BlueCare Plus Tennessee

QUALITYCARE REWARDS

2017 BlueCare Plus (HMO SNP)SM Stars Quality Attestation Form

Provider Name _____

Contract Entity/Group Name _____

Patient Name: _____ **Member ID:** _____

DOS: _____ **DOB:** _____

Preventive Screenings

Breast Cancer Screening

The Breast Cancer Screening quality measure focuses on ensuring your female patients between the ages of 52-74 receive a mammogram to screen for breast cancer.

Please fill in all appropriate dates and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)	**Date:**	**Result:**
Mammography performed any time on or between Oct. 1 two years before the current year through Dec. 31 of the current measurement year		
Excluded due to bilateral mastectomy		Surgeon:
Excluded due to two unilateral mastectomies with different dates of service 14 or more days apart		Surgeon:
Excluded due to a mastectomy on both the left and right side on the same or different dates of service		Surgeon:
Excluded due to unilateral mastectomy with a bilateral modifier		Surgeon:

Colorectal Cancer Screening

The Colorectal Cancer Screening quality measure focuses on ensuring your patients between the ages of 50-75 receive an appropriate colorectal cancer screening.

Please fill in all appropriate dates and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)	**Date:**	**Result:**
Colonoscopy performed during the measurement year or the nine years prior to the measurement year		
Flexible sigmoidoscopy performed during the measurement year or the four years prior to the measurement year		
Fecal occult blood test (FOBT) completed/resulted during the measurement year. **FOBT done during a digital rectal exam and/or from a sample collected in the office is excluded.** Exact date required.		☐ FIT/iFOBT ☐ gFOBT (3) ☐ Positive ☐ Negative
FIT-DNA Test performed during the measurement year or the two years prior		
CT Colonography during the measurement year or the four years prior		
Excluded due to total colectomy		Surgeon:
Excluded due to diagnosis of colorectal cancer		

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Fax Completed Forms **AND** Supporting Documentation from the Medical Record to 1-866-636-0162.

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BMI	**The Adult BMI quality measure focuses on ensuring your adult patients between the ages of 18-74 who you see for outpatient visits have a BMI documented in the medical record in the past two years.**		
	Please fill in appropriate date and provide evidence from the medical record to support the information provided below:	**Date:**	**Result:**
	Body mass index performed in the past two calendar years. Exact date required.		Body Mass Index (BMI) Value Ages 20 - 74: _____ Weight _____ Body Mass Index (BMI) Percentile Ages 18 & 19: _____ Height _____ Weight _____
	Excluded due to diagnosis of pregnancy during the measurement year or the year prior		

Musculoskeletal Conditions

Osteoporosis Management in Women Who Had a Fracture	**The Osteoporosis Management in Women who had a Fracture quality measure focuses on ensuring your female patients between the ages of 67-85 who suffered a fracture received either a bone mineral density test or a prescription for a drug to treat osteoporosis in the six months after the fracture.**		
	Please fill in all appropriate dates for the screening received and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)	**Date:**	**Result:**
	Fracture required hospitalization: ☐ Bone mineral density testing completed during hospitalization ☐ Long-acting osteoporosis therapy medication given during hospitalization	_____ Date of Hospitalization	Facility:
	Bone mineral density test completed within six months after the fracture		
	Excluded due to bone mineral density testing in the 24 months prior to the fracture		
	Excluded due to patient received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the fracture		

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DOS: _____ **DOB:** _____

Rheumatoid Arthritis Management

The Rheumatoid Arthritis Management quality measure focuses on ensuring your patients 18 years and older who have been diagnosed with rheumatoid arthritis were dispensed at least one ambulatory disease-modifying anti-rheumatic drug (DMARD) during the calendar year.

Please fill in all appropriate dates and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)		**Result:**	
Patient does not have diagnosis of RA	☐ If checked, move to next section. If the patient has an open gap for this measure and does not have RA, please submit corrected claim(s) for dates of service previously submitted to the plan to remove the RA diagnosis.		
Dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD)	_____ Date of Infusion/Injection	5-Aminosalicylates ☐ Sulfasalazine Alkylating agents ☐ Cyclophosphamide Aminoquinolines ☐ Hydroxychloroquine Anti-rheumatics ☐ Auranofin ☐ Gold sodium thiomalate ☐ Leflunomide ☐ Methotrexate ☐ Penicillamine	Immunomodulators ☐ Abatacept ☐ Adalimumab ☐ Anakinra ☐ Certolizumab ☐ Certolizumab pegol ☐ Etanercept ☐ Golimumab ☐ Infliximab ☐ Rituximab ☐ Tocilizumab Immunosuppressive agents ☐ Azathioprine ☐ Cyclosporine ☐ Mycophenolate Janus kinase (JAK) inhibitor ☐ Tofacitinib Tetracyclines ☐ Minocycline
Excluded due to diagnosis of pregnancy during calendar year			
Excluded due to diagnosis of HIV at any time in the patient's history through Dec. 31 of the current year			

