APRIL 2021

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

MPM Provider Quality Newsletter

To access the materials referenced in this newsletter, go to:
www.medpointmanagement.com/provider-resources

- Click on "Quality Management Information" and then "2020 Quality Newsletters."
- All materials are listed in one PDF document.
- Please also note that MedPOINT's Reference Guides are available under "HEDIS Documents."

QM Bulletin Board

Would you like input from other health centers in the MedPOINT network?

Post your question at https://qualitypoint.medpointmanagement.com and also check out the other resources available to you!

Interpreta 2021 Available Now!

Measurement Year (MY) 2021 data is now available in Interpreta for you to download your Member Gap Reports and use for outreach on HEDIS measures.

Please note:

1. Make 2021 your default year when you first sign in to Interpreta by clicking **Make this my default plan** on the right. Then click **MedPOINT MY2021** and it will always open to 2021 going forward.
2. For 2020 data, click the down arrow next to your name in the upper right-hand corner and choose **Change Plan**, then click on **MY2020**. 2021 will still be your default next time you visit Interpreta unless you change it.
3. Please contact us to schedule training or review your HEDIS measures at qualitymeasures@medpointmanagement.com, (818) 702-0100, ext. 1353, or contact your HEDIS/Stars Specialist directly.

Updated Health Plan Incentive Grid

The Health Plan Incentive Grid has been updated with 2021 incentive programs and is available by request for your IPA (email qualitymeasures@medpointmanagement.com or (818) 702-0100, ext. 1353.

Changes are highlighted and new programs will be updated as they become available.

The grid includes the following updates:

- **Health Net** – A new Member Rewards program for completed mammograms ($25), pap smears ($25) and well child vaccinations (with flu shot) (total $75). Please share the attached flyer with your staff and offer these incentives as you outreach to your Health Net patients.
- **Anthem** – Introduction of a new Healthy Rewards Program for Medi-Cal members where gap closures are loaded onto the member's Healthy Rewards account based on encounter data. Please see flyer for details.

New Record Requirement for WCV and W30

The new WCV and W30 HEDIS measures state that if no labs or diagnostic procedures are ordered, the record must indicate "**no labs/procedures ordered**." This is an important line to add to well child templates in the event supplemental data records are submitted. However, our goal is to make sure well visits are always coded correctly and submitted as encounters so that supplemental data is not needed. Please ask your HEDIS/Stars Specialist how to properly code these measures or request a copy of our **W30 & WCV–HEDIS Measure Guide**.

New WCV Customizable Member Flyer – Educates Parents about Wellness Visits!

MedPOINT has created the attached customizable member educational flyer in English and Spanish to help educate parents that their child/adolescent/young adult need to see the doctor every year for a wellness visit. Please help spread this message to increase the new Child and Adolescent Well-Care Visits (WCV) HEDIS measure and improve the health of your patients.

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HEDIS Measures to Automate in your EMR

If you have an Electronic Medical Record (EMR) system, consider automating the following HEDIS measures: Blood pressure values for CBP and CDC9, CDC A1c Test (Comprehensive Diabetes Care), COA (Care for Older Adults), WCC (Weight Assessment and Counseling), and W30 and WCV well child visits. Automation helps cut down on 'extra clicks' by providers and staff, and ensures you receive credit for routine services.

Please review the attached guide entitled "HEDIS Measures to Automate in EMR" and share with your IT department. We are happy to meet with your IT manager to further support your automation efforts and ensure correct encounter submission.

New HEDIS Frailty and Advanced Illness Exclusions

The National Committee for Quality Assurance (NCQA) added a new set of exclusions for members with advanced illness and/or frailty for select HEDIS® measures. Please see the attached flyer from United Healthcare to view the list of conditions that will indicate frailty with advanced illness for these measures: BCS, COL, CDC, CBP, ART, OMW, PBH, SPC and SPD. These exclusions are determined by claims for services obtained during the measurement year only. NOTE: Although this document was from United Health, it is applicable for all health plans.

Resources:

Patient Satisfaction – Always a Priority

Please review and share resources with your staff:

- **Alignment - ALWAYS Satisfied Patient System and Healthy Outcomes System** – The attached flyer from Alignment Health Plan can help set the standards to improve member satisfaction at your clinic.
- **AHRQ Webcasts and Guide links - The Agency for Healthcare Research and Quality (AHRQ)** has made their patient satisfaction webcasts available to all: Improving Patient Experience: Data Analysis Methods (https://www.ahrq.gov/cahps/news-and-events/events/webinar-030321.html) or Lessons From Healthcare Organizations on Improving Patient Experience (https://www.ahrq.gov/cahps/news-and-events/events/webinar-012821.html). Also check out the CAHPS Ambulatory Care Improvement Guide.

Annual Care Checklist for Members

United Healthcare has created a two-page Annual Care Checklist Form for members to fill out before any visit (attached) that will help them track their preventive care and identify questions they may want to ask their doctor. This is a great tool to hand out while members are waiting!

ACEs Screening Training Survey

Please see the attached Provider Update from Health Net asking for participation in their survey regarding the ACEs (Adverse Childhood Experiences) training.

Health Plan Guides & Resources

We have received HEDIS/Stars guides and other resources from the following health plans. Most are attached to this newsletter, however 6 guides have multiple pages and are available upon request. If you have these plans and would like a copy, we would be happy to send them to you. For easy retrieval, we will also update our website with many of these resources.

PLAN	NAME	PAGES
Anthem	Access to Care Standards	2
Anthem	Immunization and CAIR2 Tip Sheet	2
Brand New Day	Medicare Stars Guide	8
Health Net	2021 Medicare Star Ratings and Beyond – *https://providerlibrary.healthnetcalifornia.com/news/21-259m-medicare-star-ratings-for-2021-and-beyond.html*	8
LA Care	Interpreting - Quick Guide	3
Optum	Documenting to Satisfy Reporting Requirements	4
Optum	Sample Health Risk Assessment (HRA) Form	2
Optum	Social Determinants of Health (SDOH)	2
United Healthcare	'21 Medicare Advantage Screening Coding Guides	5
United Healthcare	Medicare COVID-19 Telehealth Guide	4
AVAILABLE UPON REQUEST:		
Alignment	Stars Best Practice Guide – *www.alignmenthealthplan.com/media/AHP/PDF/2020/Misc/Stars-Best-Practice-Guide-011620-r3-508.pdf*	60
LA Care	Better Communication, Better Care – Toolkit	81
Molina	MCAS Measures w/ Codes Telehealth & HEDIS '21	39
Optum	Annual Wellness Visit (AWV) Checklist	28
Optum	Closing Medicare Gaps in Quality Measures Guide	33
United Healthcare	Quality Reference Guide	269

Coming Up in May

- Healthy Vision Month
- National High Blood Pressure Education Month
- National Osteoporosis Awareness and Prevention Month
- May 9-15 - National Women's Health Week
- May 9-15 - National Women's Health Week

2021 Health Plan Incentives Grid

Information is current as of 4-27-2021.
NOTE: This Information reflects incentives for Measurement Year (MY) 2021 with changes in yellow and new in green.
All other information is based on 2020 and is subject to change and may be modified.

Incentives for Clinics/Health Centers - ANNUAL WELLNESS VISITS (AWV)			
Health Plan	**LOB**	**Program**	**Details**
Blue Shield Promise	Medicare, Cal-MediConnect Applies only to IPAs: Bella, Crown City, Global, HCLA, CCIPA and IHP	In Office Assessment (IOA) Provider Incentive Program 2021	10/2/20 – Program applies to Bella, Crown City and Global, CVIPA/PPN and Prudent. Complete the In-Office Assessment (IOA) form accurately within 60 days of visit for maximum payment of up to $200 for Medicare and $300 for CMC. After 60 days, payment is $25 for Medicare and $75 for CMC. Forms are provided by Optum. Payment is made through the IPA. Document verification included in incentive and must pass. For questions about distribution and return of forms, please email klitzsey@medpointmanagement.com. For questions about IOA, email: Sandra.Jaureguibaza@optum.com.
Brand New Day	Medicare	STARs Annual Wellness Exam (AWE)	$200 per AWE form received and complete by 6/30/21. $150 per AWE form received and complete after 6/30/21 to 12/31/21. For more details, contact provider_services@universalcare.com. (Members receive $50 for completed annual exam.)
Health Net	Medicare	Annual Wellness Program	$100 incentive for each comprehensive health assessment performed at a qualifying visit (CPT codes G0438/G0439/G0402/99396/99397). Besides the encounter submission, the corresponding medical chart must also be available to earn the incentive.
LA Care	Cal-MediConnect (CMC)	CMC Annual Wellness Exam (AWE) Incentive Program 2021	Payment is $350 for each completed and coded AWE form submitted before 12/31/21. Complete information required includes AWE Form and PHQ-9 section. Contact RiskAdjustment@lacare.org or call 213-694-1250, x4664, for more information.
Molina	Medicare, Medi-Medi, Cal-MediConnect (CMC), Covered CA	2021 Annual Exam Program	Annual wellness exam forms submitted 01/01/2021 – 12/31/21: For select members with Medicare/Medi-Medi/CMC: $125 – per complete detailed EMR, $50 Bonus if received by 07/30/2021. For select members with Covered California: $125 – per complete detailed EMR, $50 Bonus if received by 08/31/2021. Email completed forms to: AEProgramSubmissions@MolinaHealthcare.com or assigned HCLA Coder for review. For assistance with obtaining or completing forms, email klitzsey@medpointmanagement.com or your HCLA coder. Video telehealth visits are acceptable. For more details, contact: Alicia Chatterley | Associate, Risk Adjustment (801) 858-0400 x171085 or Alicia.Chatterley@molinahealthcare.com

Incentives for Clinics/Health Centers – PROGRAMS			
Health Plan	**LOB**	**Program**	**Details**
All Medi-Cal Health Plans	Medi-Cal	Value Based Payment (VBP) Program 2021 (Prop 56)	The Prop 56 VBP Program is for eligible providers (not FQHCs). The Governor's Budget proposed a VBP through Medi-Cal managed care health plans (MCPs) that provides incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. These risk-based incentive payments will be targeted at physicians that meet specific metrics targeting areas such as behavioral health integration, chronic disease management, prenatal/post-partum care and early childhood prevention. https://www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Programs-Value-Based-Payment.aspx The Prop 56 rates are confirmed for FY (Fiscal Year) 2019-2021 and will be paid at the same rates used for State Fiscal Year (SFY) 2018-2019. Please see details, measures and payments here: https://www.cahealthwellness.com/newsroom/prop-56-rates-for-sfy-2019-2021.html. FQHCs are eligible for developmental (https://www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Screenings-Developmental.aspx) and trauma (https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx) screening payments only. Specific questions regarding this program should be directed to each respective Health Plan.
Blue Shield Promise	Medi-Cal	Patient Centered Medical Home (PCMH) Certification 2021	Primary care practices are incentivized to continue ongoing PCMH certification through NCQA or the Joint Commission with two annual incentive payments payable once in April and once in October. The payments will be based on PCMH certification status and practice size ($1.50 PMPM). For questions, please email: ProviderIncentives@blueshieldca.com or click PCMH Program.
Central Health Plan	Medicare	STARs PCP Incentive Program Applies to AHISP, FCS and Global IPAs only	The 2020 program includes bonus amounts for selected measures and Excellence Reward for PCP Star Score of >4.25 Stars (range of $100 - $200 per member). Incentive Measures that include incentive amounts ($225 total) are: $10 each - mental health screening, monitor physical activity, improve bladder control, fall prevention, advance care planning, statin treatment for diabetes and cardiovascular disease, medication reconciliation. $50 - medication List review. $15 each: Medication list & review, functional status assessment, chronic pain screening. $20 each – RAS antagonists adherence, oral glycemic medication adherence, statin adherence. $0 incentive but counts toward Excellence Award - colon screening, mammogram, HTN control BP <139/89, retinal exam, A1c <8, urine microalbumin test. A minimum of 35 members are required to qualify. For further information, contact star@centralhealthplan.com.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
Health Plan	**LOB**	**Program**	**Details**
Health Net	Medi-Cal	Clinic HEDIS Improvement Program (C-HIP) 2021 - FQHCs	This financial incentive program for FQHC/RHC/IHS providers recognizes efforts to maintain open primary care provider panels, submit accurate and timely encounters and demonstrates HEDIS improvement. Incentive is from encounters and pharmacy data and rewards are based on NCQA national average performance level. 2021 HEDIS measures included: AMM Acute, AMM Cont., BCS, CBP, CCS, CDC-A1c<9, CDC A1c Test, CHL, CIS10, IMA2, Prenatal, Postpartum, W30, WCV, WCC. Payment is max $3.40 PMPM (per member per month) including meeting MPL (minimum performance level) and improvement. Providers with measures that meet the incentive criteria for 2021 (based on 2019 performance) will receive a payment advance early in 2021 (30% of the calculated incentive amount). *C-HIP is offered to clinics in all 31 counties statewide with active W-9 on file.* For more details, please contact HEDIS@healthnet.com.
Health Net	Medi-Cal	HEDIS Improvement Program (HIP) 2021 – PCPs	The HIP Program rewards PCP's efforts to improve quality in the following HEDIS measures through encounter data: CIS 10 ($200), PPC Postpartum ($75) and Prenatal ($75), AMM acute ($100) and continuation ($100), BCS ($75), CCS ($75), IMA-2 ($50), CBP ($50), CDC A1c <9 ($50) , CHL ($25), CDC A1c Test ($12.50), WCC BMI ($5), WCC Nutrition ($5), WCC Physical Activity ($5), W30 ($75), WCV ($25). Minimum of 50 members required. For more information, please contact HEDIS@healthnet.com.
LA Care Includes: Anthem Blue Cross and Blue Shield Promise	Medi-Cal	HEDIS Physician P4P Program (Pay for Performance) 2021	**HEDIS measures** include: Child and Adolescent Well-Care Visits (WCV), Depression screening and follow-up for Adolescents and Adults – Depression Screening, Asthma Medication Ratio (AMR), BCS, **CCS**, **CIS10**, CHL, **CDC A1c Control <8%**, **CBP**, IMA2, PPC Postpartum and **Prenatal**, WCC Physical Activity and W30. • Double-weighted measures are **bolded**. • Complete, timely and accurate encounter data is also key. • Contact Incentive_Ops@lacare.org for P4P and reporting questions.
LA Care	Medi-Cal	HEDIS Behavioral Health - eManagement Physician Incentive Program 2021	L.A. Care has implemented the eManagement program as a way to improve patient care for those experiencing depression, anxiety, and/or substance use issues in the primary care settings. The eManagement Physician Incentive Program provides an incentive for enrolled physicians who meet program requirements. Physicians are incentivized for completion of screening tools ($15 per eligible member) as well as initiating and completing an eManagement dialogue ($50 per eligible member). Please contact emanagement@lacare.org or (213) 694-1250 x 5635 for further information.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
Health Plan	**LOB**	**Program**	**Details**
Molina	Medi-Cal	Achieving Equity in Care Program (AECAP) 2021 Imperial, Riverside, San Bernardino, Sacramento and San Diego counties only	The goals of the program are to: 1) achieve or exceed the target thresholds for selected preventive and chronic care measures per region, and 2) to reduce targeted health disparities by 3%. The program entails a five-prong approach which includes: 1. Improve data collection 2. Data analysis 3. Member engagement 4. Provider support 5. Pilot innovations Adjustments to MY 2020 final payments will be increased for eligible providers. For further details, contact (888) 562-5442.
Molina	Medi-Cal	CHDP Wellness Incentive (Medi-Cal Wellness Services Bonus Program) (Ending)	Effective 6/30/21, Molina Healthcare of California will be **ending** the legacy Medi-Cal Services Bonus Program- formerly known as the CHDP incentive program. Additional incentive opportunities are through: • Adjusting funding in 2020 Pay-for-Performance Programs (including the Medi□-al services Bonus Program and HEDIS® P4P Program. • Offering additional funding through Molina's Achieving Equity in Care Program (AECAP) for CHDP providers who utilize the California Immunization Registry (CAIR). See JTF Update 3/15/21 "Medi-Cal Wellness Services Bonus Program or contact Molina Provider Services liaison at (888) 562-5442 for details. Does not apply to FQHCs outside of LA County. Does apply to Imperial, Riverside/San Bernardino, Los Angeles, Sacramento, San Diego counties.
Molina	Medi-Cal	HEDIS PCP P4P (Pay-for-Performance) Bonus Program 2021	The PCP P4P Program is effective as of 1/1/21 and requires a minimum of 200 Medi-Cal members to qualify for Cervical Cancer Screening (CCS) and A1c <8 performance bonus. No minimum on other measures below. <u>P4P Bonus measures include:</u> Los Angeles (LA) County: CCS ($25), CDC A1c<8 ($50), Prenatal Notification Form ($75 per form), CIS 10 ($100 for all immunizations completed). • FQHCs and Rural Health Centers in LA are eligible for this program. San Diego (SD) County: CCS ($25), CDC A1c<8 ($100), Prenatal Notification Form ($75 per form), CIS 10 ($100 for all immunizations completed). • 2021 Top Provider in each of the following measure receives $5,000 in 2nd reporting period (500 members minimum): CCS, CDC A1c<8 and CIS 10. • FQHCs and Rural Health Centers in SD, IM and IE are no longer eligible for this program but may have health center specific programs.

