JULY/AUGUST 2019

PROVIDER QUALITY NEWSLETTER

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

Interpreta

https://portal.interpreta.com
Are you using Interpreta (MedPOINT's quality tool) to outreach to your patients?

Interpreta refers to care gaps as "alerts". Due alerts are those that are coming due in the future. Overdue alerts are those that have passed the ideal time for completing the service, but there is still time to get them done before the end of the year. This set of alerts is where you have the greatest opportunity to get members in to be seen. Failed alerts are care gaps that have passed the specific due date; the only option for these care gaps is to resubmit an encounter that was missed or submit data via the supplemental data process.

To access the member gap report, just click on any of the highlighted number of gaps and the member list will pop up on your screen. You can choose to export one category of alerts or "All" in the box in the upper right hand side of the window. Click " Export Data" on the upper right to extract a gap report that can be downloaded in Excel and filtered by measure and alert status.

If you need any help with Interpreta or would like to set up your account, please email *interpreta@medpointmanagement.com*.
If you would like to schedule a training, please contact your HEDIS/Stars Specialist by email at *qualitymeasures@medpointmanagement.com* or call 818-702-0100, x1353.

Denominator Alerts: 42,757 Eligible Alerts: 42,850 Excluded Alerts: 93

Compliant alerts	Due alerts	Overdue alerts	Failed alerts
24.735 **58%**	3.179 **7%**	12.540 **29%**	2.303 **5%**

HEDIS 2020 Technical Specifications and Value Sets Released!

The new HEDIS measures and changes for 2020 that affect our current measurement year (MY) 2019 have been released by NCQA (National Committee for Quality Assurance). We are in the process of analyzing the changes and will have more information soon. Until then, please take note of the following significant changes:

Changes to AWC and W34:

1. Added a Note to clarify that handouts given during a visit **without evidence of a discussion does not meet criteria** for Health Education/Anticipatory Guidance.

Changes to PPC:

1. Prenatal and Postpartum Care (PPC) – The measurement year has been changed to **10/8/2018 -10/7/2019** (it was 11/6/18 – 11/5/19).

2. Postpartum Care – Timing was changed from "The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery" to **7 and 84 days after delivery.**

For further information, please consult the HEDIS 2020 Volume 2 Technical Specifications for Health Plans by NCQA.

Back-to-School Shots Time!

August is National Immunization Awareness Month. As you plan your outreach for school immunizations, be sure to check if kids age 11 to 13 have received their vaccines for meningococcal conjugate and Tdap vaccines, plus 2 doses of HPV (for ages 9 and 13). Start calling members now to get their shots before the back-to-school rush!

CAHPS Patient Satisfaction Survey

Make it a team effort! Share the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey form with your staff to show them how they impact these results. Also consider including the survey in your new hire packets.

CAHPS surveys are sent out every year to your members by CMS (Centers for Medicare & Medicaid Services), health plans and medical groups to understand patient experiences and areas where improvements are needed.

A sample of the Adult CAHPS Survey is attached for you to share with staff. Please note that the Child survey also asks about the "provider's attention to your child's growth and development" as well as "provider's advice on keeping your child safe and healthy."

HEDIS Tools You Can Use

Health Net has created the attached tools to help educate your staff and providers on HEDIS. Whether you have members with Health Net or not, you will benefit from these materials:

- Provider Guide – Improve Health Outcomes
- HEDIS Quick Reference Guide
- Breast Cancer Screening Tip Sheet
- Health Outcomes Survey (HOS) Tip Sheet – Improve Patient Care and Quality of Life (Medicare)

Incentive Guides

We have attached the Quality Incentive Initiatives 2019 grid with incentives broken down by health plan and categories (annual wellness visits, direct to health center, IPA incentives and member incentives) for your reference. This is a constant work in progress as new information becomes available so check back with us at *qualitymeasures@medpointmanagement.com* for updates.

Also attached is a chart of all the HEDIS measures that are incentivized by health plan. We hope you find these helpful.

HbA1c Finger Stick

Did you know that a finger stick will count toward the Comprehensive Diabetes Care (CDC) HbA1c measure? If you do point-of-care tests with the HbA1c machine that fills a capillary tube, then it will count. CPT code 83036 is the correct code for point of care testing that will give you credit for this measure.

New Enrollees

It is important to call new members to come in for an initial office visit. MedPOINT's Provider Portal provides a report called "New Enrollees" under "My Documents" and then "Eligibility Reports" that you can download each month. This report should be retrieved every month!

MedPOINT MANAGEMENT
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Health Plan HEDIS Incentives Grid 2019

Changes to the incentives for 2019 are in black and are subject to change. Other information in dark blue is for 2018 and will be revised as information becomes available.

Incentives - for Health Centers – Annual Wellness Visits (AWV)

Plan	Category	Program	Details
Anthem Blue Cross	Medical Record Incentive	Annual Wellness Visit (AWV) Commercial only	The Anthem Commercial Risk Unit is offering a $50 incentive for each completed 2018 Annual Wellness Visit progress note that is faxed to them. (2018)
Blue Shield Promise (Blue Shield/ Care 1st)	STARs Annual Wellness Exam Forms	2019 Annual Wellness Exam (AWE) Provider Incentive Program Medicare, Cal MediConnect (CMC)	Complete the HQPAF (Health Quality Patient Assessment Form) form accurately within 60 days of visit for maximum payment of up to $200 for Medicare, $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.
Brand New Day	STARs Annual Wellness Exam Forms	Annual Wellness Exam (AWE) Medicare	$150 per AWE form in 2019. For info, contact provider_services@universalcare.com.
Health Net	STARs Annual Wellness Exam Forms	Annual Wellness Program Medicare	$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 provided to earn the full incentive.
LA Care	CMC Annual Wellness Exam Forms	Annual Wellness Exam (AWE) Program Cal MediConnect (CMC) only	For members enrolled 2018 to 3/2019, $350 for AWE forms submitted before 7/31/19, $175 if submitted 8/1/19 - 12/31/19. Starting 4/2019, $350 if submitted less than 90 days from date of service (DOS), $175 if after 90 days DOS. For info, email RiskAdjustment@lacare.org or call 213-694-1250, x4952.
Molina	STARs Annual Wellness Exam Forms	Annual Comprehensive Exam (ACE) Medicare/Duals	Molina is partnering with Inovalon to target certain members and health centers are notified if their members are included. For details, please contact: MHCRiskAdjustmentDepartment@molinahealthcare.com.

