressure measurement of the year determines compliance (must be < 140/90 mm Hg). Take multiple readings if initial reading is out of range. Bring patient back for nurse visit to recheck BP before the end of the year if needed. **NEW:** May use a patient-reported reported blood pressure obtained during a telehealth, telephone or e-visit. When blood pressure readings are taken, submit claims with CPT Category II codes. This will reduce the need to submit medical records for review. • 3074F – most recent systolic blood pressure < 130 mm Hg • 3075F – most recent systolic blood pressure 130 – 139 mm Hg • 3077F – most recent systolic blood pressure ≥ 140 mm Hg • 3078F – most recent diastolic blood pressure < 80 mm Hg • 3079F – most recent diastolic blood pressure 80 – 89 mm Hg • 3080F – most recent diastolic blood pressure ≥ 90 mm Hg	**Office Visit Note** • Portion of the medical record showing the last blood pressure reading of the measurement year. **NEW:** Patient reported blood pressure readings obtained during telehealth, telephone and e-visits are acceptable and must be documented, dated and maintained in the patient's legal record by the provider managing the patient's hypertension. **NOTE:** if the patient reports they manually took their blood pressure using a stethoscope and BP cuff, this would not be an acceptable blood pressure reading.

Date ranges per Star Measure

This table lists the date ranges for the current measurement year. If your patient requires any of these services, they must be completed during the dates listed in the table to meet the Star Measures in the HEDIS® Technical Specifications.

*Must be the most recent result in the measurement year

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

ICD-10-CM diagnosis codes and ICD-10-CM Official Guidelines for Coding and Reporting are subject to change. It's the responsibility of the provider to ensure that current ICD-10-CM diagnosis codes and the current ICD-10-CM Official Coding Guidelines for Coding and Reporting are reviewed prior to the submission of claims

Star Measure	Sub measure or procedure	Compliant date ranges
Colorectal Cancer Screening	Colonoscopy	Current year + nine (9) years prior
	Flexible Sigmoidoscopy	Current year + four (4) years prior
	FIT test or FOBT	Current year
	CT - Colonography	Current year + four (4) years prior
	sDNA/Cologuard	Current year + two (2) years prior
Controlling Blood Pressure	Blood pressure reading*	Current year - latest result
Hemoglobin A1c Control for Patients with Diabetes	HbA1C* lab result	Current year - latest result
Eye Exam for Patients with Diabetes	Eye exam - Negative for retinopathy	Current or prior year
	Eye exam - Positive for retinopathy	Current year
Breast Cancer Screening	Mammogram	Current year + end of October of two years prior
Osteoporosis Management in Women who had a fracture	Bone mineral density compliant date ranges: Within six (6) months after fracture	Osteoporosis Drug therapy compliant date ranges: Within six (6) months after fracture
Statin Therapy for Patients with Cardiovascular Disease	Moderate/High Intensity Statin Therapy	Current year

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