Incentives for Clinics/Health Centers – PROGRAMS (continued)			
Health Plan	**LOB**	**Program**	**Details**
Molina	Medi-Cal	HEDIS P4P Program (Pay-for-Performance) for **FQHC/RHCs** 2021 Applies to FQHCs outside of LA County only	**Molina Update 5-20-20** states that goals were reduced and payment was allowed even if the 50th percentile was not met. The member growth component has been removed. PMPM payment was changed to $3.00 PMPM. Minimum of 500 Molina Medi-Cal members needed. To qualify for any payment, all goals for "NCQA 2020 Threshold" for each measure must be met. This will trigger a $3.00 PMPM payment. Additional payment is then based on how many of the stretch goals are met and if the Member Satisfaction component is met. Payments will be paid annually after final HEDIS rates are announced. **2021** measures include BCS, CBP, CCS, CHL, CIS-10, CDC>9%, IMA-2, PPC Prenatal, PPC Postpartum, WCC-BMI, WCC-N, WCC-PA, W30A (0-15 mos.), W30B (15-30 mos.), WCV, CDF (Clinical Depression Screening and Follow-Up) and Lead Screening in Children. For questions, please email: MHCQuality@MolinaHealthCare.com. Please refer to JTF notice dated 1/31/2020. MCAS measures are listed here: https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.

Incentives for MEMBERS			
Health Plan	**LOB**	**Program**	**Details**
Alignment	Medicare	Jump Start Assessment (JSA) 2021	Eligible members who complete the Jump Start Assessment receive $20 on their Concierge Card. Patients receive initial assessment within the first 30-90 days of membership and annual wellness visits at Care Centers in Los Angeles, Stockton and Modesto. See https://www.alignmenthealthplan.com/members/find-a-care-center for details.
Alignment	Medicare	Member Rewards Program - Access on Demand Concierge Card 2021	Eligible members are automatically enrolled in the Concierge program and earn rewards for completing select wellness behaviors and preventive screenings between 01/01/2021 and 12/31/2021: Colorectal Cancer Screening ($10), DEXA Scan ($50), Mammogram ($25) and Flu Shot ($5). There may be additional rewards available to members throughout the year. For certain plans, the card also may also provide a monthly grocery benefit ($10 to $20) and a monthly benefit for over-the-counter (OTC) medicine and health aid benefit items such as cold and allergy medicine, denture products and diabetes care accessories at participating drug stores. Contact 833-242-2223 for further information.
Anthem Blue Cross	Commercial and Covered CA	Member Incentive Program – Preventive Care 2021	Adult and pediatric members who receive a mailing from Anthem with screenings due receive a **$25** Visa gift card for each preventive screening completed for the following HEDIS measures: CDC A1c Test, CDC Eye Exam, CDC Nephropathy, BCS, CCS and WCV (age 3-21). Incentives are offered during June to December (Eye, CCS, A1c and BCS) or May to December (Nephropathy, WCV). Covered CA members who complete their mammogram will receive a **$50** gift card.

Incentives for Members (continued)			
Health Plan	**LOB**	**Program**	**Details**
Anthem Blue Cross	Covered CA	Blood Pressure Member Incentive Program – Hypertension 2021	Members with a diagnosis of hypertension with high blood pressure readings are mailed blood pressure monitors and given four $25 gift cards ($100 total) for 4 follow-up visits for hypertension management in the measurement year. This is a limited program that is offered during April to December 2021.
Anthem Blue Cross	Medi-Cal	Healthy Rewards Program 2021	Incentives are given based on claims data and loaded into the member's Healthy Rewards account for the following HEDIS measures and services: $25: WCV age 3-21, CIS10, IMA2, CHL, CDC A1c, Prenatal $50: BCS, CCS, Postpartum $40 ($10 each): High blood pressure medication refill, ADHD medication management, Antidepressant medication management $80 ($10/8 visits): W30
Blue Shield Promise and Blue Shield Commercial	Medicare	Member Incentive Program 2021	Gift card to members for completing healthcare activities for 10 measures through self-attestation: (1) $25 for Annual Wellness Visit, (2) $25 for Diabetes Eye Exam, (3) $25 for Diabetes A1c Test, (4) $50 for Breast Cancer Screening; (5) $50 for Colorectal Cancer Screening; (6) $10 for Annual Flu Vaccine; (7) $25 for Bone Density Test; (8) $10 for Statin Treatment Review; (9) $5 for Medication Review; (10) $10 for Pain Screening. Medicare members can learn more at: www.blueshieldca.com/promise/appreciation. For questions email: MedicareStarRating@blueshieldca.com.
Brand New Day	Medicare	Rewards Plus Program 2021	Gift cards for completing preventive screening: $50 for Annual Wellness Exam, (2) $10 for Health Risk Assessment, (3) $10 for annual exercise plan, (4) $25 for mammogram, (5) $25 for colonoscopy or $10 for stool test, (6) $25 for diabetic members who have A1c, eye exam and nephropathy, and (7) $25 for weight management program for members with a BMI greater than 30. Rewards are loaded on a Rewards Plus Card to use at selected retailers for health related and personal care items. Call 866-255-4795 for questions.
Health Net	Medi-Cal	Medi-Cal Reward Cards Program	Members receives information from Novu Health vendor by print communication, email and online. Member attests to completion of screening and gift cards are mailed by Health Net. Rewards include: $25 for Adolescent Well Care, $10 x 6 for Well Child in first 15 months of life, $25 for Asthma Medication Ratio and $15 for Flu. For questions, email: HEDIS@healthnet.com.
Health Net	Medi-Cal Medicare	Point-of-Care Reward Card Program	Select health centers receive $20 gift cards for the measures below and give them to the member after the visit is completed at the clinic. A log of cards distributed to members is required. Measures: Flu Vaccine, Mammography, Bone Mineral Density, HRA or Personal Wellness Assessment (SNPs only), Colorectal Cancer Screening, CDC Eye, CDC A1c and Annual Wellness Visit. *Health Centers who use this program will opt out of the Novu incentives and mailings above for 2020.*

Incentives for Members (continued)			
Health Plan	**LOB**	**Program**	**Details**
LA Care	Medi-Cal, Covered CA, Cal-MediConnect	Healthy Mom Program 2021	This member incentive program aids in educating mothers about the importance of the postpartum visit, provides appointment reminders, and creates a positive relationship between mothers and the health plan. MCLA, L.A. Care Covered and Cal MediConnect women who have just given birth can receive a $40 gift card incentive for attending their postpartum appointment 21-56 days after delivery.
LA Care	Medi-Cal	Family Resource Center New Member Orientation 2021	L.A. Care Medi-Cal members can receive a $10 gift card for attending a Family Resource Center (FRC) orientation, which provides information on the various offerings at L.A. Care's six FRC locations. L.A. Care members can receive a gift card once for attending the Member Orientation. One gift card per household. L.A. Care member (or guardian) must be present.
LA Care	Covered CA	Cerner My Health in Motion Rewards Program 2021	The program is designed to encourage LACC members to participate in online based health and wellness activities, including completing a health assessment survey, enrolling in health coaching, and completing weight management and smoking cessation workshops. Enrolled members receive varying points for each completed activity, which can be used to redeem gift cards instantly. 1 point = $1 in value.
LA Care	Cal-MediConnect, Covered CA	Follow-up after Hospitalization (FUH) Member Incentive 2021	The goal of the FUH Member Incentive is to increase the 30-day compliance rate for a follow-up visit with a provider after the member is discharged from an inpatient facility with a principle diagnosis for a mental health disorder. The member will receive a $25 debit card when they go in for their visit. This program is in collaboration with Beacon.
LA Care	Medi-Cal, Covered CA, Cal-MediConnect	Healthy Pregnancy and Healthy Heart Member Survey Incentive Program 2021	In response to COVID-19, L.A. Care Health Plan launched the Healthy Pregnancy Health Heart Program to support providers in delivering telehealth services to pregnant members and members diagnosed with Congestive Heart Failure (CHF). L.A. Care provided a blood pressure monitor & cuff and a weight scale to members in order to allow for remote monitoring and reporting of blood pressure and weight. In order to evaluate the program, the first 100 members who complete a survey mailed out by L.A. Care will receive a $10 debit card.
WellCare (Easy Choice)	Medicare (AHISP, Bella, FCS and Global)	Healthy Rewards Program	Member receives reward amounts in a Walmart, Subway or reloadable Visa prepaid card as follows: Annual wellness ($50), arthritis management ($25), bone density test ($50), BCS ($25), COL ($25-$50), Diabetic A1c test ($25), Diabetic eye exam ($25), Diabetic kidney exam ($25), flu shot ($10) and taking care of your overall health ($10). https://wellcare.com/california. 888-283-8064. Brochure available upon request.

Please submit any additions or comments to: qualitymeasures@medpointmanagement.com.

HEDIS Measures to Automate in EMR

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Initials	Measure	Code	Description
CBP CDC9	Controlling High Blood Pressure Comprehensive Diabetes Care - BP Control <140/90 * Encounter must include code for outpatient, telephone or nursing facility visit, online assessment or remote blood pressure monitoring.	3074F	Systolic <= 129
		3075F	Systolic = 130-139
		3077F	Systolic >= 140 (noncompliant)
		3078F	Diastolic <= 79
		3079F	Diastolic = 80-89
		3080F	Diastolic >= 90 (noncompliant)
CDC1	Comprehensive Diabetes Care - HbA1C Test	3044F	A1c <= 6.9%
		3051F	A1c = 7.0% - 7.9%
		3052F	A1c = 8.0% - 9.0% (compliant for some programs)
		3046F	A1c > 9.0% (noncompliant)
COA2	Care for Older Adults - Medication review - **both codes**	1159F	Medication list present in record
		1160F	Medication reviewed
COA4	Care for Older Adults - Pain assessment	1125F	Pain present
		1126F	Pain not present
COA3	Care for Older Adults - Functional status assessment	1170F	Functional Status Assessment done
COA1	Care for Older Adults - Advance Care Plan	1157F	Advance Care Plan documented in chart
		1158F	Advance Care Plan discussed
WCCA	Weight Assessment and Counseling - BMI percentile - age 3-17	Z68.51	< 5th percentile for age
		Z68.52	= 5th to 84.99th percentile for age
		Z68.53	= 85th - 94.99th percentile for age
		Z68.54	>= 95th percentile for age
WCCB	Weight Assessment and Counseling - Nutrition	Z71.3	Dietary counseling and surveillance
WCCC	Weight Assessment and Counseling - Physical Activity	Z71.82	Exercise counseling
		Z02.5	Sports Physical
W30A W30B	Well-Child Visits First 30 Months - Age 0-15 months Well-Child Visits First 30 Months - Age 15-30 months	Z00.121	Encounter for routine child health examination with abnormal
		Z00.129	without abnormal findings (age 0-17)
		99381	age <1 year new patient
		99391	age <1 year established patient
		99382	age 1-4 new patient
		99392	age 1-4 established patient
WCV	Child and Adolescent Well-Care Visits - age 3-21	Z00.121	Encounter for routine health examination with abnormal findings (age 0-17)
		Z00.129	without abnormal findings (age 0-17)
		Z00.00	with abnormal findings (age 18+)
		Z00.01	without abnormal findings (age 18+)
		Z02.5	Sports Physical
		99382	age 1-4, new patient
		99392	age 1-4, established patient
		99383	age 5-11, new patient
		99393	age 5-11, established patient
		99384	age 12-17, new patient
		99394	age 12-17, established patient
		99385	age 18+, new patient
		99395	age 18+, established patient

Note: Z-codes are measure compliant when used with visit codes 99381-99395 and 99202-99215, subject to any health plan program limitations.

04/16/2021

Introducing the ALWAYS Satisfied Patient System: Your guide to improving patient perception and CAHPS

Success Comes From Your Satisfied Patients

Our shared goal is ALWAYS providing high quality patient care. Every year, CMS may send your patient a CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey asking patients to rate their experiences and overall satisfaction **with the care you provided.** The answers to these questions will impact Alignment's Overall Star Rating, which may impact payment from your medical group.