Incentives – Direct to Health Center

Plans	Category	Program	Details
Blue Shield Promise (Blue Shield/ Care 1st)	HEDIS Postpartum Forms Incentive	Provider Postpartum Incentive	Care 1st reimburses $50 for CMS (HCFA) 1500 Claim Forms sent to their Quality Improvement Dept. for postpartum visits between 21 and 56 days after birth (to be confirmed). For questions, call Aracely Soriano at 619-528-4800, x7644.

Incentives – Direct to Health Center (continued)

Central Health Plan	STARs Incentive	PCP Incentive Program Medicare	The 2019 program has not been released but will be similar to 2018, which included the following measures: Mental Health Screening, Monitor Physical Activity, Improve Bladder Control, Fall Prevention, BMI, Colorectal Cancer, Mammogram, Medication Reconciliation, Blood Pressure </= 139/89, Eye Exam, HbA1c <8%, Nephropathy, Medication list and review, Care for Older Adults and Statin Treatment, plus 3 adherence measures. A minimum of 35 members are required to qualify.
Health Net	HEDIS Incentive	Clinic HEDIS Improvement Program (C-HIP) 2019 Medi-Cal only	Eligibility for 2019 C-HIP bonus payment depends on 0.5% year over year improvement or exceeding the following benchmarks in these HEDIS measures: BCS (60%), CCS (67%), CDC HbA1c Test (93%), CIS Combo 10 (TBD), IMA Combo 2 (40%) and W34 (81%).
Health Net	HEDIS Incentive	HEDIS Improvement Program (HIP) 2019 Medi-Cal only	HIP rewards PCP's efforts to improve quality in the following measures by using encounter data and lab results (CPT II codes are encouraged): BCS ($50), CCS ($100), CDC-HbA1c Test ($75), CIS Combo 10 ($150), IMA Combo 2 ($50) and W34 ($100). 1% year-over-year improvement is required. Other criteria apply. For questions, call Provider Services at 800-675-6110.
Health Net	HEDIS Prenatal/ Postpartum Forms Incentive	Perinatal Notification Incentive Program (PNIP) for Prenatal and Postpartum Care Medi-Cal only	Health Net reimburses providers/health centers $50 for each completed "Timely Prenatal Visit and Pregnancy Notification Form" and "Postpartum Care Notification Form" up to June 2019. No incentive post June 2019.
LA Care	HEDIS Incentive	Physician P4P (Payment for Performance) Medi-Cal only Includes plan partners: Anthem Blue Cross and Blue Shield Promise	Measures, reports and provides significant financial rewards for performance on Access/Availability (must pass audit for urgent care process, 24/7 physician access and after hours calls returned within 30 minutes) and HEDIS measures. The 15 HEDIS measures include CIS10*, W34*, IMA2, CCS*, CHL, BCS, PPC (prenatal and postpartum*), CDC (HbA1c screening and Control <8, Eye Exams), AAB, CWP, AMR and WCC. Double-weighted measures are indicated by *. HEDIS measures must meet minimum threshold of 50th percentile score to qualify. Each performance measure has an attainment score and improvement score. Complete, timely and accurate encounter data is also key. Contact Incentive_Ops@lacare.org for P4P and reporting questions.
LA Care	HEDIS Behavioral Health Incentive	eManagement Physician Incentive Program Medi-Cal only	Incentive is for completion of screening tools for members experiencing depression, anxiety, and/or substance use issues in the primary care setting. $50 for screening tools, $50 for eManagement dialogue.

Incentives – Direct to Health Centers (continued)

Molina	HEDIS Incentive	HEDIS P4P (Pay-for-Performance) Program Medi-Cal and Marketplace	The P4P Program HEDIS measures and payment were revised on 6/14/19. Payment has been revised with some measures paid from 4th quarter performance rates and NCQA benchmarks achieved. Measures included in the program are: **Medi-Cal:** Breast Cancer Screening (BCS), Comprehensive Diabetes Care (CDC) for HbA1C Control, Childhood Immunization Status (CIS) Combo 10, Well Child visits 3-6 years (W34), Timeliness of Prenatal Care - First Visit, Timeliness of Postpartum Care, Adolescent Well Care (AWC) and Asthma Medication Ratio (AMR). **Marketplace**: CDC HbA1c <8.0% and Prenatal Care. Revised details are on the Molina "Just the Fax" Update on 6/14/19. Contact Provider Services liaison at (855) 322-4075 for questions.
Molina	HEDIS Incentive	CHDP Wellness Incentive Medi-Cal only	Health Centers with minimum of 200 members (minimum only applies to LA County) receive incentive bonus payments from complete, accurate and timely wellness services submitted via the encounter process within 60 days from the date of service. Bonus amounts are listed as fee-for-service on the Molina "Just the Fax" update dated 1/18/19. Contact Molina Provider Services liaison at (855) 322-4075 for questions.