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Comprehensive Diabetes Care

HbA1C Control

The HbA1C Control quality measure focuses on ensuring that your patients between the ages of 18-75 diagnosed with Type 1 or Type 2 Diabetes have evidence of an HbA1C performed in the calendar year and have evidence of HbA1c control.

Please fill in all appropriate dates and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)	**Date:**	**Result:**	
HbA1C performed this year (most recent). Exact date required.		☐ HbA1c level is: _____	Good Control (Compliant) = 8.9 and under Poor Control (Non-Compliant) = 9.0 and over
Excluded due to diagnosis of gestational diabetes in past two calendar years and who did not have diagnosis of diabetes			
Excluded due to diagnosis of steroid induced diabetes in past two calendar years and who did not have diagnosis of diabetes			

Retinal Eye Exam

The Retinal Eye Exam quality measure focuses on ensuring your patients between the ages of 18-75 diagnosed with Type 1 or Type 2 Diabetes have had an eye screening for diabetic retinal disease by an eye care professional in the calendar year.

Please fill in all appropriate dates for screenings received and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)	**Date:**	**Result:**
Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during current measurement year. Exact date required.		Name of Optometrist or Ophthalmologist (required): _____ ☐ Positive for Retinopathy ☐ Negative for Retinopathy
NEGATIVE retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the previous calendar year. Exact date required.		
Excluded due to diagnosis of gestational diabetes in past two calendar years and who did not have diagnosis of diabetes		
Excluded due to diagnosis of steroid induced diabetes in past two calendar years and who did not have diagnosis of diabetes		

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Comprehensive Diabetes Care *(continued)*

Medical Attention for Nephropathy

The Medical Attention for Nephropathy quality measure focuses on ensuring your patients between the ages of 18-75 diagnosed with Type 1 or Type 2 Diabetes have had a nephropathy screening test or documentation of evidence of nephropathy within the calendar year.

Please fill in all appropriate dates for the screening received and provide evidence from the medical record to support the information provided below (only ONE is needed to meet the measure)	**Date:**	**Result:**
Nephropathy screening or monitoring test during calendar year (urine protein test). Exact date required.		☐ 24-hour urine for albumin or protein ☐ Timed urine for albumin or protein ☐ Spot urine for albumin or protein ☐ Urine for albumin/creatinine ratio ☐ 24-hour urine for total protein ☐ Random urine for protein/creatinine ratio
Evidence of treatment for nephropathy or angiotensin-converting enzyme (ACE) Inhibitor/angiotensin receptor blocker (ARB) therapy during calendar year		Name of medication: Dosage:
Nephrologist visit during calendar year		
Evidence of Stage 4 Chronic Kidney Disease		
Evidence of End Stage Renal Disease		
Evidence of kidney transplant		
Excluded due to diagnosis of gestational diabetes during past two calendar years and who did not have diagnosis of diabetes		
Excluded due to diagnosis of steroid induced diabetes during past two calendar years and who did not have diagnosis of diabetes		

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Controlling Blood Pressure	**The Controlling Blood Pressure quality measure focuses on ensuring your patients between the ages of 18-85 with a diagnosis of HTN had adequate BP control in the calendar year.**				
	Please fill in appropriate date and provide evidence from the medical record to support the information provided below for screening received:	**Date:**	**Result:**		
	Blood pressure screening performed this year (most recent). Exact date required.		Most Recent Systolic BP reading _____	Most Recent Diastolic BP reading: _____	Compliant = 139/89 and under for: • Ages 18-59 • Diabetics Ages 60-85 Compliant = 149/89 and under for: • Non-Diabetics Ages 60-85
	Excluded due to diagnosis of end stage renal disease (ESRD)				
	Excluded due to history of kidney transplant		Transplant Facility: _____ Surgeon: _____		
	Excluded due to diagnosis of pregnancy during the measurement year				
	Excluded due to non-acute inpatient admission during the measurement year				

For more information about the measures included in the Quality Care Rewards Program, please visit www.bcbst.com/providers/quality-initiatives

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Care for Older Adults

Advance Care Planning

The Advance Care Planning quality measure focuses on ensuring your patients age 66 and older have evidence of advance care planning during the measurement year documented in the medical record. Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end-of-life care.