Incorporating the ALWAYS Satisfied Patient System in your offices can help your patients always answer ALWAYS!

The ALWAYS Satisfied Patient System

- ✓ ALWAYS reserve daily time blocks for walk-in and urgent same-day appointment ensuring your patients that you are ALWAYS there for them
- ✓ ALWAYS provide the phone number for a 24/7 or after-hours Urgent Care facility on your answering service. The Alignment Health Plan Concierge team is also available 24/7 at **(833) 242-2223 (TTY: 711)**
- ✓ ALWAYS set expectations for in-office wait time by providing patients with estimated wait time and updated during check-in; this can improve perceived wait time.
- ✓ ALWAYS have the patient leave the office with something in-hand such as an appointment reminder card or copy of a referral to decrease delays in care and improve perception of getting care as soon as needed.
- ✓ ALWAYS have the office staff assist in scheduling a specialty appointment or follow-up visit prior to the patient leaving the office.
- ✓ ALWAYS review/update the patient's medication list at every visit – make sure the patient understands the prescribed medications and encourage adherence.
- ✓ ALWAYS set expectation with patients on receiving their test results. Set a practice goal to communicate test results to patients within 24 hours of receipt.
- ✓ ALWAYS ask the patient if they have any questions and address any additional concerns before the end of the appointment.

ALIGNMENT HEALTH PLAN

Introducing the Healthy Outcomes System: Your guide to improving patient health outcomes and HOS

Success Comes From IMPROVING Your Patients Health

Our shared goal is IMPROVING patient health. Every year, CMS may send your patient a Health Outcomes Survey (HOS) asking patients to evaluate their health and **recall the health discussions they had with you**. The answers to these questions will impact Alignment's Overall Star Rating, which may impact payment from your medical group.

Practicing the Healthy Outcomes System can help your patients ALWAYS respond positively!

The Healthy Outcomes System

- ✓ IMPROVE physical health by establishing health interventions, such as monthly physical therapy, as part of their care plan.
- ✓ IMPROVE health habits with goal setting and action plans to help patients take active roles in improving their health. Set follow-up appointments for goal check-ins.
- ✓ IMPROVE emotional health by educating patients on staying positive, practicing mindfulness, getting enough sleep, eating healthy, limiting alcohol, and staying connected with loved ones.
- ✓ IMPROVE mental health by referring patients to behavioral health services when clinically appropriate.
- ✓ IMPROVE physical health by setting weight-loss, fitness, and mobility goals. Alignment's ACCESS On-Demand Concierge team is available 24/7 at **(833) 242-2223 (TTY: 711)** to provide a list of no-cost gym memberships to help patients reach these goals.
- ✓ IMPROVE self-sufficiency by referring patients with limited or decreased mobility to physical therapy to learn safe/effective exercises.
- ✓ IMPROVE patient understanding of how to control leakage of urine by educating them on treatment options such as medication, engagement in bladder training exercises, or surgery.
- ✓ IMPROVE patient safety by reducing fall risk! Encourage patients to remove throw rugs, clutter, and tripping hazards. Advise proactive solutions such as handrails on stairways, grab bars in bathrooms, non-slip shower mats, and use of nightlights throughout the home.
- ✓ IMPROVE financial well-being. Alignment's ACCESS On-Demand Concierge team is available 24/7 at **(833) 242-2223 (TTY: 711)** to provide patients with their Over-The-Counter allowance for help with obtaining personal care items, hearing aids, or other health supplies.

Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Provider Bulletin
March 2021

Access to care standards

Participating providers are responsible for offering members access to covered services 24/7. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. Providers are also required to meet appointment access standards as described below.

After-hours calls:

- The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be immediately directed to dial **911** or to proceed directly to the nearest hospital emergency room.
- If staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct members with emergency healthcare needs to dial **911** or go directly to the nearest hospital emergency room. The message must also give members an alternative contact number so they can reach the primary care physician (PCP) or on-call provider with medical concerns or questions.
- Non-English-speaking members who call their PCP after hours should expect to get language-appropriate messages. In the event of an emergency, these messages should direct the member to dial **911** or proceed directly to the nearest hospital emergency room.
- In a nonemergency situation, members should receive instruction on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter. All calls taken by an answering service must be returned.

Appointment access

Healthcare providers must make appointments for members from the time of request as follows:

General appointment scheduling	
Emergency examination	Immediate access, 24/7
Urgent (sick) examination	Within 48 hours of request if authorization is not required or within 96 hours of request if authorization is required, or as clinically indicated
Nonurgent (sick) examination	Within 48 to 72 hours of request or as clinically indicated
Routine primary care examination (nonurgent)	Within 10 business days of request
Nonurgent consults/specialty referrals	Within 15 business days of request
Nonurgent care with nonphysician mental health providers (where applicable)	Within 10 business days of request
Nonurgent ancillary	Within 15 business days of request
Mental health appointment, nonphysician	Within 10 business days of request

Services for members under the age of 21 years	
Initial health assessments:	
Children from birth to 20 years of age	Within 120 days of enrollment
Preventive care visits	Within 14 days of request

https://providers.anthem.com/ca

ACAPEC-2797-21 March 2021

Services for members 21 years of age and older	
Initial health assessments	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Routine physicals	Within 30 days of request
Prenatal and postpartum visits	
1st and 2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancy	Within 3 days of identification
Postpartum	Between 21 and 56 days after delivery
Long-term services and supports	
Skilled nursing facility	• Rural and small counties — within 14 business days of request • Medium counties — within 7 business days of request • Small counties — within 5 business days of request
Intermediate care facility/developmentally disabled (ICF-DD)	• Rural and small counties — within 14 business days of request • Medium counties — within 7 business days of request • Small counties — within 5 business days of request
Community-based adult services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2021 level

Specialists

The following guidelines are in place for our specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within 15 business days of receiving the request.
- A copy of the medical records and/or results of the visit should be sent to the PCP's office to allow continuity of care.

Wait times

When a provider's office receives a call from an Anthem Blue Cross (Anthem) member during regular business hours for assistance and possible triage, the provider or another healthcare professional must either take the call or call the member back **within 30 minutes** of the initial call.

When an Anthem member arrives on time to an appointment, the member should be seen within 15 minutes of the scheduled appointment.

When Anthem members and/or prospective members call a physician's office, they should not be placed on hold for longer than 10 minutes.

Noncompliance

Please ensure that you comply with the standards described; compliance with these standards is a contractual requirement. Anthem monitors compliance through a number of mechanisms, including annual telephonic surveys, to determine if participating provider offices meet the above standards. For additional details, please review the provider operations manual at **https://providers.anthem.com/california-provider/resources/manuals-policies-guidelines**.

Immunization and CAIR2 Tip Sheet

Anthem BlueCross

California Immunization Coalition (CIC) has information on how to boost vaccinations in response to low vaccination rates seen during the COVID-19 outbreak.

Don't Wait Vaccinate Campaign. **https://www.immunizeca.org/dontwaitvaccinate**

CAIR2 Tips

Anthem Blue Cross (Anthem) receives immunization data files from CAIR2 to supplement our claims and encounter files for the HEDIS® Immunization measures, improve your Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) HEDIS scores by entering all immunizations into CAIR2 (see links to CAIR2 below) and reviewing the following suggestions to improve your rates:

Main CAIR2 site:
http://cairweb.org

CAIR2 *List of Frequently Asked Questions (FAQ)*:
http://cairweb.org/cair-user-faqs

CAIR2 staff help:
http://cairweb.org/cair-regions

Assign an immunization coordinator at the clinic or site.

Utilizing *CAIR2 Reports*:
http://cairweb.org/cair2-training-resources

Locked records: Anthem cannot get immunization information when the CAIR2 entry is *locked*. Make sure that the parent understands the reason for sharing their child's immunization status with other providers and their health plan. If they do choose to opt out of sharing, revisit the question at a later date.

If the parent does not have information on the birth HepB, check for this vaccine under the child's last name, DOB, and *BABY* in CAIR2 and then reconcile.

Enter **birth HepB** and any historical vaccines that are not listed in CAIR2.
http://cairweb.org/docs/CAIR2_Guide_Historical_Immunizations.pdf

Explore a data exchange between your electronic health record and CAIR2. CAIR2 has dedicated staff to assist with this process. Bidirectional data exchange allows immunizations that the office gives to be automatically sent to CAIR2 and any immunizations that are in CAIR2 to be sent back to the patient medical record.
http://cairweb.org/data-exchange

If your office manually enters immunizations into CAIR2, make sure that the name is spelled correctly, all antigens in multi-vaccine formularies are entered separately, and that the *Disclose* box has been checked.

Have a staff member do a chart/CAIR2 reconciliation to ensure that all vaccines that are in the medical record are listed in CAIR2 and vice versa.

Make sure that staff use the name on the child's Anthem ID card (Medi-Cal card) when creating their CAIR2 registration.

Tips for Immunizations

Schedule the next appointment before the parent leaves the office for time-sensitive vaccine series.

Rotavirus — 2- to 3-dose series needs to be completed by 8 months of age. Schedule the next vaccine appointment during check-out.

Pneumococcal-13 vaccine — 4-dose series recommended. Schedule a follow-up appointment during check-out.

Influenza — First time flu vaccines need two doses. Schedule the second dose four weeks or more after the first dose.

Target 9 to 11 year olds first HPV for IMA and 11 to 12 year olds to make sure the second HPV is completed by age 13. The minimum interval for the second dose of HPV is five months.

Use electronic medical record alerts for immunizations in the health maintenance section to serve as reminders. Consider a Population Health platform to indicate needed or overdue immunizations.

Perform previsit chart immunization record reviews prior to well-visits to review all vaccines that are due.

Consider Standing Orders for immunizations: **https://www.immunize.org/standing-orders**

Recommended Child and Adolescent Immunization Schedule can be accessed at **https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**.

Common CAIR Review Findings

- PPSV23 entered instead of PCV13
- Td entered instead of Tdap
- Tdap given before age 10
- Tdap only given prior to seventh grade when adolescent goes to public health or a pharmacy in order to start the school year.
- Verify correct vaccine and CPT® code(s) are entered into CAIR2 and claim/encounter file.

HEDIS Measures for Immunizations

Childhood Immunization Status (CIS) Combo 10 to be completed on or before second birthday:

Vaccine	Count of doses	Vaccine	Count of doses	Vaccine	Count of doses	Vaccine	Count of doses
DTaP	4	**Influenza**	2	**VZW**	1	**Rotarix***	2
IPV	3	**Hep B**	3	**Hep A**	1	**RotaTeq***	3
HIB	3	**PCV13**	4	**MMR**	1		

* Rotavirus vaccine series must be completed by 8 months of age.

Immunizations for Adolescents (IMA) Combo 2 (to be complete on or before the thirteenth birthday):

Vaccine	HEDIS age range	Vaccine	HEDIS age range	Vaccine	HEDIS age range
Tdap	10 to 13 years	**MCV**	11 to 13 years	**HPV** (2 doses, 6 months apart)	9 to 13 years

https://providers.anthem.com/ca

ACAPEC-2623-20

Healthy Rewards Program

The Healthy Rewards Program helps you increase your quality scores and our members earn rewards.

Through our Healthy Rewards Program, members can earn $10 to $50 for getting certain health services. At the same time, you increase your practice's quality scores by providing members with the vaccinations, screening visits and medications they need.

When an Anthem Blue Cross (Anthem) member meets the eligibility criteria for the activities listed below and completes the service, they will earn the corresponding reward amount after the service is confirmed by the Claims department. The reward dollars are loaded into the member's Healthy Rewards account on the online portal and can be redeemed for a variety of retail gift cards. **Please ensure you file your claims timely so the members can receive their rewards.**

To help your practice, all Healthy Rewards activities are tied to HEDIS® scores and/or health initiatives. They include:

Healthy activities	Who's eligible	Reward	Frequency
Note: Incentive eligibity varies by county and members should enroll in the program to see which rewards they are able to earn.			
Child and Adolescent Wellness Visit	M, F, ages 3 to 21	$25	1 per 12 months
Childhood Immunization Status — Combo 10	M, F, ages 0 to 1 (stops at 2nd birthday)	$25	1 per member
Immunizations for Adolescents — Combo 2	M, F, ages 11 to 12 (stops at 13th birthday)	$25	1 per member
Breast Cancer Screening	F, ages 50 to 74	$50	1 per 24 months
Chlamydia Screening	F, ages 16 to 24	$25	1 per 12 months
Cervical Cancer Screening	F, ages 21 to 64	$50	1 per 36 months
Diabetic A1c Screening	M, F, ages 18 to 75	$25	1 per 12 months

Anthem® BlueCross®

Healthy activities	Who's eligible	Reward	Frequency
Note: Incentive eligibity varies by county and members should enroll in the program to see which rewards they are able to earn.			
High Blood Pressure Medication Refill	M, F, ages 18 to 75	$10, max $40	1 per quarter
ADHD Medication Management	M, F, ages 6 to 12	$10, max $40	1 per quarter
Antidepressant Medication Management	M, F, ages 18 and older	$10, max $40	1 per quarter
1st Prenatal Care Visit	F, ages 13 to 55	$25	1 per pregnancy
Postpartum Care Visit	F, ages 13 to 55	$50	1 per pregnancy
Well-Child Visits in the First 30 Months of Life	M, F, ages 0 to 30 months	$10, max $80	6 times in 15 months; 2 times between 15 and 30 months

Please remind your Anthem patients about the Healthy Rewards Program at their next office visit. By working together, we can encourage good habits and help our members get the right care, and you can improve your quality scores.

If your Anthem patients have questions regarding the program, please have them call Healthy Rewards at **1-888-990-8681 (TTY 711)** or visit the Benefit Reward Hub at **https://anthem.com/ca/medi-cal** for more information.

To earn rewards, members must enroll in the program prior to or within 30 days of the date of service.

https://providers.anthem.com/ca

brand new day
HEALTHCARE YOU CAN FEEL GOOD ABOUT

HEDIS Stars Measures Reference Guide for 2020-2021

Brand New Day requires all contracted providers and groups to adhere to the current NCQA HEDIS guidelines for preventive care screenings & CMS best practices for managing chronic disease. Below is an outline of primary STAR & HEDIS measures to meet criteria and specific ICD-10, CPT coding.

Breast Cancer Screening (BCS)

The percentage of women age 50–74 who had a mammogram to screen for breast cancer within the measurement year.