Incentives – IPA

Plans	Category	Program	Details
Blue Shield Promise (Blue Shield/ Care 1st)	HEDIS Incentive	IPA Incentive Program Commercial and Medi-Cal	Blue Shield of California Promise Health Plan has aligned their Medi-Cal and Commercial lines of business with the Integrated Healthcare Association (IHA) statewide quality performance and payment incentive model called "Align. Measure. Perform." (AMP). The IHA incentive is based on scores calculated as part of the Integrated Health Association's (IHA) Value Based Pay for Performance Program (PVP4P.)
Blue Shield Promise (Blue Shield/ Care 1st)	HEDIS Incentive	Value Initiative Program Los Angeles (VIP LA)	Incentives are calculated based on LA Care's VIIP scores for 5 domains – access and availability, HEDIS, member satisfaction, utilization and encounter timeliness. Two incentive tiers: 90th – 100th percentile and 50th – 89th percentile.
Blue Shield Promise (Blue Shield/ Care 1st)	HEDIS/STARs Incentive	Depression Screening Incentive Commercial, Medi-Cal, Medicare, Medi-Medi	Care 1st reimburses $30.00 for each eligible depression screening procedure code for all members over 12 years using a standardized tool. Encounters must be submitted through the standard encounter data process, plus a monthly invoice submitted within 30 days of date of service. (2018)
Health Net	HEDIS Incentive	HQIP (HEDIS Quality Incentive Program) for PPGs 2019 Medi-Cal only	Incentive is based on encounter volume (≥ 75th percentile, plus improvement scores), accuracy and timeliness (75% within 75 days), and quality improvement in HEDIS Measures: AMR (goal is 62%), CBP (71%), CCS (67%), CDC-HbA1c Testing (93%), CIS10 (TBD), IMA2 (40%), PPC Prenatal (89%) & Postpartum (60%) and W34 (81%). Award multiplier up to $1.25 also applies. For further details, contact MedPOINT Quality Management at (818) 702-0100, x1353.

Incentives – IPA (continued)

LA Care	HEDIS Incentive	LA VIIP (Value Initiative for IPA Performance) + P4P (Pay-for-Performance Program) Medi-Cal only Includes plan partners: Anthem Blue Cross and Blue Shield Promise	Incentive has changed and includes significant financial rewards for performance across the following domains and measures. Each performance measure includes attainment and improvement scores. **HEDIS (30%) -** The 15 HEDIS measures include: CIS10*, W34*, IMA2, CCS*, CHL, BCS, PPC (prenatal* and postpartum), CDC (A1c screening, A1c Control <8% and Eye Exam), AAB, CWP, WCC, and AMR. Controlling High Blood Pressure is a test measure this year. **Member Experience (30%)** - for both Adult and Child includes: (1) Timely Care and Service*, (2) Getting Needed Care*, (3) Rating of all Health Care and (4) Rating of PCP. Double-weighted measures above are indicated by "*." **Utilization Management (20%)** – Includes (1) Acute Hospitalization Admission Rate (AHU), (2) Plan All-Cause Readmissions (PCR) and (3) Emergency Dept. Utilization. **Encounters (20%)** – Includes (1) Timeliness within 60 days of service and (2) Volume per member per year. NOTE: MY2019 ranking data will be unblinded to groups. Contact VIIP@lacare.org if you have questions.
LA Care	HEDIS Incentive	L.A. Care Covered VIIP (Value Initiative for IPA Performance) Program LA Care only Commercial (AMP) LA Covered (LACC)	Commercial incentive through the Integrated Healthcare Association (IHA) on the Align. Measure. Perform (AMP) Program, with payout in 2020 for 2019 data (no 2018 payment). **HEDIS (30%)** – Total of 24 HEDIS measures include: CDC (A1c Control <8%, Nephropathy, Eye Exam, Blood Pressure Control, A1c Poor Control >8%), SPD & SPC (Statin Therapy for Patients with Diabetes and Cardiovascular Disease), Proportion on days covered by medications (for Oral Diabetes Medications and RAS Antagonists and Statins), CBP, AAB, BCS, CCS, COL, CHL, CIS10, CWP, IMA2, AMR, Concurrent Use of Opioids and Benzodiazepines and Use of Opioids at High Dosage. **Member Experience (30%)** – Includes Care Coordination, Office Staff, Overall Ratings of Care, Provider Communication and Access. Prenatal is a test measure for 2019. **Utilization Management (20%)** – Includes ER utilization, All-Cause Readmission, Inpatient utilization, Acute hospital utilization, Ambulatory care, Outpatient procedures, Generic prescribing and Frequency of Selected Procedures. **Encounters (20%)** – Includes (1) Timeliness within 60 days of service and (2) Volume by professional and facility and by per member per year. Contact VIIP@lacare.org if you have questions.

Incentives – IPA (continued)

LA Care	HEDIS Incentive	Cal MediConnect VIIP (Value Initiative for IPA Performance) Program LA Care only Cal MediConnect (CMC)	Medi-Medi incentive, with payout in 2020 for 2019 data (no 2018 payment). **HEDIS (25%)** – HEDIS measures include: BCS, COL COA, CDC (A1c<8%, Eye Exam, Blood Pressure Control), AMM (Antidepressant Med. Mgmt.) and DAE (Use of High Risk Medications in the Elderly). **Care Management (20%)** – Includes Annual Wellness Exam, care coordinator and care team contact, timely ICP completion and log accuracy and completeness. **Member Experience (20%)** – Includes disenrollment (TRR), retention over 90 days (TRR) and Member Satisfaction for getting care quickly, getting needed care, rating of PCP and rating of health care quality. **Utilization Management (15%)** – Includes All-Cause Readmission (PCR), ED utilization (EDU) and reduction in ED use for seriously mentally ill and substance use disorder members. **Encounters (10%)** – Includes (1) Timeliness within 180 days of service and (2) Volume by per member per year. **Pharmacy (10%)** - Includes Part D Medication Adherence for Oral Diabetes, Hypertension and Cholesterol (Statins). Contact VIIP@lacare.org if you have questions.