Please fill in the appropriate dates and provide evidence from the medical record to support the information provided below. Any ONE of the following meets criteria:	**Date:**	**Result:**
Presence of an advance care plan in the medical record		Advance Directive:_____ Living Will:_____ Actionable Medical Order:_____ Surrogate Decision Maker:_____ Other*(please list)*:_____ **(Please place an "X" to indicate document present)**
Documentation of an advance care planning discussion with the provider and date discussed		
Notation that the member previously executed an advance care plan		

Medication Review

The Medication Review quality measure focuses on ensuring your patients 66 years of age and older have at least ONE medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year AND the presence of a medication list in the medical record.

Please fill in the appropriate dates and provide evidence from the medical record to support the information provided below. Any ONE of the following meets criteria:	**Date:**	**Result:**
BOTH of the following on the same date of service and in the same chart during the measurement year: • At least ONE medication review conducted by a prescribing practitioner or clinical pharmacist • The presence of a medication list in the medical record		Name of Prescribing Physician or Clinical Pharmacist: _____
Notation that the member is NOT taking any medication and date noted.		**Note: A review of side effects for a single medication at the time of prescription alone is not sufficient.**

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DOS: _____ **DOB:** _____

Care for Older Adults *(continued)*

Functional Status Assessment

The Functional Status Assessment quality measure focuses on ensuring your patients 66 years of age and older have at least ONE functional status assessment during the measurement year documented in the medical record.

Please fill in the appropriate dates and provide evidence from the medical record to support the information provided below. Notations for a complete functional status assessment must include ONE of the following:	**Date:**	**Result:**
Notation that Activities of Daily Living (ADL) were assessed or that at least **FIVE** of the following were assessed: bathing, dressing, eating, transferring, using toilet, and/or walking.		Bathing:_____ Dressing: _____ Eating: _____ Transferring: _____ Using Toilet: _____ Walking: _____ **(Please place an "X" to indicate ADL assessed)**
Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least **FOUR** of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications and/or handling finances.		Shopping:_____ Driving/Public Transportation:_____ Telephone Usage:_____ Meal Prep:_____ Housework:_____ Home Repair:_____ Laundry:_____ Taking Medications:_____ Handling Finances:_____ **(Please place an "X" to indicate IADL assessed)**
Result of assessment using a standardized functional status assessment tool, not limited to: • Assessment of Living Skills (ALSAR) • Barthel ADL Index Physical Self-Maintenance Scale • Bayer ADL (B-ADL) Scale • Barthel Index • Extended ADL (EADL) Scale • Katz Index of Independence in ADL • Kenny Self-Care Evaluation • Klein-Bell ADL Scale • Kohlman Evaluation of Living Skills (KELS) • Lawton & Brody's IADL scales		Name of Assessment/Functional Status Tool Used: _____
Notation of at least **THREE** of the following four components assessed: • Cognitive Status • Ambulation Status • Hearing, Vision and Speech • Other Functional Independence		Cognitive Status:_____ Ambulation Status:_____ Hearing, Vision and Speech:_____ Other Functional Status:_____ **(Please place an "X" to indicate Status assessed)**

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Care for Older Adults *(continued)*

Pain Assessment

The Pain Assessment quality measure focuses on ensuring your patients 66 years of age and older have at least ONE pain assessment during the measurement year documented in the medical record.

Please fill in the appropriate dates and provide evidence from the medical record to support the information provided below. Notations for a Pain Assessment must include ONE of the following:	**Date:**	**Result:**
Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)		
Result of assessment using a standardized pain assessment tool, not limited to the following: • Numeric Rating Scale (verbal OR written) • Face, Legs, Activity, Cry, Consolability (FLACC) Scale • Verbal Descriptor Scale • Pain Thermometer • Pictorial Pain Scale (Faces Scale, Wong-Baker Scale) • Visual Analogue Scale • Brief Pain Inventory • Chronic Pain Grade • PROMIS Pain Intensity Scale • Pain Assessment in Advanced Dementia (PAINAD) Scale		Name of Pain Assessment Tool Used: _____

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Please include your plan of care details here.

Attestation Statement

☐ **By checking this box I hereby attest that the information entered above is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability. I understand that BlueCross BlueShield of Tennessee may perform an audit of my patient's chart to verify that these measures have been properly documented and I will submit the medical records requested in a timely manner.**

Sign: _____ **Credentials:** _____

Print: _____ **NPI:** _____

Date: _____

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