Measure Compliance:	Exclusions:
CPT: 77055–77057, 77061–77063, 77065 –77067 **HCPCS:** G0202, G0204, G0206 Preventive care screening to detect breast cancer in women. All types and methods of mammograms qualify.	• Hx bilateral mastectomy or unilateral mastectomy **ICD-10:** Z90.13 or Z90.11 Right, Z90.12 Left **IDC-10 PCS:** 0HTV0ZZ, 0HTU0ZZ, 0HTT0ZZ **CPT:** 19180, 19200, 19220, 19240, 19303 - 19307 • Age 66 or older with advanced illness and frailty • Hospice

Colorectal Cancer Screening (COL)

The percentage of members age 50–75 who had screening for colorectal cancer.

Measure Compliance:		
Colonoscopy during measurement years or the 9 years prior to the measurement year	**CPT:** 44388- 44394, 44397, 44401-44408, 45355, 45378-45393, 45398 **HCPCS:** G0105, G0121	
FOBT (g-FOBT or FIT) during measurement year	**CPT:** 82270, 82274	**HCPCS:** G0328
FIT-DNA (Cologuard®) during measurement year or the two years prior to measurement year	**CPT:** 81528	**HCPCS:** G0464
Flexible Sigmoidoscopy during measurement year or the four years prior to measurement year	**CPT:** 45330– 45335, 45337–45342, 45345-45347, 45349, 45350	**HCPCS:** G0104
CT colonography during the measurement year or the four years prior to measurement year	**CPT:** 74261, 74262, 74263	

Exclusions:
- Colorectal cancer:
  - **ICD-10:** Z85.038 (Personal hx of other malignant neoplasm of large intestine)
  - **ICD-10:** Z85.048 (Personal hx of other malignant neoplasm of rectum, rectosigmoid junction, and anus)
  - **ICD-10:** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5,
  - **ICD-9:** 153.0-154.1, 197.5, V10.05, V10.06
  - **HCPCS:** G0213-G0215, G0231
- Total colectomy:
  - **CPT:** 44150 – 44153, 44155 – 44158, 44210 – 44212
  - **ICD-10:** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ
  - **ICD-9:** 45.81, 45.82, 45.83
- Age 66 or older with advanced illness and frailty Hospice

Comprehensive Diabetes Care (CDC)

Diabetic Control: Member identified by two outpatient visits with a diabetes diagnosis, or one acute inpatient encounter with a diabetes diagnosis; or pharmacy claims for insulin or oral anti-diabetic agents during the measurement year or the year prior to the measurement year.

Exclusions:
- Gestational diabetes or steroid-induced diabetes during measurement year or the year prior to measurement year
- Age 66 or older with advanced illness and frailty

HgbA1c Good Control

The percentage of members age 18-75 with diabetes whose most recent HbA1c test during the measurement year ≤ 9%.

Measure Compliance: The most recent HgbA1c value ≤ 9%. Medical record must include a note with date when HbA1c test was done with a distinct numeric result.

HbA1c Test Coding: **CPT:** 83036, 83037 **CPT II:** 3044F, 3046F, 3051F, 3052F

Dilated or Retinal Eye Exam

The percentage of members age 18-75 with diabetes who had screening or monitoring for diabetic retinal disease.

Measure Compliance: Screening or monitoring for diabetic retinal disease, including diabetics who have had a retinal or dilated eye exam by an optometrist or ophthalmologist in the measurement year, **or** had a negative retinal or dilated eye exam(negative for retinopathy) by an optometrist or ophthalmologist in the year prior to the measurement year.

Documentation in the medical record must include one of the following:
- A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was done and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an optometrist or ophthalmologist reviewed the results.
- Documentation of a negative retinal or dilated eye exam by an optometrist or ophthalmologist in the year prior to the measurement year; results indicating retinopathy was not present.
- Documentation anytime in the member's history of evidence that the member had bilateral eye enucleation or acquired absence of both eyes.

Dilated Retinal Screening: **CPT:** 67028-67113, 67121-67221, 67227-67228, 92002-92014, 92018, 92019, 92134, 92225-92240, 92250-92260 **HCPCS:** S0620, S0621, S3000
CPT II (with evidence of retinopathy)**:** 2022F, 2024F, 2026F **CPT II** (without evidence of retinopathy)**:** 2023F; 2025F; 2033F

Dilated Retinal Screening – Negative in prior year: **CPT II:** 3072F

Unilateral Eye Enucleation: **CPT:** 65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114
ICD-10: (Left) 08B10ZX, 08B10ZZ, 08B13ZX, 08B13ZZ, 08B1XZX, 08B1XZZ **(Right)** 08B00ZX, 08B00ZZ, 08B03ZX, O8B03ZZ, 08B0XZX, 08B0XZZ

Nephropathy Screening

The percentage of members age 18-75 with diabetes who had nephropathy screening or monitoring test during the measurement year or evidence of nephropathy during the measurement year.

Measure Compliance:

Any of the following meets criteria for a nephropathy screening or monitoring test or evidence of nephropathy:
- A ***urine*** test for albumin (micro albumin) or protein during the measurement year; documentation must include a note indicating the date the urine test was done and the result or finding. One of the following will meet criteria: 24-hour urine for albumin or protein; time urine for albumin or protein; spot urine (urine dipstick or urine test strip) for albumin or protein; urine for albumin/creatinine ratio; 24-hour urine for total protein; random urine for protein/creatinine ratio
- Documentation of a visit to a nephrologist
- Documentation of a renal transplant
- Documentation of medical attention for nephropathy includes any of the following documented in the measurement year: Nephropathy, end-stage renal disease (ESRD), chronic renal failure, stage 4 chronic kidney disease, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis, nephrectomy kidney transplant
- Documentation includes a note that member received a prescription for an ACE inhibitor/ARB or has taken an ACE inhibitor/ARB in the measurement year

Urine Protein Test: **CPT:** 81000-81005, 82042-82044, 84156 **CPT II:** 3060F, 3061F, 3062F

Nephropathy Treatment: **CPT II:** 3066F, 4010F
ICD-10: E08.21-E08.29, E09.21-E09.29, E10.21-E10.29, E11.21-E11.29, E13.21-E13.29, I12.0-I15.1, N00.0-N08, N14.0-N14.4, N17.0-N19, N25.0-N26.9, Q60.0-Q61.9, R80.0-R80.9

Stage 4 Chronic Kidney Disease: **ICD-10:** N18.4 **ESRD:** N18.5, N18.6, Z99.2 **Nephrectomy**: **CPT:** 50340, 50370 **ICD-10**: 0TB00ZX, 0TB00ZZ, 0TB03ZX, 0TB03ZZ, 0TB04ZX, 0TB04ZZ, 0TB07ZX, 0TB07ZZ, 0TB08ZX, 0TB08ZZ, 0TB10ZX, 0TB10ZZ, 0TB13ZX, 0TB13ZZ, 0TB14ZX, 0TB14ZZ, 0TB17ZX, 0TB17ZZ, 0TB18ZX, 0TB18ZZ

Dialysis: **CPT**: 90935, 90937, 90945, 90947, 90997, 90999, 99512 **HCPCS**: G0257, S9339 **ICD-10:** 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z

Rheumatoid Arthritis (ART)

The percentage of members age 18 and older as of December 31of the measurement year, who were diagnosed rheumatoid arthritis and dispensed prescription for a disease-modifying anti-rheumatic drug.

Identifying Event	Measure Compliance	Exclusions:
Two dates of service on or between January 1 and November 30 of measurement year. *OP visit with any diagnosis of RA *Non-acute IP any diagnosis of RA *Telephone visit assessment with a RA diagnosis **Rheumatoid Arthritis** ICD-10: M05.00-M06.39 M06.80-M06.9	**Measure Compliance:** Dispensed at least one ambulatory prescription for DMARD. This measure requires proof that the member received the medication, which can be through a prescription claim or documentation indicating dispensing or infusion administration date. Prescribing intent in medical record will not meet the requirement for this measure. • Qualifying the diagnosis can be completed with a CCPA lab or Rheumatologist consult report **DMARD** • HCPCS: J0129, J0135, J0717, J1438, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310, J9311, J9312, Q5102, Q5103, Q5014, Q5109 • Rx claims information for the following medications: sulfasalazine, cyclophosphamide, hydroxychloroquine, auranofin, leflunomide, penicillamine, methotrexate, abatacept, adalimumab, anakinra, certolizumab, certolizumab pegol, etanercept, golimumab, infliximab, rituximab, sarilumab, tocilizumab, azathioprine, cyclosporine, mycophenolate, tofacitinib, minocycline, baricitinib	• HIV anytime during the member's history through December 31 of measurement year • Pregnancy any time during measurement year • Age 66 or older with advanced illness and frailty

Osteoporosis Management in Women with a Fracture (OMW)

The percentage of women age 67-85 who suffered a fracture and who had either a bone mineral density scan or a prescription for a drug to treat osteoporosis in the six months after the fracture.

Identifying Event	Measure Compliance:	Exclusions:
Woman, age 67-85 years, who suffered a fracture	Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following: • BMD test or osteoporosis therapy in any setting within 180-days (6 months) after the fracture **Bone Mineral Density Test** CPT: 76977, 77078, 77080, 77081, 77082, 77085, 77086 ICD-9: 88.98 ICD-10 PCS: BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1 **Osteoporosis Medication** HCPCS: J0897, J1740, J3110, J3489 Rx Claims information for osteoporosis therapy: • Bisphosphonates: alendronate, alendronate-cholecalciferol, risedronate, zoledronic acid, ibandronate • Other agents: abaloparatide, denosumab,raloxifene, teriparatide	• Had BMD test within the 24 months prior to the fracture • Received osteoporosis therapy during the 12 months prior to the fracture • Received a dispensed Rx or had an active Rx to treat osteoporosis during the 365 days prior to the fracture • Age 67-80 with advanced illness and frailty

Flu Shot

The percentage of sampled Medicare members who received an influenza vaccination in the measurement year.

Health Plan CAHPS question: Have you had a flu shot during the flu season? Survey period is a sample from March through early June, each year.

Statin Therapy for members with cardiovascular disease (SPC)

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

Measure Compliance: Dispensed at least one high or moderate intensity statin medication during the measurement year.

Intensity	Prescription (Formulary Tier applies to generic formulation)	
High-intensity statin therapy	atorvastatin 40-80 mg amlodipine–atorvastatin 40-80 mg	simvastatin 80 mg rosuvastatin 20-40 mg ezetimibe–simvastatin 10-80 mg
Moderate-intensity statin therapy	atorvastatin 10-20 mg lovastatin 40 mg amlodipine–atorvastatin 10-20 mg ezetimibe–simvastatin 20-40 mg fluvastatin XL 80 mg fluvastatin 40 mg	simvastatin 20-40 mg rosuvastatin 5-10 mg pravastatin 40-80 mg pitavastatin 2-4 mg

Exclusions:

- Myalgia, myositis, or rhabdomyolysis during the measurement year
- **ICD-10:** G72.0, G72.2, G72.9, M60.8-M60.9, M62.82, M79.1-M79.18
- ESRD during measurement year or the year prior
- Cirrhosis during measurement year or the year prior
- Pregnancy, IVF or dispensed at last one Rx for clomiphene during the measurement year or the year prior
- Age 66 or older with advanced illness and frailty

Statin Therapy for Persons

The percentage of members age 40-75 who were dispensed at least two diabetes medication (oral hypoglycemic or insulin)

Numerator Compliance: At least one statin prescription (any intensity) dispensed in the measurement year

Statin Medications		
lovastatin	atorvastatin	simvastatin
pravastatin	rosuvastatin	
pitavastatin	fluvastatin	
Statin CombinationProducts		
atorvastatin and amlodipine	ezetimibe and simvastatin	

Exclusions:

- ESRD

Medication Adherence: Part D Pharmacy Quality Alliance measure

Eligible Population: The number of members who were dispensed two or more diabetes prescriptions, who received statin medication for the measurement year.

Adherence is calculated and benchmarked solely on pharmacy claims.

Exclusions:

- Members with ESRD, identified using ICD-10 codes and/or by the Rx HCC for dialysis status

Supplemental data use is not permitted for Part D measures.

Transitions of Care (TRC)

The percentage of discharges an inpatient facility stays between January 1 and December 1 of the measurement year for members age 18 and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

All documentation must come from the same outpatient medical record

Notification of Inpatient Admission

Documentation of receipt of notification of inpatient admission within 72 hours of admission

Measure Compliance: Documentation in the outpatient medical record must include evidence of receipt of notification (time/date stamped) of inpatient admission on the day of admission or the following day.

Examples: Communication between the emergency department (ED), inpatient providers or staff and the member's primary care physician (PCP) or ongoing care provider (e.g., phone call, email, fax).

Communication about the admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission via ADT alert system; or a shared electronic medical record.

Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.

Indication that the PCP or ongoing care provider placed orders for tests and treatments during the member's inpatient stay. Indication that the admission was elective and the member's PCP or ongoing care provider was notified or had performed a preadmission exam.

Receipt of Discharge Information

Documentation of receipt of discharge information within 72 hours of discharge

Measure Compliance: Evidence of the date when the documentation was received. Information must include practitioner responsible for member's care during the inpatient stay; procedure or treatment provided; diagnosis at discharge; current medication list; testing results or documentation of pending test or no test pending; instructions for patient care.

Examples: Discharge information may be included in a discharge summary or summary of care record or be in structured fields in an electronic health record.

Patient Engagement After Inpatient Discharge

Documentation of patient engagement (e.g., office visit, visit to the home, or telehealth) provided within 30 days after discharge. Does not count on date of discharge

Measure Compliance: Documentation in the outpatient record must include evidence of patient engagement within 30 days after discharge. Day of discharge does not count. Any of the following meet criteria: Outpatient visit (including office and home visits); telephone visit; or synchronous telehealth visit.

***If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria

CPT: Outpatient visits: 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483; Telephone visit: 98966-98968, 99441-99443; Transition of care management: 99496, 99495

HCPCS: G0402, G0438, G0439, G0463, T1015 **Rev Codes:** 0510-0517, 0519-0523, 0526-0529, 0982, 0983

Care for Older Adult

Eligible Population: Medicare Special Needs Plan members, 66 years and older as of December 31 of the measurement year.

Exclusions: Hospice

Medication Review

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.

Measure Compliance: Either of the following will meet the measure's criteria:

1) Medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist with the date it was performed (must be in the same medical record)
2) Notation that the member is not taking any medication and the date when it was noted

Medication Review: **CPT:** 90863, 99483, 99605, 99606 **CPT II:** 1160F **Medication List:** **CPT II:** 1159F **HCPCS:** G8427
Transitional Care Management Services during the measurement year: **CPT:** 99495, 99496

Functional Assessment

A functional status assessment during the measurement year, as documented through either administrative claim data or medical record review.