Incentives – Member

Source	Category	Program	Details
Alignment	STARs	Jump Start Assessment (JSA) Medicare Advantage members	Eligible members who complete the JSA receive a $25 grocery gift certificate. Patients receive initial assessment within first 30-90 days of membership and annual wellness visits. Patients call: 844-215-2443 Clinic location: 6201 Whittier Blvd., East LA 90022 Hours: 8:00 am – 5:00 pm. (2018)
Anthem Blue Cross	Commercial	Member Incentive Program – Preventive Care Commercial Members	$25 Visa gift card sent to members for completion of HbA1c test, diabetic eye exam, cervical cancer screening, breast cancer screening, well child 3-6 years visit and adolescent well care visit. (2018)
Anthem Blue Cross	Commercial	Member Incentive Program – Hypertension Commercial Members	Members with a diagnosis of hypertension with high blood pressure readings will be offered to come to the clinic and offered lifestyle and diet modification education materials (provided by Anthem) and a free BP monitor and $25 visa gift card at the time of the visit. (2018)
Blue Shield	STARS	Member Incentive Program Medicare Advantage Prescription Drug (MAPD) Members	Gift card to members for completing healthcare activities for seven measures through self-attestation: (1) $50 for Colorectal Cancer Screening; (2) $25 each for Annual Wellness Visit, (3) Eye Exam, (4) Diabetes Blood-Sugar Controlled, (5) Breast Cancer Screening; (6) Osteoporosis Bone Density Test; and (7) $10 for annual flu vaccine. $25 Bonus for completing all 3 Colorectal, Eye Exam and BCS.
Brand New Day	STARS	Rewards Plus Program	Gift cards for completing preventive screening: (1) $50 for Annual Wellness Exam in 2019, (2) $25 for colonoscopy or $10 for stool FIT test, (3) $10 for Health Risk Assessment, (4) $10 for annual exercise plan, (5) $25 for mammogram and (6) $25 for diabetic members who have A1c, eye exam and nephropathy. Call 866-255-4795 for questions.

Incentives – Member (continued)

Health Net	HEDIS	Preventive Care Incentives Medi-Cal only	Members received mailer with attestation form and mails it back to the plan with provider signature and receives $25 prepaid card for each completed screening - Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS) or Well Child Visit (W34). $50 for all 3 tests for Comprehensive Diabetes Care (CDC) - HbA1c test, Nephropathy and Eye Exam, and $50 for Childhood Immunization Status (CIS 10) in 2019. Forms for each measure are available in 12 languages on the Health Net provider portal at *Working with Health Net > Quality > Member Incentives Medi-Cal* or fax 800-628-2704.
Health Net	Stars	Medicare HMO Incentives Medicare	Eligible Medicare members received a mailer in March and receives a Visa prepaid card for encounters received for the following: Breast Cancer Screening ($20), Ongoing Diabetes Care (CDC) ($20 to $50), and $20 each for Health Risk Assessment, Bone Density test and Flu testing. Incentive varies with product.
Health Net	HEDIS	Prenatal and Postpartum Care Member Incentive Medi-Cal only	$25 Visa gift card for receiving a timely prenatal (ends June 2019) or postpartum care visit in 2019 (new 2019 postpartum incentive is being planned to align with changes to measure in July). Members receive the gift card upon receipt of a provider-completed Perinatal Notification Incentive Program (PNIP) form.
Molina	HEDIS	Member Incentive Program Medi-Cal and Marketplace	$75 Walmart gift card for completion of Adolescent Well Care (AWC) and Well Child age 3-6 (W34) well visits during 2019. Eligible members will receive a mailing that includes the incentive requirements and a Molina Cares Well-Child Annual Visit Form. A provider signature will be requested on the form along with the details included In the well-child visit record.
Molina	HEDIS	Postpartum In-Home Assessment – "MOM Program"	Molina tote bag with diapers and materials after in-home assessment.

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

07/31/2019

Health Plan HEDIS Incentivized Measures 2019

HEDIS	Health Net C-HIP (Hlth Ctr)	Health Net HQIP (IPA)	LA Care Anthem/ BS Promise P4P (Hlth Ctr) & VIIP (IPA)	LA Care only VIIP (AMP) (IPA)	LA Care only VIIP (scoring only) (IPA)	Molina P4P (Hlth Ctr) **
Measures	**Medi-Cal**	**Medi-Cal**	**Medi-Cal**	**Commercial/ LA Covered**	**CMC - Cal MediConnect**	**Medi-Cal**
AAB - Avoidance of Antiobiotics for adult bronchitis			X	X		
AMR - Asthma Medication Ratio		X	X	X		X
AMM - Antidepressant Med. Mgmt.					X	
AWC - Adolescent Well Care						X
BCS - Breast Cancer Screening	X		X	X	X	X
CBP - Controlling Blood Pressure		X	Reporting	X		
CCS - Cervical Cancer Screening	X	X	X*	X		
CDC - Blood Pressure Control <140/90				X	X	
CDC - HbA1c Poor Control >9%				X		
CDC - HbA1c Control <8%			X	X	X	X***
CDC - HbA1c Testing	X	X	X			
CDC - Eye Exam			X	X	X	
CDC - Nephropathy				X		
CHL - Chlamydia			X	X		
CIS - Combo 10 - Childhood Immunization Status	X	X	X*	X		X
COA - Care for Older Adults					X	
COL - Colorectal				X	X	
CWP - Testing for Children with Pharyngitis			X	X		
DAE - Use of High Risk Medications in the Elderly					X	
IMA - Combo 2 - Immunization for Adolescents	X	X	X	X		
PPC - Postpartum		X	X			X
PPC - Prenatal		X	X*			X***
SPC - Statin Therapy with Cardiovascular Disease				X		
SPD - Statin Therapy with Diabetes				X		
W34 - Well Child age 3-6	X	X	X*			X
WCC - Weight Assessment/Nutrition/Phys Activity - BMI total			X			
Concurrent Use of Opioids and Benzodiazepines				X		
Use of Opioids at High Dosage				X		