Measure Compliance: Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.
Documentation in the medical record must include one of the following:

- Result of assessment using a standardized functional status assessment tool, not limited to: SF-36®, ALSAR, ADLS, B-ADL, Barthel Index, EADL, ILS, Katz6 Index of Independence in ADL, Kenny Self-Care Evaluation, Klein-Bell ADL Scale, KELS, Lawton & Brody's IADL, PROMIS, Staying Healthy Assessment tool, 602A form

Functional Status Assessment: **CPT:** 99483 **CPT II:** 1170F **HCPCS:** G0438, G0439

Pain Assessment

At least one pain assessment during the measurement year; documented through either administrative claims data or medical record review.

Measure Compliance: Documentation in the medical record must include evidence of a pain assessment and the date it was performed. Notations for a pain assessment must include one of the following:

- Documentation that the member 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 numeric rating scales (verbal or written), FLACC, verbal descriptor scales, pain thermometer, pictorial pain scales, visual analogue scale, brief pain inventory, chronic pain grade, PROMIS pain intensity scale, PAINAD

Pain Assessment: **CPT II:** 1125F, 1126F

Advance Care Planning

Evidence of advance care planning, as documented through either administrative claims data or medical record review.

Measure Compliance: Documentation in the medical record of advance care planning. Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record during the measurement year
- Documentation of an advance care planning discussion with the provider and the date it was discussed. The discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan. The notation must be dated during the measurement year.

Examples: Advance directive, actionable medical orders, living will, surrogate decision-maker
HCPCS: S0257 **ICD-10:** Z66 **Assessment:** **CPT:** 99483, 99497 **CPT II:** 1123F, 1124F, 1157F, 1158F

Plan All-Cause Readmission

For members age 18 and older, 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.

Plan all cause readmission assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge.

** Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.

A lower rate indicates better performance.

Exclusions:

- Exclude an inpatient hospital stay if:
  - The principal diagnosis of pregnancy or a condition originating in the perinatal period is documented on the discharge claim
  - The member died during the stay
- Any first hospital stay if it is for:
  - Principal diagnosis of maintenance chemotherapy or rehabilitation
  - Organ transplant
  - Certain potentially planned procedures without a principal acute diagnosis

Controlling High Blood Pressure

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

Identifying Event:
Two or more visits on different dates of service up to 6/30 of the measurement year with a diagnosis of HTN during the measurement year or the year prior.

Any of the following code combinations meet criteria:

- Outpatient visit with a diagnosis of hypertension
- A telephone visit with a diagnosis of hypertension
- An online assessment with a diagnosis of hypertension

Measure Compliance:
Adequate control:
For BP to be identified as controlled, the systolic and diastolic BP must be lower than 140/90 mm HG.

The representative BP is the most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple blood pressures are recorded during an eligible visit, the lowest systolic and lowest diastolic BP reading will count toward the measure.

If you recheck a blood pressure during a visit due to an original elevated reading, please be sure to record the reading in the medical record!

BP readings from acute inpatient stay, ED visit, day of major diagnostic or surgical procedures, or member-reported **do not** count toward meeting the measure. It must be entered into a progress note.

BP readings can be captured through codes reported on claims or through medical record review.

Systolic: **CPT II:** 3074F, 3075F, 3077F
Diastolic: **CPT II:** 3078F, 3079F, 3080F

Exclusions:

- ESRD
- Kidney transplant
- Pregnancy during measurement year
- Age 66 or older with advanced illness and frailty

Frailty Frailty coded once during the measurement year.
Home visit for mechanical care (99504); Home visit for stoma care and maintenance including colostomy and cystostomy (99505) Cane (E0100, E0105); Walker (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149); Commode chair (E0163, E0165, E0167, E0168, E0169, E0170, E0171) Hospital bed (E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0270, E0290-E0297, E301-E0304); Oxygen (E0424, E0425, E0430, E0431, E0433, E0434, E0435, E0439, E0440-E0444) Rocking bed (E0462); Home ventilator (E0465, E0466); Respiratory assist device (E0470-E0472); Humidifier used with positive airway pressure device (E0561-E0562) Wheelchair (E1130, E1140, E1150, E1160, E1161, E1240, E1250, E1260, E1270, E1280, E1285, E1290, E1295, E1296, E1297, E1298) Skilled RN services related to home health/hospice setting (G0162, G0299, G0300, G0493, G0494, S9123, S9124, T1000 – T1005, T1019 – T1022, T1030, T1031) Physician management of member home care, hospice (S0271) Comprehensive management (S0311) Pressure ulcer (L89.119, L89.139, L89.149, L89.159, L89.209, L89.309, L89.899, L89.90) Muscle wasting and atrophy, not elsewhere classified, unspecified site (M62.50); Muscle weakness (generalized) (M62.81); Sarcopenia (M62.84) Ataxic gait (R26.0); Paralytic gait (R26.1); Difficulty in walking, not elsewhere classified (R26.2); Other abnormalities of gait & mobility (R26.89); Unspecified abnormalities of gait & mobility (R26.9) Age-related cognitive decline (R41.81); Weakness (R53.1); Other malaise (R53.81); Other fatigue (R53.83); Age-related physical debility (R54) Adult failure to thrive (R62.7); Abnormal weight loss (R63.4); Underweight (R63.6); Cachexia (R64) Fall (W01.0XXA, W01.0XXD, W01.0XXS, W01.10XA, W01.10XD, W01.10XS,W01.110A, W01.110D, W01.110S, W01.111A, W01.111D, W01.111S, W01.118A, W01.118D, W01.118S, W01.119A, W01.119D, W01.119S, W01.190A, W01.190D, W01.190S,W01.198A, W01.198D, W01.198S, W06.XXXA, W06.XXXD, W06.XXXS, W07.XXXA, W07.XXXD, W07.XXXS, W08.XXXA, W08.XXXD, W08.XXXS, W10.0XXA, W10.0XXD, W10.0XXS, W10.1XXA, W10.1XXD, W10.1XXS, W10.2XXA, W10.2XXD, W10.2XXS, W10.8XXA, W10.8XXD, W10.8XXS, W10.9XXA, W10.9XXD, W10.9XXS, W18.00XA, W18.00XD, W18.00XS, W18.02XA, W18.02XD, W18.02XS, W18.09XA, W18.09XD, W18.09XS, W18.11XA, W18.11XD, W18.11XS, W18.12XA, W18.12XD, W18.12XS, W18.2XXA, W18.2XXD, W18.2XXS, W18.30XA, W18.30XD, W18.30XS, W18.31XA, W18.31XD, W18.31XS,W18.39XA, W18.39XD, W18.39XS, W19.XXXA, W19.XXXD, W19.XXXS) Unspecified place in other specified residential institution as the place of occurrence of the external cause (Y92.199) Problems related to living in residential institution (Z59.3); Limitation of activities due to disability (Z73.6); Bed confinement status (Z74.01); Other reduced mobility (Z74.09) Need for assistance with personal care (Z74.1); Need for assistance at home and no other household member able to render care (Z74.2); Need for continuous supervision (Z74.3); Other problems related to care provider dependency (Z74.8); [Z74.9] Problem related to care provider dependency, unspecified (Z74.9) History of falling (Z91.81); Dependence on respirator [ventilator] status (Z99.11); Dependence on wheelchair (Z99.3); Dependence on supplemental oxygen (Z99.81) Dependence on other enabling machines and devices (Z99.89)

PROVIDER*Update*

Health Net®

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Improve ACEs Screening Training and Implementation with this Brief Survey

The survey will help remove barriers to training and improve provider education

Take one of the five-minute surveys described below. It will let us know whether you have taken the training to screen patients for adverse childhood experiences (ACEs). It will also help us better understand clinics' implementation and how we can support you.

Choose one survey

- If you **have taken** ACEs training and attested to completing the training, visit surveymonkey.com/r/DWTGBQD to take the survey.
- If you **have not taken** ACEs training and have not completed the attestation, visit surveymonkey.com/r/DD2LVYL to take the survey.

Individual survey responses are anonymous. Please respond to the survey by May 30, 2021.

Additional information

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries and more.

If you have questions regarding the information contained in this update, contact the Health Net* Medi-Cal Provider Services Center within 60 days at 800-675-6110.

Go to the online COVID-19 alerts page for info about COVID-19 vaccines!

At **provider.healthnet.com > *COVID-19 Updates > Health Net Alerts***, you will find information about COVID-19 vaccines. This includes COVID-19 vaccine coverage details, how to enroll to administer the COVID-19 vaccine, and COVID-19 vaccine reporting and coding requirements. Also, access key tips you can use to help talk with and answer questions from your patients about the COVID-19 vaccine, especially those who are hesitant to receive it.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ● Hospitals
- ● Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ● Molina
  - ● Riverside
  - ● Sacramento
  - ● San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES
provider_services@healthnet.com

800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS
provider.communications@healthnet.com

Health Net®

Medi-Cal Member Reward Cards Program

IMPROVE YOUR HEDIS® SCORES AND HELP YOUR MEMBERS EARN REWARDS

When patients close their care gaps, your HEDIS scores improve.

Help close patient care gaps

- Reach out to help schedule their office visits for the below health care activities.
- Educate and promote timely completion of these health care activities.

Activities that earn members rewards

In 2021, select Health Net* members who have yet to complete their 2021 health care activities outlined below will receive an offer to get a reward for completing a service. Health Net will share with members instructions on how to attest and redeem rewards.

To get their prepaid retailer gift card rewards, **members must complete and attest to the below health care activities by December 31, 2021.**

Targeted health care activities below are based on HEDIS measures.

Medi-Cal counties:
Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, and Tulare

Health care activities	Reward value
Breast Cancer Screening (BCS)[1]	**$25**
Cervical Cancer Screening (CCS)[1]	**$25**
Well Child Visits in the first 15 months of life +Flu Shot	**$10 for each of six recommended visits Plus an additional $15 for completing a flu shot**

(continued)

[1]Eligible members can receive only one incentive for completing this screening in 2021.

When members close their care gaps, they earn a prepaid gift card and your HEDIS scores improve.

PROVIDER COMMUNICATIONS

Coverage for every stage of life™

Each step counts

1 Program details.

Eligible members will receive information with complete instructions about the program through different channels of communication such as email, an automated call or a mailer.

2 Complete health care activities.

Members schedule suggested screenings and complete their health care activity by December 31, 2021.

3 Provide proof of completion.

Members can attest to completion of health care activities by telephone, mail or online. Doctor attestation is not required

4 Gift cards issued.

After attestation, members will have an option to choose a reward card for their completed health care activities.

For questions about the Health Net Medi-Cal Member Reward Cards Program, members can refer to the program details they will receive from Health Net or call the Member Services number listed on their ID card.

21-241m/FLY92424EH01w (3/21)

News

21-259m Medicare Star Ratings for 2021 and Beyond

Date: 03/31/21

This information applies to Physicians, Participating Physician Groups (PPGs), Hospitals, and Ancillary providers.

Changes and resources to help you provide patients the highest quality of care and experience

Medicare uses a Star Ratings System to measure how well Medicare Advantage (MA) and Part D plans perform. Medicare scores how well plans perform in several categories, including quality of care and customer service. Ratings range from one to five stars, with five being the highest and one being the lowest.

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) made some changes to the 2021 and 2022 Star Ratings. The changes ease data requirements to help data collection disruptions, reduce member interaction, and lessen provider office burden.

We support and work with providers in their efforts to focus on their patients and improve Star Ratings.

Member expectations

With CMS placing a heavier emphasis on member needs and experiences, it is important to understand members' expectations in order to deliver optimal personalized care and support. Strategies to increase member engagement will have significant impact on health plans' overall Star Ratings. Innovative tools and technology, expansion of telehealth services and utilization of virtual health platforms can help Medicare plans and providers improve quality measurement and reporting amid the COVID-19 pandemic.

Proposed new measure concepts

CMS solicited feedback on the two new measure concepts listed below, and continues to explore their utility and feasibility. If these measures are included in the CMS Star Ratings, they will be on the display page[1] for at least two years prior to becoming a Star measure.

- **Provider Directory Accuracy:** A new measure that considers what percent of plan information is inaccurate.

- **COVID-19 vaccination:** Pending rule making, include a COVID-19 vaccination measure on the display page for 2024 as a potential Star Ratings measure.

Codified changes to the Star Ratings Program

The changes below to the Star Ratings Program were proposed October 30, 2020 in the 2022 MA and Part D Advance Notice Part II. They were codified in the 2022 MA and Part D Final Rule announcement on January 15, 2021.

Table 1: CMS Reporting Year (RY) 2021- 2024

	RY2021	**RY2022**	**RY2023**	**RY 2024**
Healthcare Effectiveness Data and Information Set (HEDIS®) Data	2020 data not collected (use measurement year (MY) 2018 data)	MY 2020	MY 2021	MY 2022
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Data[2]	2020 data not collected (use survey year 2019 data)	2021	2022	2023
CAHPS measures			Increase weight to 4x	

It is important to note the quadruple-weight increase for the CAHPS measures in the Star Ratings, with greater emphasis on overall member experience. The increased weight from 2x to 4x began January 1, 2021 (impacting 2023 Star Ratings). Measures impacted include CAPHS, disenrollment, appeals, complaint tracking modules (CTMs), call center and complaints measures.

CMS also made the changes below to Star measure cut-point calculations:

- Removed Tukey outliers[3] from cut points beginning MY 2022.
- Cut-point guardrails[3] implementation delayed until the 2023 Star Ratings.

Star Ratings Measurement changes

Refer to the table below on changes to existing, display, retired and proposed measures for the upcoming years.

Table 2: Changes to Star Ratings Measures

CHANGES	DESCRIPTION
Changes to existing measures	**Statin Use in Persons with Diabetes (SUPD)** The percent of Medicare Part D beneficiaries ages 40 to 75 who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period. The index prescription start date for the SUPD measure should occur at least 90 days prior to the end of the measurement year (MY). Beneficiaries are included in the SUPD measure calculation if the earliest date of service for a diabetes medication is at least 90 days prior to the end of the MY. The measure will be a weight of 1x for the 2023 Star Ratings.
Display measures	**Controlling Blood Pressure (CBP)** Temporarily moved to the display page for the 2020 and 2021 Star Ratings due to substantive National Committee for Quality Assurance (NCQA) changes to the measure specification. Since HEDIS data was not collected for 2021 Star Ratings, this measure remains as a display measure for 2022, and will be used in calculating the 2023 Star Ratings with a weight of 1x. The measure will increase in weight to 3x for 2024 Star Ratings (MY 2022). **Medicare Health Outcomes Survey (HOS) Measures: Improving or Maintaining Physical Health (IPH) and Improving or Maintaining Mental Health (IMH)** Moved to the display page for at least two years beginning in MY 2022 due to substantive measure specification changes. Possible return to 2026 Star Ratings with a weight of 1x. **Care for Older Adults (COA) – Functional Status Assessment** Moved to the display page for the 2022 Star Ratings due to a substantive measure specification changes.

	Plan All-Cause Readmissions (PCR) Temporarily moved to the display page for the 2021 and 2022 Star Ratings due to substantive NCQA changes to the measure specification. It will be on the display page for the 2022 and 2023 Star Ratings, and return for MY 2022 with a weight of 1x for the 2024 Star Ratings.
Retired measures	**Adult BMI Assessment (ABA)** Retire with the 2022 Star Ratings.
	Rheumatoid Arthritis Management (ART) Retire with the 2023 Star Ratings.
	Medication Reconciliation after Discharge (MRP) Retired as a standalone measure in MY 2022 for the 2024 Star Ratings. MRP will continue as a Star measure – as a sub-measure – under the new Transitions of Care measure (listed below).
	Osteoporosis Testing in Older Women (OTO) Retire for MY 2020 and will be removed from the display page in 2023.
Proposed measures	**Follow up After ED Visit for Persons with Multiple Chronic Conditions (FMC)** Percentage of emergency department (ED) visits for members ages 18 and older who have multiple high-risk chronic conditions and had a follow-up service within seven days of the ED visit. Eligible members must have two or more of these chronic conditions: COPD and asthma; Alzheimer's disease and related disorders; chronic kidney disease; depression; heart failure; acute myocardial infarction; atrial fibrillation; and stroke and transient ischemic attack. This will be a Star measure starting RY 2024 with a weight of 1x

	Transitions of Care (TRC) Percentage of discharges for members ages 18 and older who had each of the following: 1) notification of admission and post discharge: 2) receipt of discharge information, 3) patient engagement, and 4) medication reconciliation. This will be a Star measure starting RY2024 with a weight of 1x. **Cardiac Rehabilitation (CRE)** The percentage of members ages 18 and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. **Kidney Health Evaluation for Patients with Diabetes (KED)** The percentage of members ages 18 to 85 with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. **Osteoporosis Screening in Older Women (OSW)** The percentage of members ages 65 to 75 who received osteoporosis screening.

Non-substantive changes to Star Measures

There are several non-substantive changes to existing measures for 2022 Star Ratings that allow for additional data sources as part of the measure. Since these are non-substantive changes to the measures, CMS will not move them to the display page as they would for new measures and those with substantive specification changes. The majority of these measures are revised to include telehealth (telephone visit, e-visit, virtual check-in) as qualifying numerator/denominator events, and for advanced illness exclusions to ensure Medicare beneficiaries have access to necessary care during the pandemic.

Table 3: Non-Substantive Changes to Star Measures – Telehealth Updates

MEASURE	CHANGE DESCRIPTION

Breast Cancer Screening (BCS)	Added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.
Care for Older Adults (COA)	Clarified that for the numerator, services rendered during a telephone visit, e-visit or virtual check-in meet criteria for Functional Status Assessment and Pain Assessment numerator indicators.
Controlling High Blood Pressure (CBP)	Removed the restriction that only one of the two visits with a hypertension diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis and added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion. This measure allows patient self-reported blood pressure readings using any digital device to be included in the data capture.
Comprehensive Diabetes Care (CDC)	Removed from the denominator the restriction that only one of the two visits with a diabetes diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in (when identifying the event/diagnosis) and added telephone visit, e-visit and virtual check-in encounter codes that could be used to identify the advanced illness diagnosis exclusion.
Colorectal Cancer Screening (COL)	Added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.
Osteoporosis Management in Women Who Had a Fracture (OMW)	Added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.
Plan All-Cause Readmissions (PCR)	Added telephone visits to the Risk Adjustment Comorbidity Category Determination in the Guidelines for Risk Adjusted Utilization Measures.

Statin Therapy for Patients with Cardiovascular Disease (SPC)	Removed the restriction from the denominator that only one of the two visits with an ischemic vascular disease (IVD) diagnosis could be an outpatient telehealth, telephone visit, e-visit or virtual check-in (when identifying the event/diagnosis) and added telephone visit, e-visit and virtual check-in encounter codes to identify the advanced illness diagnosis exclusion.

Provider resources to help improve outcomes

In addition to adherence with CMS Star Ratings, Health Net collaborates with participating providers to improve the overall health care delivered to Health Net MA members through the following efforts:

- Quality Improvement initiatives – As part of Health Net's Star Ratings initiatives, Health Net performs member outreach through mail, email and interactive voice response (IVR) calls to promote best practices in preventive screening, medication adherence and chronic care. Members are encouraged to complete annual wellness visits and talk to their doctor about fall risk, urinary incontinence and physical activity. Collaborating with providers to implement strategies promoting best practices can have a meaningful impact on Health Net's Medicare Star Ratings. A provider quality improvement (QI) toolkit is available with information about QI activities and CMS Star Ratings, as well as provider and member resources. In addition, provider educational teleconferences on various health topics, including HEDIS best practices, are available to medical groups throughout the year.
- Quality Improvement Corner tools – Providers can log in to Health Net's provider portal (http://provider.healthnet.com) and select Working with Health Net > Quality to access QI tools created to improve Star Ratings in Part C and Part D clinical measures. By adhering to best practices to strengthen patient engagement and close gaps in care, providers can directly impact HEDIS, HOS and CAHPS quality measures. The QI tools located on this site include documentation guides; provider tip sheets to improve preventive care, chronic care and patient experience; wellness and preventive care checklists; and educational office posters. Hard copies can be requested via email (mailto:cqi_medicare@healthnet.com).
- Collaborating with Health Net – To identify areas for improvement on specific HEDIS measures, Health Net provides medical groups with year-to-date HEDIS quality report cards and care gap reports available online (http://provider.healthnet.com).

Additional information

If you have questions regarding the information contained in this update, contact the Health Net Provider Services Center by email (mailto:provider_services@healthnet.com) within 60 days, by telephone at 800-929-9224.

[1] CMS publishes display measures each year, which include measures that have been transitioned from the Star Ratings, new measures that are tested before inclusion into the Star Ratings, or measures displayed for informational purposes only. These are separate and distinct from CMS's Part C & D Star Ratings.

[2] Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys ask consumers and patients to report on and evaluate their experiences with health care.

[3] For more information, refer to the CMS Medicare 2021 Part C & D Star Ratings Technical Notes (http://www.cms.gov/files/document/2021technotes20201001.pdf-0).

Last Updated: 03/31/2021

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Nondiscrimination Notice (/non-discrimination-notice.html)
Privacy Policy (/privacy-policy.html)
Notice of Privacy Practices (/privacy-practices.html)

You will need Adobe Reader to open PDFs on this site.

Download the free version of Adobe Reader. (https://get.adobe.com/reader/)

(https://get.adobe.com/reader/)

Interpreting Services (PPGs)

No-cost interpreting services including American Sign Language are available to L.A. Care members 24 hours a day, 7 days a week.

Provider Responsibilities - Important Regulatory Things to Remember

- Post translated signage (interpret poster) about no-cost interpreting services at all key points of contact.
- Offer no-cost face-to-face and telephonic interpreting services to patients.
- Never imply, request, or require patients to provide their own interpreters.
- Strongly discourage using friends, family members, and especially minors as interpreters, except in emergency situations.
- Document patient's preferred spoken and written language as well as request or refusal of interpreting services in their medical record.
- Maintain appropriate documentation on file for bilingual practitioners and office staff who communicate with limited English proficient (LEP) patients in a language other than English.
    - Use the no-cost interpreting services offered by L.A. Care if their language proficiency is not assessed, and they are not qualified.
- Ensure that the answering machine informs patients on how to access interpreting services after-hours.

Telephonic Interpreting Services

1. Dial **1.855.322.4022**
2. Press:
    - 1 for Spanish
    - 2 for Other Languages
    - 3 for Operator
3. Provide:
    - Independent Physician Association (IPA) name
    - L.A. Care member ID number
4. Document the interpreter name and ID # for reference.
5. Brief the interpreter, and give any special instructions.
6. Dial the patient into the call.

L.A. Care HEALTH PLAN
For All of L.A.

Face-to-Face Interpreting Services

1. Call the phone numbers below to request an interpreter at least 10 business days prior to a patient's medical appointment. American Sign Language is also available for deaf and hard of hearing patients.

   IMPORTANT: Call L.A. Care immediately if there are any changes to a patient's appointment.

L.A. Care		Plan Partners	
Medi-Cal	1.888.839.9909	Anthem Blue Cross	1.888.285.7801
Cal MediConnect	1.888.522.1298	Care1st	1.800.605.2556
L.A. Care Covered	1.855.270.2327	Kaiser Permanente	1.800.464.4000
PASC-SEIU	1.844.854.7272		

2. Provide the following information:

   Patient Information
   - Patient's name
   - L.A. Care member ID number
   - Language requested
   - Preferred gender of interpreter

   Appointment Information
   - Date, time and duration of appointment
   - Doctor's name
   - Address and phone number
   - Purpose of appointment

Limited English Proficient (LEP) Patients

Offer no-cost interpreting services to the patient in a respectful manner when you notice:
- Patient is quiet or does not respond to questions.
- Patient simply says "yes" or "no", or gives inappropriate or inconsistent answers to your questions.
- Patient may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate.
- Patient self identifies as LEP by requesting language assistance.

How to Work Effectively with Interpreters

- Plan more time for a medical appointment or a call that will require an interpreter.
- Brief the interpreter on the purpose of the appointment or call.
- Talk directly to the patient. Speak in the first person.
- Speak in a normal voice, not too fast or too loud.
- Pause after a short sentence for the interpreter to interpret.
- Give information in small chunks and verify comprehension before going on.
- Use plain language. Avoid acronyms, medical jargon, and technical terms.
- Do not say anything you don't want the patient to hear. It is the interpreter's job to interpret everything.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Communicating with Deaf and Hard of Hearing Patients

- Dial **711** to access the California Relay Services. It is a no-cost relay services provided by the Federal Communications Commission.
- American Sign Language interpreters are available for medical appointments. Please call L.A. Care Customer Solution Center to request an interpreter.

Tools and Resources

You can *order* the below tools through the Online Tool Order Form:
https://external.lacare.org/HealtheForm/

- Interpreting services poster
- Telephonic interpreting card
- C&L provider toolkit

Additional materials are also available for *download* from the L.A. Care's website:
http://www.lacare.org/providers/provider-resources/tools-toolkits

- Go to *Manuals and Forms* to download:
  - ICE employee language skills assessment tool
  - Health Education referral form (C&L appropriate community services)
  - Preferred language labels
  - Interpreting request/refusal labels
- Go to *Toolkits* to download:
  - C&L provider toolkit

C&L Trainings

The following trainings are available to L.A. Care network providers at no cost:

- Communicating through Healthcare Interpreters (CME)
- Cultural Competency
- Disability Sensitivity

To receive more information about upcoming trainings or to schedule an on-site training session, contact us at CLStrainings@lacare.org.

Contact Information

For more information about the L.A. Care's Cultural & Linguistic services, email us at CulturalandLinguisticServices@lacare.org.

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Sample Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) questions outlined below are provided as examples. They represent one HRA model. Use of this model is not a requirement for the Medicare Annual Wellness Visit HRA, as a variety of HRA instruments will meet the Medicare HRA definition. Physician discretion will guide the implementation and use of HRAs. HRAs are not intended to be prescriptive, and physician judgment will identify appropriate interventions for individual patients. The sample questions reflect available scientific evidence.

Physical Activity

In the past 7 days, how many days did you exercise? _____ days

On days when you exercised, for how long did you exercise (in minutes)? _____ minutes per day ☐ Does not apply

How intense was your typical exercise?

☐ Light (like stretching or slow walking)
☐ Moderate (like brisk walking)
☐ Heavy (like jogging or swimming)
☐ Very heavy (like fast running or stair climbing)
☐ I am currently not exercising

Tobacco Use

In the last 30 days, have you used tobacco? Smoked:

☐ Yes ☐ No

Used a smokeless tobacco product: ☐ Yes ☐ No

If Yes to either, Would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

Alcohol Use

In the past 7 days, on how many days did you drink alcohol? _____ days

On days when you drank alcohol, how often did you have _____ (5 or more for men, 4 or more for women and those men and women 65 years old or over) alcoholic drinks on one occasion?

☐ Never
☐ Once during the week
☐ 2–3 times during the week
☐ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking? ☐ Yes ☐ No

Nutrition

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.) _____ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?

(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.) _____ servings per day

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.) _____ servings per day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____ sugar sweetened beverages consumed per day

Seat Belt Use

Do you always fasten your seat belt when you are in a car?

☐ Yes ☐ No

Depression

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends? ☐ Yes ☐ No

Anxiety

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

☐ Almost all of the time
☐ Most of the time
☐ Some of the time
☐ Almost never

High Stress

How often is stress a problem for you in handling such things as:

–Your health?
–Your finances?
–Your family or social relationships?
–Your work?

☐ Never or rarely
☐ Sometimes
☐ Often
☐ Always

- continued on other side -

Social/Emotional Support

How often do you get the social and emotional support you need:

☐ Always ☐ Rarely
☐ Usually ☐ Never
☐ Sometimes

Pain

In the past 7 days, how much pain have you felt?

☐ None ☐ Some ☐ A lot

General Health

In general, would you say your health is

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How would you describe the condition of your mouth and teeth—including false teeth or dentures?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? ☐ Yes ☐ No

Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications? ☐ Yes ☐ No

Sleep

Each night, how many hours of sleep do you usually get? _____ hours

Do you snore or has anyone told you that you snore?

☐ Yes ☐ No

In the past 7 days, how often have you felt sleepy during the daytime?

☐ Always ☐ Rarely
☐ Usually ☐ Never
☐ Sometimes

Biometric Measures— Self-Reported

(To be completed by the patient only when the HRA is not prepopulated using laboratory, electronic medical record (EMR), patient health record (PHR), or other medical practice source data.)

Blood Pressure

If your blood pressure was checked within the past year, what was it when it was last checked?

☐ Low or normal (at or below 120/80)
☐ Borderline high (120/80 to 139/89)
☐ High (140/90 or higher)
☐ Don't know/not sure

Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

☐ Desirable (below 200) ☐ High (240 or higher)
☐ Borderline high (200–239) ☐ Don't know/not sure

Blood Glucose

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

☐ Desirable (below 100) ☐ High (126 or higher)
☐ Borderline high (100–125) ☐ Don't know/not sure

If diabetic, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?