* LA Care double weighted measures.
** Molina also has a Medi-Cal CHDP Incentive Program.
*** Molina also incentivizes CDC HbA1c <8% and Prenatal for Marketplace members.

Incentive payments for these HEDIS measures are dependent on other factors, such as encounters and payment gates. Please refer to the health plan documents for further details.

Program Definitions:
· *Health Net **C-HIP** - Clinic HEDIS Improvement Program*
· *Health Net **HQIP** - HEDIS Quality Incentive Program*
· *LA Care **VIIP** - Value Initiative for IPA Performance*
· ***P4P** - Pay 4 Performance*

Major health plans are represented above; other plans may also offer incentives not included in this grid.

7/18/19

SURVEY OF YOUR EXPERIENCE WITH YOUR PROVIDER

YOUR PROVIDER

1. Our records show that you got care from the provider named below in the last 6 months.

Is that right?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 38*

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

- ○ 1 Yes
- ○ 2 No

3. How long have you been going to this provider?

- ○ 1 Less than 6 months
- ○ 2 At least 6 months but less than 1 year
- ○ 3 At least 1 year but less than 3 years
- ○ 4 At least 3 years but less than 5 years
- ○ 5 5 years or more

4. Which of the following best describes how you became this provider's patient?

- ○ 1 I requested to be assigned to this provider
- ○ 2 I did not know this provider previously, and selected this provider from the health plan's list of providers when I enrolled
- ○ 3 I was assigned to this provider by my health plan
- ○ 4 This provider was the next available provider when I called or visited the clinic to get medical care
- ○ 5 Other: _____

YOUR CARE FROM THIS PROVIDER IN THE LAST 6 MONTHS

These questions ask about <u>your own</u> health care. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

5. In the last 6 months, how many times did you visit this provider to get care for yourself?

- ○ 1 None → *If None, go to Question 38*
- ○ 2 1 time
- ○ 3 2
- ○ 4 3
- ○ 5 4
- ○ 6 5 to 9
- ○ 7 10 or more times

6. In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that <u>needed care right away</u>?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 8*

7. In the last 6 months, when you contacted this provider's office to get an appointment for <u>care you needed right away</u>, how often did you get an appointment as soon as you needed?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

8. In the last 6 months, did you make any appointments for a <u>check-up or routine care</u> with this provider?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 10*

9. In the last 6 months, when you made an appointment for a <u>check-up or routine care</u> with this provider, how often did you get an appointment as soon as you needed?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

10. Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?

- ○ 1 Yes
- ○ 2 No

11. In the last 6 months, did you contact this provider's office with a medical question during regular office hours?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 13*

12. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

13. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see this provider <u>within 15 minutes</u> of your appointment time?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

MANAGING YOUR CARE

14. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

15. In the last 6 months, how often did this provider listen carefully to you?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

16. In the last 6 months, how often did this provider seem to know the important information about your medical history?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

17. In the last 6 months, how often did this provider show respect for what you had to say?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

18. In the last 6 months, how often did this provider spend enough time with you?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

19. In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 21*

20. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

OVERALL RATING OF PROVIDER

21. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- ○ 0 Worst provider possible
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 Best provider possible

22. Would you recommend this provider?

- ○ 1 Yes, definitely
- ○ 2 Yes, maybe
- ○ 3 Undecided
- ○ 4 No, not likely
- ○ 5 No, never

ADDITIONAL EXPERIENCE WITH PROVIDER

23. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 25*

24. In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

Please answer these questions about the provider named in Question 1 of this survey.

25. In the last 6 months, did someone from this provider's office talk with you about specific goals for your health?

- ○ 1 Yes
- ○ 2 No

26. In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health?

- ○ 1 Yes
- ○ 2 No

27. In the last 6 months, did you and this provider talk about a healthy diet, healthy eating habits, and keeping a healthy weight?

- ○ 1 Yes, definitely
- ○ 2 Yes, somewhat
- ○ 3 No

28. In the last 6 months, did you talk with this provider about the exercise and physical activity that you get?

- ○ 1 Yes, definitely
- ○ 2 Yes, somewhat
- ○ 3 No

29. In the last 6 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress?

- ○ 1 Yes
- ○ 2 No

30. In the last 6 months, how often did you feel sad, empty, depressed, or stressed?

- ○ 1 Never → *If Never, go to Question 32*
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

31. In the last 6 months, did anyone at this provider's office recommend treatment for your depression or stress, such as medication, counseling, a class, or any other help?

- ○ 1 Yes, definitely
- ○ 2 Yes, somewhat
- ○ 3 No

32. In the last 6 months, did you take any prescription medicine?

- ○ 1 Yes
- ○ 2 No → *If No, go to Question 34*

33. In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

34. If you asked this provider for help in managing your pain, how would you rate the help you got?

- ○ 1 Excellent
- ○ 2 Very good
- ○ 3 Good
- ○ 4 Fair
- ○ 5 Poor
- ○ 6 I did not ask for help in managing my pain

35. In the last 6 months, when you needed an interpreter to talk with doctors or staff at this provider's office, how often did you get one?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always
- ○ 5 I did not need an interpreter to talk with doctors or staff at this provider's office in the last 6 months

CLERKS AND RECEPTIONISTS AT THIS PROVIDER'S OFFICE

36. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

37. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always

ADDITIONAL EXPERIENCE

38. What can your provider or the clinic staff do to improve the health care or services or information that you get?

_____

_____

_____

39. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always
- ○ 5 I did not try to get care, tests, or treatment in the last 6 months

40. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- ○ 1 Never
- ○ 2 Sometimes
- ○ 3 Usually
- ○ 4 Always
- ○ 5 I did not try to get an appointment to see a specialist in the last 6 months

41. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

- ○ 0 Worst health plan possible
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 Best health plan possible

42. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

- ○ 0 Worst health care possible
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 Best health care possible

ABOUT YOU

43. In general, how would you rate your overall health?

- ○ 1 Excellent
- ○ 2 Very good
- ○ 3 Good
- ○ 4 Fair
- ○ 5 Poor

44. In general, how would you rate your overall <u>mental or emotional</u> health?

- ○ 1 Excellent
- ○ 2 Very good
- ○ 3 Good
- ○ 4 Fair
- ○ 5 Poor

45. What is your age?

- ○ 1 18 to 24
- ○ 2 25 to 34
- ○ 3 35 to 44
- ○ 4 45 to 54
- ○ 5 55 to 64
- ○ 6 65 to 74
- ○ 7 75 or older

46. Are you male or female?

- ○ 1 Male
- ○ 2 Female

47. What is the highest grade or level of school that you have completed?

- ○ 1 8th grade or less
- ○ 2 Some high school, but did not graduate
- ○ 3 High school graduate or GED
- ○ 4 Some college or 2-year degree
- ○ 5 4-year college graduate
- ○ 6 More than 4-year college degree

48. Are you of Hispanic or Latino origin or descent?

- ○ 1 Yes, Hispanic or Latino
- ○ 2 No, not Hispanic or Latino

49. What is your race? Mark one or more.

- ○ a White
- ○ b Black or African American
- ○ c Asian
- ○ d Native Hawaiian or Other Pacific Islander
- ○ e American Indian or Alaska Native
- ○ f Other

50. What language do you mainly speak at home?

- ○ 1 English
- ○ 2 Spanish
- ○ 3 Some other language (please print)

_____

THANK YOU

When you are done, please use the enclosed prepaid envelope to mail the questionnaire to:
Center for the Study of Services, PO Box 10820, Herndon VA 20172-9940

Health Net®

Improve Health Outcomes

A GUIDE FOR PROVIDERS

PROVIDER COMMUNICATIONS

Coverage for every stage of life™

Contents

You Can Improve Your Patients' Health Outcomes and Quality of Care

Our providers' commitment to provide the highest quality of care to their patients is vital to improving health outcomes. This includes taking actions to meet this goal:

- *Identify and close care gaps for preventive screenings, annual exams and vaccinations.*
- *Complete timely submission of claims or encounters data.*
- *Share health education to impact patient behavior.*
- *Provide care coordination and timely access to care and services.*
- *Meet the cultural and linguistic needs of each person.*
- *Follow recommended clinical, preventive health guidelines and best practices.*

Health Net knows the importance of working with, and helping providers in their efforts to improve their patients' health to meet quality standards. This toolkit provides information about performance measures. It also contains useful tools to support your practice.*

We have the same goal – to help improve your patients' health outcomes and provide the highest quality of care.

Health Care Performance Measurement Systems

Health Net covers patients across multiple health insurance markets to meet the needs of its diverse patient population. We monitor quality of care and patient experience metrics to improve patient health outcomes and satisfaction.

Reporting on care and service performance metrics is required by the:

- Centers for Medicare & Medicaid Services (CMS).
- Department of Health Care Services (DHCS).
- National Committee for Quality Assurance (NCQA).
- State of California's Office of the Patient Advocate (OPA) .

Medicare Star Ratings

CMS uses a five-star quality rating system to measure the overall experience Medicare patients have with their Medicare Advantage (MA) health plans. Health plans are assigned a rating of one to five stars, with five stars being the highest, based on performance.

The quality rating combines medical and pharmacy services when both are provided by the plan and are published on the CMS website at www.medicare.gov. The star rating impacts an MA plan's financial payment from CMS. It is essential to receive a rating of at least four stars.

The quality of plan services rating includes many measures in several categories:

- Staying healthy, including screenings, tests and vaccines.
- Managing chronic conditions.
- Patient satisfaction, including access to care.
- Patient complaints.
- Customer service.
- Patient experience with the drug plan, including safety and accuracy of pricing.

Managed Care Accountability Set

DHCS oversees the Medi-Cal health insurance program. They require Medi-Cal managed care plans (MCPs) to meet minimum performance levels on measures key to the health of this population. DHCS informs health plans of the measures, known as the Managed Care Accountability Set, and requires performance to be reported to DHCS annually.

MCPs must meet minimum performance levels established by DHCS for the Managed Care Accountability Set measures. Health Net works with providers and conducts performance improvement projects (PIPs) to address areas below benchmarks.