☐ Desirable (6 or lower) ☐ High (8 or higher)
☐ Borderline high (7) ☐ Don't know/not sure

Overweight/Obesity

What is your height without shoes? (for example, 5 feet and 6 inches = 5'6") Feet _____ Inches _____

What is your weight? Weight in pounds _____

Goetzel, RZ; Staley, P; Ogden, L; Stange, P; Fox, J; Spangler, J; Tabrizi, M; Beckowski, M; Kowlessar, N; Glasgow ,RE, Taylor, MV. A framework for patient-centered health risk assessments – providing health promotion and disease prevention services to Medicare beneficiaries. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2011. Available at: cdc.gov/policy/opth/hra/

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Social Determinants of Health (SDOH)

Social determinants of health such as housing, food security, and transportation can have an immense impact on the physical and mental health of patients. Capturing SDOH data can help to improve patient outcomes which may assist patients with barriers related to housing and transportation, social support, health literacy, nutritional support and financial assistance.

By addressing these determinants, providers can identify patients who may need assistance with additional resources potentially available through their health plan and/or local community. It is vital that these determinants are accurately documented and coded, when applicable, to assist in identifying patients who may qualify for needed resources.

Please note that these codes are for supplemental reporting purposes and should not be used as primary diagnosis codes. Additionally, the list of determinants and their diagnosis codes below is not all-inclusive, please consult the ICD-10-CM code book for additional applicable codes.

Problems related to housing and economic circumstances	
Example Question: Describe your current living and financial situation. Do you have transportation to attend appointments and other necessary activities?	
Document and code if applicable:	
Z59.0	Homelessness
Z59.1	Inadequate housing (lack of heating, restriction of space, technical defects in home preventing adequate care, unsatisfactory surroundings)
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution (boarding-school resident)
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (isolated dwelling, foreclosure on loan, problems with creditors)
Z59.9	Problems related to housing and economic circumstances, unspecified
Z75.3	Unavailability and inaccessibility of health care facilities

Problems related to education and literacy	
Example Question: Do you experience language barriers?	
Document and code if applicable:	
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified

Problems Related to Employment and Unemployment	
Example Question: Do you need/want help finding or keeping work or a job?	
Document and code if applicable:	
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment (difficult conditions at work)
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment

Problems Related to Social Environment & Lifestyle	
Example Question: Do you have family and/or community support with day-to day activities such as preparing meals, shopping, bathing, managing finances, etc.? Do you feel lonely or isolated? In the last month how many times have you consumed alcoholic drinks or used tobacco products? How often have you felt down, depressed, or hopeless? Are you able to exercise regularly?	
Document and code if applicable:	
Z60.0	Problems of adjustment to life-cycle transitions (empty nest syndrome, phase of life problem, problem with adjustment to retirement)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problems related to social environment, unspecified
Z72.0	Tobacco use
Z72.3	Lack of Physical Exercise
Z72.4	Inappropriate diet and eating habits
Z72.6	Gambling and betting
Z72.811	Adult antisocial behavior
Z72.820	Sleep Deprivation
Z72.821	Inadequate sleep hygiene
Z72.89	Other problems related to lifestyle (self-damaging behavior)

Other Problems related to Primary support group, including family circumstances	
Example Question: Do you feel safe at home? Do you feel regularly under stress at home?	
Document and code if applicable:	
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member (bereavement)
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support Group
Z63.9	Problems related to primary support group (relationship disorder)
Z65.9	Problem related to unspecified psychosocial circumstances

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The following references were used in creating this document:
Optum 360 ICD-10-CM: Professional for Physicians 2020. Salt Lake City, UT: 2019.
National Association of Community Health Centers. https://www.nachc.org. Accessed September 1, 2020.
CMS & AHCM screening tool example. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf. Accessed September 1, 2020.

2021 Annual Care Checklist

Nothing is more important than your health. That's why you can count on UnitedHealthcare® to help you get the care you need, when you need it. Take this checklist with you to your next appointment.

Good preventive care helps catch health issues early when they may be easier to treat. Have this checklist handy at your next appointment. Together, you and your primary care provider (PCP) can decide which tests and care services are right for you. Recommended preventive care services may include the following[1]:

Once a Year	Date Done
☐ Flu shot (every flu season)	
☐ Vaccine review (See what shots you may be due for.)	

Annual Wellness Visit/ Routine Physical	Date Done
☐ Blood pressure check	
☐ Head-to-toe examination	
☐ Height, weight and body mass index (BMI)	
☐ Lifestyle screening check such as alcohol use, help quitting tobacco and healthy eating, if applicable.	

As Recommended by Your PCP	Date Done
☐ Cervical cancer screening (Pap smear) for women ages 21–65 years old	
☐ Cholesterol screening	
☐ Dental exam	
☐ Discuss screening and prevention of osteoporosis	
☐ Eye exam	
☐ Fasting blood sugar screening	
☐ Hearing exam	

As Needed	Date Done
☐ Colon cancer screening (for adults age 50 or older)	
☐ Hepatitis C virus infection screening (for people at high risk and a one-time test for adults born between 1945–1965)	
☐ Mammogram screening (every year starting at age 45; starting at age 55 it can change to every other year[2])	

For People with Diabetes	Date Done
☐ Exam to detect diabetes-related issues for eyes	
☐ Exam to detect diabetes-related issues for feet	
☐ Hemoglobin A1c (HbA1c)	
☐ LDL cholesterol	
☐ Statin medication, if clinically appropriate	
☐ Urine test for protein	

See back for important topics to prepare for your next appointment.

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Important topics to discuss with your PCP

Prepare for your appointment by filling in the information below. Then, write down any recommendations your PCP may have about these topics and treatment options during your visit.

Medications

- ☐ Write down your prescriptions, over-the-counter medications, supplements or vitamins you're taking. Ask:
  - Am I taking them correctly?
  - Are there any side effects?
  - Is there a lower-cost option?

Physical Activity

- ☐ Discuss your level of physical activity with your PCP. Ask if you should start, increase or maintain your current exercise level.

Care Team

- ☐ List any specialists or other providers you're seeing. This will help your PCP coordinate your overall care.

Tests and Treatments

- ☐ Discuss any tests ordered during your appointment. Ask:
  - When can I expect results?
  - Will I receive a follow-up call?
  - Do I need a follow-up appointment?

Health Evaluations

Risk of Falls

- ☐ I have had a fall
- ☐ I have problems with balancing or walking
- ☐ I don't have problems with balancing or falling

Mental Health

- ☐ I feel calm and peaceful
- ☐ I have a lot of energy
- ☐ I feel sad or blue
- ☐ I am having difficulty sleeping
- ☐ I don't experience any of the above

Bladder Control

- ☐ I have problems with bladder control
- ☐ I have problems with leaking of urine
- ☐ I don't have bladder or urine leakage problems

Physical Health

- ☐ I have limitations with my regular daily activities
- ☐ I have pain that interferes with my normal work
- ☐ I have limitations with my social activities
- ☐ I don't experience any of the above

If you have questions, please call the Customer Service number on the back of your member ID card. From scheduling your next checkup appointment to finding a provider, you can always count on us to help you get the care you need, when you need it.

[1] This is a list of suggested screenings. Coverage for these screenings (including how often they are covered) may vary by plan. If you have questions about your specific benefits or coverage details, please call Customer Service at the number on the back of your member ID card or check your Evidence of Coverage.

[2] American Cancer Society, 2020.

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SPRJ59133

Frailty and Advanced Illness Exclusions

As a care provider, you make sure your patients are getting the preventive care they need, when they need it. We want to help complement your efforts by providing the latest updated information on frailty and advanced illness exclusions for your UnitedHealthcare Medicare Advantage plan members.

What You Need to Know

The National Committee for Quality Assurance (NCQA) added a new set of exclusions for members with advanced illness and/or frailty for select HEDIS® measures. They made this change because quality measures originally meant for the general adult population may not be appropriate for people with frailty and/or advanced illness. The exclusions are determined by claims during the measurement year only.

Frailty With Advanced Illness Exclusion

This exclusion is applicable for members ages 66 and older as of December 31 of the measurement year with frailty and advanced illness during the measurement year. Advanced illness is identified by counting a member's diagnoses or services during the measurement year or year prior to the measurement year.

Measures impacted:	Conditions flagged as indicating frailty with advanced illness include, but are not limited to:
• Breast cancer screening (BCS) • Colorectal cancer screening (COL) • Comprehensive diabetes care (CDC) • Controlling high blood pressure (CBP) • Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (ART) • Osteoporosis management in women who had fracture (OMW) • Persistence of beta-blocker treatment after a heart attack (PBH) • Statin therapy for patients with cardiovascular disease (SPC) • Statin therapy for patients with diabetes (SPD)	• Creutzfeldt-Jakob disease • Dementia: Alzheimer's disease, amnesia, Lewy body dementia or member dispensed a dementia medication • Heart disease: Congestive heart failure (CHF), left ventricular failure or heart failure • Hepatic: Cirrhosis, hepatitis, fibrosis or sclerosis • Hypertensive heart with one or more of the following: – Heart failure, end-stage renal disease (ESRD) or kidney disease • Malignancy: Pancreas, brain, lymph, respiratory, digestive, renal, leukemia or hepatic • Nervous system: Huntington's disease, Parkinson's disease or Pick's disease • Renal: Chronic kidney disease or ESRD • Respiratory: Emphysema, pulmonary fibrosis or respiratory failure

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Exclusion Criteria for BCS, COL, CDC, CBP, ART, OMW, PBH, SPC and SPD Measures

Exclusion	Timeframe
Members ages 66 and older as of December 31 of the measurement year who had a diagnosis of frailty and advanced illness. Advanced illness is indicated by one of the following: • Two or more outpatient, observation, emergency room (ER) or non-acute inpatient visits on separate dates of service with a diagnosis of advanced illness • One or more inpatient visit(s) with a diagnosis of advanced illness • Dispensed a dementia medication including Donepezil, galantamine, rivastigmine or memantine	**Frailty** diagnosis must be in the measurement year. **Advanced illness** diagnosis must be in the measurement year or year prior to the measurement year.

For a comprehensive list of all NCQA HEDIS® technical frailty and advanced illness codes with descriptions, please see the 2019 Reference Guide for Adult Health available at **UHCprovider.com/path.**

Contact us to learn more.
For more information, please contact your UnitedHealthcare representative.

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PCA-1-20-00212-M&R-FLYR-01272020

UnitedHealthcare Medicare Advantage COVID-19 Telehealth Considerations

CMS Star Ratings Provider Quick Reference Guide

During the national public health emergency period, we're working to provide resources and streamline processes, so that you can focus on delivering care. To help address opportunities in care, we've provided a guide for Centers for Medicare & Medicaid Services (CMS) Star Rating measures to reference for telehealth visits.

Measure	Closure Requirement		Telehealth	Guidance	CPT II CODES
Care for Older Adults (COA) - Advanced Care Planning (ACP)	**Conversation with Patient**	**Documentation of conversation between provider and patient or patient declining to have conversation about ACP**	✓	Consider the following questions: • Does the patient have an advanced directive? • Has the patient discussed end-of-life care during this visit? • Has the patient been provided verbal discussion of an Advanced Directive? • Does the patient have a Health Care Surrogate/Proxy?	1123F 1124F 1157F 1158F
COA - Considerations	**n/a**	**n/a**	✓	Ask the member if there are questions (e.g., "What questions can I help answer about your medications?" and "What questions do you have about your health?") • Finish the review by asking for questions (e.g., "I've reviewed a lot of information with you. Do you have any other health-related questions?")	

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Measure	Closure Requirement		Telehealth	Guidance	CPT II CODES
COA - Functional Status Assessment	**Conduct Assessment**	**Completed Assessment in Medical Record**	✓	• Include the following: ADL/IADL; Ambulatory Status; Cognitive Status; Sensory Hearing; Sensory Speech; Sensory Vision. Assessment of at least four Instrumental Activities of Daily Living, including, but not limited to: • Laundry • Cleaning • Cooking • Driving, (or using public transportation) • Grocery shopping • Home repair, maintenance • Paying bills or other financial tasks • Taking prescribed medications Assessment of at least five ADLs, including, but not limited to: • Bathing/hygiene • Dressing • Eating • Getting up and down from sitting or lying position • Toileting/Using the restroom • Walking Body systems assessment that includes three of the four: • Ambulation status • Cognitive status • Functional independence -(exercise, housework, work outside of the home) • Sensory status – hearing, vision and speech Note: If functional status compromise is identified, assure the appropriate diagnosis is documented and coded in the note and billing.	1170F
COA – Pain Screening	**Conduct Assessment**	**Completed Assessment in Medical Record**	✓	Ask the member questions, for example: • On a scale of 1-10, with 0 being no pain and 10 being the worst pain you can imagine, how does it hurt right now? • Where does it hurt? • Is the pain constant? Y/N • Type of pain (e.g., ache, deep, sharp, hot, cold, sensitive skin) • Describe the onset, duration, variations of the pain. • What relieves the pain? Screening for chest pain or documentation of chest pain alone will not meet compliance. A pain assessment related to a single body part, with the exception of chest, meets compliance.	1125F 1126F
COA - Medication Review	**Conduct Assessment**	**Completed assessment, by qualified clinician in medical record**	✓	• COA medication review must be completed by the prescribing physician or pharmacist only. • Prescribing physician or pharmacist must go through the medication list with the member.	1159F 1160F

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Measure	Closure Requirement		Telehealth	Guidance	CPT II CODES
Controlling Blood Pressure	**Conduct Assessment - Blood Pressure**	**Completed blood pressure in medical record**	✓	**Guidance** For members 66-80, exclusion criteria require BOTH the appropriate (per the HEDIS Value Set Data) Advanced Illness coding, as well as the Frailty coding. For members 81+, exclusion criteria only require the Frailty coding. For BP readings received from any digital devices, they must be digitally stored and transmitted to the provider. Member can take a BP on their digital device and show the provider the stored BP on the device during a telehealth visit (i.e., the patient holds the device up to the screen). Provider must document that the reading is recorded on an electronic device, and the results were digitally stored and transmitted to the provider for interpretation. Note: Member-reported results not shown to the provider from a remote monitoring device are not acceptable. Administrative Reporting: • The last BP of the measurement year is identified through administrative data and a member automatically becomes numerator compliant, and there is no further action needed.	3074F 3075F 3077F 3078F 3079F 3080F
Medication Reconciliation Post-Discharge (MRP)	**Conduct Assessment**	**Completed Reconciliation by qualified clinician in medical record on day of discharge through 30 days after discharge (31 days total)** **A medication reconciliation performed without the member present meets criteria**	✓	• MRP measure can be closed by telehealth or telephone support by a clinician. This includes MD, RN or pharmacist and does not require that the PCP is the one reconciling the medication. • The documentation is sufficient for the MRP measure if the outpatient medical record includes evidence of medication reconciliation and date when it was performed. Any of the following examples meet criteria if the documentation includes: • Current medications with a notation that the provider reconciled the current and discharge medications (e.g., no changes in medication since discharge, same medications at discharge, discontinue all discharge meds) • Current medications with a notation that the discharge medications were reviewed • The current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service • The current medication list with evidence that the member was seen for post-discharge follow-up with documentation that the provider was aware of the hospitalization or discharge • Documentation in the discharge summary (filed in the outpatient chart on the date of discharge through 30 days after discharge [31 total days]), that the discharge medications were reconciled with the most recent medication list in the outpatient medical record • Notation that no medications were prescribed or ordered upon discharge If MRP is conducted by telehealth or telephone support, submission of administrative codes (1111F, 99495, 99496, 99483) will bypass the need for documentation evidence.	1111F