Marketplace Quality Rating System (QRS)

CMS requires commercial health plans taking part in the Marketplace to submit a comprehensive set of clinical measures and survey results. Plan performance is rated on a five-star scale. Health Net's overall rating for preventive and chronic care measures, patient experience, and plan administration is displayed by CMS on their website at www.medicare.gov.

Office of the Patient Advocate (OPA) Quality Report Cards

California's Office of the Patient Advocate (OPA) publicly reports information on commercial HMO and PPO plans.

The OPA Report Cards are based on a five-star quality rating system.

The OPA Health Care Quality Report Card at www.opa.ca.gov, also reports medical group performance on specific measures.

These provider performances help consumers compare quality when making health plan choices. These include:

- Asthma care.
- Diabetes care.
- Heart care.
- Preventive screening.
- Treating children.
- Appropriate use of tests, treatments and procedures.

Making sure these metrics are at least four stars ensures that patients are getting the right care.

Performance Measures

THESE MEASURES ARE USED TO REPORT, COMPARE AND RATE

Patients' experience and quality of care.

Your practice's preventive and chronic care efforts – used to determine incentive programs.

Overall performance of health plans.

Health outcomes to identify best practices or improvements needed.

Regulators use NCQA's standardized Healthcare Effectiveness Data and Information Set (HEDIS®) metrics and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to rate health plans. HEDIS and CAHPS measures also drive improvements in health care performance.

Providers have a direct impact on affiliated health plans and provider organization performance ratings based on patient experience and the care provided.

HEDIS Measures

HEDIS is a set of standardized measures developed by NCQA to measure, report and compare performance across health plans. Visit the NCQA website at www.ncqa.org for more information.

HEDIS results for health plans and provider organizations are publicly reported in the NCQA Quality Compass and state and federal Quality Report Cards. They are used by purchasers and consumers to compare performance between health plans.

CAHPS Survey

The CAHPS survey is conducted annually on a random sample of patients. CAHPS results are used to measure patient experience with:

- ✔ **Access to care.**
- ✔ **Care coordination.**
- ✔ **Getting the care needed.**
- ✔ **Interactions with providers.**
- ✔ **Services delivered by the health plan.**

The CAHPS Survey Tip Sheet gives examples of survey questions. It also provides recommendations to improve providers' CAHPS performance. More information about how to improve these measures can be found in the Tips and Guidelines for Access to Care brochure on the Health Net provider portal.

Health Outcomes Survey (HOS)

The HOS is sent to a random sample of Medicare patients between April and July of each year. It evaluates baseline physical and mental health status and other health-related topics. The HOS is then sent to the same patients two years later to determine changes over time.

Provider interactions with patients have a direct impact on the following HOS star metrics:

- Improving or maintaining physical health.
- Improving or maintaining mental health.
- Monitoring physical activity.
- Reducing risk of falling.
- Improving bladder control.

Pharmacy Measures

Pharmacy measures evaluate appropriateness and patient adherence to taking prescribed medications. This can include the percentage of patients appropriately prescribed, monitored or adherent for:

- Antidepressants
- Asthma medications
- Beta blockers
- Bone strengthening
- Cholesterol medications
- Diabetes medications
- Hypertension medications
- Opioids

Patient eligibility and performance on medication measures are based on evidence-based clinical guidelines and prescription claims.

Providers have the greatest impact on:

- **Prescribing appropriate treatment.**
- **Promoting medication adherence.**
- **Addressing patient barriers, such as knowledge deficits and side effects.**

To learn more about survey questions and actions providers can take to improve performance, refer to the HOS Tip Sheet included in the pocket of this toolkit.

Quality Improvement Activities

Health Net conducts patient outreach activities to promote healthy preventive and chronic care practices, including:

- Mailed materials, such as flyers, postcards, health calendars, and newsletters.
- Educational emails.
- Live and programmed calls.
- Health education classes.
- In-home visits.
- Text messaging.

Health Net works with providers to improve health outcomes and data capture of measures by:

- Offering weekend and extended access clinics.
- Providing online patient care gap lists.
- Data sharing, such as pharmacy/lab data and electronic medical records.
- Creating provider and patient tools.

Incentive Programs

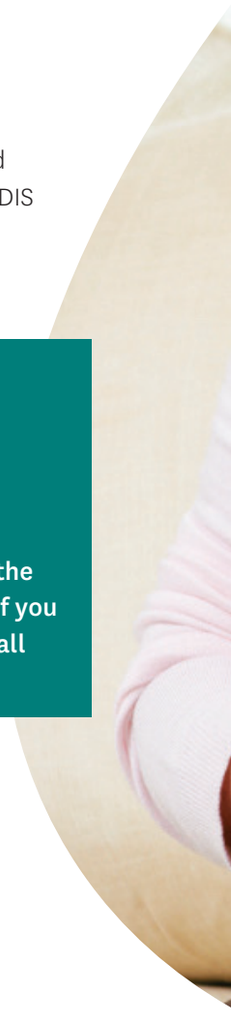
Your performance scores are used to measure your practice's quality improvement and preventive care efforts. Performance-based incentive programs reward participating primary care physicians (PCPs), clinics and participating physician groups (PPGs) based on care gap closures and HEDIS performance from claims and encounters data.

Provider Portal

The Health Net provider portal allows easy access to:

- **Patient eligibility.**
- **Prior authorizations.**
- **Claims status.**
- **Medical policies.**
- **Quality improvement resources and tools.**

You must have a website account to access secure information on the provider portal. If you don't have an account, it's easy to register. If you are not able to register on the provider portal or have questions, call technical support.



Quality Improvement Resources Online

Navigating the Quality Improvement Corner

Health Net's Quality Improvement Department posts helpful tools on the Quality Improvement (QI) Corner in the provider portal.