Measure	Closure Requirement		Telehealth	Guidance	CPT II CODES
Medication Therapy Management - Comprehensive Medication Review (MTMCMR)	**Conduct Assessment**	**Comprehensive medication review completed through interactive, real-time discussion by a qualified clinician within the outcomes of MTM provider network and documented in the outcomes of MTM vendor platform**	✓	• Providers can discuss open opportunity for Comprehensive Medication Review (CMR) with the patient and recommend the patient contact UnitedHealthcare's MTM pharmacy team at **866-216-0198** to complete their annual medication review. • Notify patient that UnitedHealthcare's MTM Pharmacy team may be reaching out by telephone to complete the CMR and request they do so if contacted. Patient may also be contacted by their retail pharmacist to complete. • Let eligible patients know that the annual medication review can help them: – Take their medications as prescribed – Recognize the benefits of their medications – Better understand side effects to help lower the risk for adverse reactions • If there are any urgent issues or concerns, the pharmacist will contact the provider, and the provider will let member know of that communication.	N/A
Statin Use for Patients with Cardiovascular Disease (SPC)	**Medication**	**Moderate or High Intensity Statin Medication Fill through the Part D benefit**	✓	• Providers can discuss open opportunity for statin gap with patient and consider prescribing a moderate or high intensity statin when clinically appropriate. **Risk:** prescribing statin may be dependent on lab work (e.g., LFTs, lipid panel etc.)	N/A
Statin Use in Patients with Diabetes SUPD	**Medication**	**Statin fill thru the Part D benefit**	✓	• Providers can discuss open opportunity for statin gap with patient and consider prescribing a statin when clinically appropriate. **Risk:** prescribing statin may be dependent on lab work (e.g., LFTs, lipid panel etc.)	N/A
Medication Adherence (Diabetes, Hypertension, Cholesterol)	**Prescription drug coverage of 80% or more at the end of measurement period**	**Member needs to have qualifying medication(s) on hand for at least 80% of the measurement period. Qualifying medications must be processed using Part D benefit.**	✓	Medication adherence can be discussed with patients using telehealth visits or telephone visits. Consider addressing the following: • If patient has enough medication(s) on hand; encourage member to refill their medication(s) if they are out. • Send additional refills to pharmacy for chronic medications, if needed. • Discuss home delivery of medications with patients either by retail or mail delivery. • Consider writing for 90-day supply to ensure patient has medication on hand. • Counsel patient on the importance of continuing to take medications as prescribed.	N/A

Resources

For additional information, please reach out to your assigned UnitedHealthcare representative. Stay informed about the latest UnitedHealthcare COVID-19 related resources at UHCprovider.com/covid19.

United Healthcare®

2021 Medicare Advantage Preventive Screening Guidelines

Frequently asked questions

Coding procedures for a Welcome to Medicare visit, annual wellness visit and other preventive screenings

The following coding procedures for UnitedHealthcare Medicare Advantage plans in 2021 can help you determine the appropriate submission codes for covered preventive services. For more information about the Centers for Medicare & Medicaid Services (CMS) policies that define the procedures, and to determine if a service is covered by Medicare, please click on the appropriate link in the following list:

- **Medicare Physician Fee Schedule**
- **CMS Internet-Only Manuals (IOM)**
- **CMS National Correct Coding Initiative (NCCI)**
- **CMS Medicare Coverage Database (NCD/LCD Lookup)**
- **CMS Preventive Services Guide**

A note about cost sharing

All references to cost sharing for out-of-network care providers apply only to UnitedHealthcare Medicare Advantage PPO, RPPO and POS plans with out-of-network coverage. UnitedHealthcare Medicare Advantage private fee-for-service plans don't have provider networks. For these plans, the in-network cost sharing shown in each table applies.

Wellness visits/routine physicals

Service	Covered by	Copayment	Visit frequency	Submission codes
Welcome to Medicare Initial preventive physical exam (IPPE)	• Original Medicare • UnitedHealthcare Medicare Advantage plans when performed by the member's primary care professional (PCP)	• $0 in network • A copay or may apply if a member uses an out-of-network benefit, if available.	Within the first 12 months of Medicare Part B (once per lifetime)	• G0402*
Annual wellness visit Personalized prevention plan services (PPPS)	• Original Medicare • UnitedHealthcare Medicare Advantage plans when performed by the member's PCP	• $0 in network • A copay or may apply if a member uses an out-of-network benefit, if available.	Every calendar year (visits do not need to be be 12 months apart)	• G0438* (first visit) • G0439* (subsequent visit)
Annual routine physical exam	• UnitedHealthcare Medicare Advantage plans when performed by the member's PCP • Not covered by Original Medicare	• $0 in network • A copay or may apply if a member uses an out-of-network benefit, if available.	Every calendar year (visits do not need to be be 12 months apart)	• 99385, 99386, 99387 • 99395, 99396, 99397

* A Welcome to Medicare Visit or an annual wellness visit performed in a federally qualified health center (FQHC) is payable under the FQHC prospective payment system (PPS). Code G0468 must be accompanied by qualifying visit code G0402, G0438 or G0439.

Wellness visits/routine physicals (continued)

Notes

- See the "Types of Office Visits" section for specific services to be provided during each type of visit.
- Annual routine physical exam coverage: If you bill the 99XXX codes for these services, you must provide a head-to-toe exam and can't bill for a separate breast and pelvic exam, digital rectal exam or counseling to promote healthy behavior. See the "Types of Office Visits" section for a list of the specific components included in the visit.
- Members may receive either the Welcome to Medicare Visit or the annual wellness visit, along with the annual routine physical exam, on the same day from the same PCP, as long as all components of both services are provided and fully documented in the medical record. Please don't submit either of these two visits with a -25 modifier.
- When you perform a separately identifiable, medically necessary Evaluation and Management (E/M) service, in addition to the IPPE, you may also bill CPT® codes 99201–99215 reported with modifier -25. When medically indicated, this additional E/M service is subject to the applicable copayment for an office visit. Any additional services provided are subject to applicable cost sharing. See **CMS National Correct Coding Initiative (NCCI).**
- Coverage for an annual routine physical exam under Medicare Advantage employer group plans may vary.

Additional services provided in conjunction with the wellness visit/routine physical

Only the codes listed on the "wellness visits/routine physicals" chart are included in the $0 copayment for wellness visits. If you also bill other services with the visit, and those services are normally subject to a copayment or coinsurance, that copayment or coinsurance applies, even if the primary reason for the visit was for a wellness exam.

Service	Covered by	Copayment	Visit frequency
Abdominal aortic aneurysm screening	• Original Medicare • UnitedHealthcare Medicare Advantage plans	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available.	One time only for at-risk members when a referral for the screening is received as a result of the wellness visit
Advanced care planning	• Original Medicare • UnitedHealthcare Medicare Advantage plans	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available.	Can be performed at the time of the wellness visit or outside of the annual wellness visit, as necessary
Electrocardiogram screening	• Original Medicare • UnitedHealthcare Medicare Advantage plans	Subject to member cost sharing in most plans	One time only when provided during the Welcome to Medicare visit
Any clinical laboratory tests or other diagnostic services CMS recognizes and defines as medically necessary rather than preventive	• Original Medicare • UnitedHealthcare Medicare Advantage plans	Subject to member cost sharing in most plans	As medically necessary

Pap/pelvic exam

Service	Covered by	Copayment	Visit frequency	Submission Codes
Pap/pelvic exam, including pelvic exam and/or pap collection	• Original Medicare • UnitedHealthcare Medicare Advantage plans	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available.	• Every calendar year for those at high risk (visits do not need to be 12 months apart) • Every 2 calendar years for women not considered high risk (visits do not need to be 24 months apart)	• Exam: G0101 • You may bill a separate E/M code only if you provided a separately identifiable E/M service.

When a member sees an obstetrician or gynecologist who isn't their assigned PCP for a routine pap/pelvic exam, only the Medicare-covered annual pap/pelvic service should be performed and billed. Please refer members to their assigned PCP if a more comprehensive preventive service is needed.

Types of office visits

Welcome to Medicare visit

A one-time preventive E/M service that includes the following:

1. Review of a member's medical and social history
2. Review of a member's potential risk factors for depression
3. Review of a member's functional ability and level of safety, including hearing impairment, daily living activities, fall risk and home safety
4. Review of a member's full list of medications and supplements, including calcium and vitamins
5. An exam with height, weight, body mass index, blood pressure, visual acuity and other measurements
6. End-of-life planning assistance, such as an advance directive or health care proxy, with a member's consent
7. Education, counseling and referral, based on the results of numbers 1-5 in this list
8. Education, counseling and referral, including a brief written plan for obtaining a screening EKG, as appropriate, and other appropriate screenings and/or Medicare Part B preventive services

Annual wellness visit

Allows the physician and member to develop a personalized prevention plan and may include the following:

1. Established or updated record of member's medical and family history
2. Review of a member's potential risk factors for depression
3. Review of a member's functional ability and level of safety, including hearing impairment, daily living activities, fall risk and home safety
4. Review of a member's full list of medications and supplements, including calcium and vitamins
5. An exam with height, weight, body mass index, blood pressure and other routine measurements
6. List or updated list of a member's medical care providers and suppliers
7. Detection of any cognitive impairment
8. Established or updated screening schedule for the next 5–10 years, as appropriate
9. Established or updated list of a member's risk factors
10. Personalized health advice and appropriate referrals to health education or preventive services

Pap/pelvic exam

Well-woman exams should include at least 7 of the following:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry or nipple discharge
2. Digital rectal examination, including sphincter tone and presence of hemorrhoids or rectal masses
3. Examination of external genitalia – For example, general appearance, hair distribution or lesions
4. Examination of urethral meatus – For example, size, location, lesions or prolapse
5. Examination of urethra – For example, masses, tenderness or scarring
6. Examination of bladder – For example, fullness, masses or tenderness
7. Examination of vagina – For example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele or rectocele
8. Examination of cervix – For example, general appearance, lesions or discharge
9. Specimen collection for pap smears and cultures

Annual routine physical exam

This comprehensive physical examination screens for disease, promotes a healthy lifestyle and assesses a member's potential risk factors for future medical problems. It includes the components listed below. Any clinical laboratory tests or other diagnostic services performed at the time of the wellness visit may be subject to a copay or coinsurance.

1. Health history
2. Vital signs
3. General appearance
4. Heart exam
5. Lung exam
6. Head and neck exam
7. Abdominal exam
8. Neurological exam
9. Dermatological exam
10. Extremities exam
11. Male physical exam
    - Testicular, hernia, penis and prostate exams
12. Female physical exam
    - Breast and pelvic exams
13. Counseling to include healthy behaviors and screening services

You may not bill separate codes for components with 99385, 99386, 99387, 99395, 99396 or 99397. Payment for these codes includes reimbursement for all services listed.

Common preventive services and screenings

All UnitedHealthcare Medicare Advantage plans cover the following Medicare-covered preventive services at the same frequency as covered by Original Medicare, except where otherwise noted, for a $0 copay. All preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. In general, screening lab work isn't covered by Medicare and, therefore, not covered by UnitedHealthcare Medicare Advantage plans. The exceptions are listed in the following list of commonly covered preventive services and screenings.

- Alcohol misuse screening and counseling
- Bone mass measurement for those at high risk
- Cardiovascular disease screening tests
- Colorectal cancer screening[1]
- Counseling to prevent tobacco use
- Depression screening
- Diabetes screening
- Diabetes self-management training
- Glaucoma screening for those at high risk[2]
- Hepatitis B virus screening
- Hepatitis B virus vaccine and administration
- Hepatitis C virus screening
- Human papillomavirus (HPV) test
- HIV screening
- Influenza virus vaccine and administration (flu shot)[3]
- Intensive behavioral therapy for cardiovascular disease
- Intensive behavioral therapy for obesity
- Lung cancer screening with low-dose computed tomography
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Pneumococcal vaccine and administration
- Prostate cancer screening (prostate-specific antigen [PSA] test)[4]
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling to prevent STIs
- Screening mammography (2D and 3D mammograms)[5]
- Screening pap tests and pelvic examinations

These additional preventive services and screenings can be provided and billed separately, in addition to the subsequent annual wellness visit (G0439), as long as Medicare guidelines are met. This doesn't apply to the Welcome to Medicare visit (G0402) or the first annual wellness visit (G0438).

Colonoscopies and related subsequent diagnostic procedures

A colonoscopy that begins as an in-network screening service is subject to the $0 screening cost share, regardless of whether a polyp is found and/or removed during the procedure, under all UnitedHealthcare Medicare Advantage plans.

Colonoscopy coding

Code(s)	Type of colonoscopy	Cost sharing
Endoscopy codes G0104, G0121 or G0105	Screening colonoscopy	In network: $0 cost share per the Medicare preventive services coverage guidelines Out of network: Applicable cost share

Resources

To stay up-to-date on current CMS program information and changes, you can subscribe to **Medicare Learning Network® MLN Matters®.** If you have questions, please call the Customer Service number listed on the plan member's ID card.

We're here to help

For more information about how our programs can help support your patients, who are UnitedHealthcare Medicare Advantage plan members, please contact your UnitedHealthcare representative. Thank you.

[1] A colonoscopy that begins as a Medicare-covered screening service is subject to the $0 screening cost share, regardless of whether a polyp is found and/or removed during the procedure. In 2021, all UnitedHealthcare Medicare Advantage plans have a $0 copayment in-network for diagnostic colonoscopies and therapeutic colonoscopies and sigmoidoscopies. (Exception: Group Retiree plans may apply outpatient surgery cost sharing.)

[2] Glaucoma screening is $0 for most non-special needs plans. Special needs plans may apply the same cost sharing as Original Medicare.

[3] Flu shots are covered for a $0 copay with both in-network and out-of-network providers.

[4] A digital rectal exam (DRE) may be subject to cost sharing, depending on the plan. (Note: Most Non-SNPs have a $0 copayment for this service.)

[5] In 2021, many UnitedHealthcare Medicare Advantage plans have a $0 copayment in-network for diagnostic mammograms. (Exception: Special needs plans and Group Retiree plans may apply radiologic diagnostic cost sharing.)

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