USEFUL INFORMATION ON HEALTH CARE TOPICS INCLUDES

- **Access to care.**
- **Behavioral health.**
- **Care coordination.**
- **Disease management.**
- **Maternity and obstetrics.**
- **Patient safety.**
- **HEDIS tip sheets and guides.**

Health Net encourages the use of these tools. They can be used to help patients better understand their health care. These tools also help to improve patient recall, their experience and meet quality of care standards.

Provider Library

The online Provider Library allows providers to access relevant items in real time. This includes operations manuals, updates and letters, forms, contacts, Online News, help, and more.

Provider Reports

The provider portal allows PPGs to access provider care gaps and report cards. These reports assist in closing care gaps and improving compliance.

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Health Net®

HEDIS®
Quick Reference Guide

USE THIS TOOL TO HELP CODE AND UNDERSTAND QUALITY MEASURES

PROVIDER COMMUNICATIONS

Coverage for every stage of life™

How are rates calculated?

Healthcare Effectiveness Data and Information Set (HEDIS®) rates can be calculated in two ways: administrative data or hybrid data.

- Administrative data consists of claims or encounter data submitted to the plan.
- Hybrid data consists of administrative data and a sample of medical record data. It also requires review of a random sample of member medical records to abstract data for services that were rendered but were not reported to the plan through claims or encounter data.

Submitting accurate and timely claim and encounter data reduces the need for medical record review. If services are not billed or billed accurately, they are not included in the calculation.

How can I improve my HEDIS scores?

- Submit claim/encounter data for services rendered.
- Make sure that chart documentation reflects all services billed.
- Bill (or report by encounter submission) for all delivered services, regardless of contract status.
- Make sure that all claim/encounter data is submitted in an accurate and timely manner.
- Consider adding CPT II codes to provide more details and reduce medical record requests.

Questions?

Contact the Quality Improvement Department by email at **cqi_dsm@healthnet.com** or **cqi_medicare@healthnet.com**.

For more information, visit **www.ncqa.org**.

Providers and other health care staff should document to the highest specificity to aid with the most correct coding choice.

Ancillary staff: Please check the tabular list for the most specific ICD-10 code choice.

This quick reference guide (QRG) has been updated with information from the July and October 2018 release of the HEDIS 2019 Volume 2 Technical Specifications.

The information provided in this HEDIS QRG is to help you increase your practice's HEDIS rates. The information is subject to change based on guidance and updates from the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS) and state regulations and recommendations. Refer to the appropriate agency for additional billing guidance to ensure codes are coverable prior to submission. Codes listed are not all inclusive and can be changed, deleted or removed at any time. This document is not intended to replace professional coding standards and additional codes that meet exclusion criteria or numerator compliance may be omitted.

A

ADHERENCE TO ANTIPSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA (SAA)

The percentage of members ages 19–64 during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

HCPCS
J2794, J0401, J1631, J2358, J2426, J2680

ADOLESCENT WELL-CARE VISITS (AWC)

The percentage of enrolled members ages 12–21 who had at least one comprehensive well-care visit with a primary care physician (PCP) or an obstetrics/gynecology (OB/GYN) practitioner during the measurement year.

Documentation in the medical record must include evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

CPT	HCPCS	ICD-10
99384–99385 99394–99395	G0438, G0439	Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0–Z02.6, Z02.71, Z02.82, Z76.1, Z76.2

ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES (AAP)

The percentage of members age 20 and older who had an ambulatory or preventive care visit during the measurement year.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

The rates are stratified by the following age brackets:

- 20–44 years.
- 45–64 years.
- 65 years and older.
- Total.

CPT	CPT Modifier	HCPCS	ICD-10
99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 92002, 92004, 92012, 92014, 99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337, 98966–98968, 99441–99443, 98969, 99444, 99483	95, GT	G0402, G0438, G0439, G0463, T1015, S0620, S0621	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0–Z02.6, Z02.71, Z02.79, Z02.81–Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

ADULT BMI ASSESSMENT (ABA)

The percentage of members ages 18–74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Criteria	ICD-10
For members younger than age 20/ages 18 & 19 on date of service	Z68.51–Z68.54
For members age 20 or older	Z68.1, Z68.20–Z68.39, Z68.41–Z68.45

ANNUAL DENTAL VISIT (ADV)

The percentage of members ages 2–20 who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.

The rates are stratified by the following age brackets:

- 2–3 years.
- 4–6 years.
- 7–10 years.
- 11–14 years.
- 15–18 years.
- 19–20 years.
- Total.

Note: Any visit with a dental practitioner during the measurement year meets criteria.

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS (MPM)

The percentage of members age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.

- **ACE or ARB.** Members who are age 18 and older who received at least 180 treatment days of angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), within the past year should have at least one:

Panel/Test	CPT
Lab panel	80047, 80048, 80050, 80053, 80069
Annual serum potassium test	80051, 84132
Annual serum creatinine test	82565, 82575

- **Diuretics.** Members who are age 18 and older who have received at least 180 treatment days of a diuretic within the past year should have at least one:

Panel/Test	CPT
Lab panel	80047, 80048, 80050, 80053, 80069
Annual serum potassium test	80051, 84132
Annual serum creatinine test	82565, 82575

ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)

The percentage of members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment.

- **Effective Acute Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- **Effective Continuation Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 180 days (six months).

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS (CWP)

The percentage of children ages 3–18 who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Panel/Test	CPT
Lab panel	87070, 87071, 87081, 87430, 87650–87652, 87880

APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION (URI)

The percentage of children ages 3 months to 18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

ASTHMA MEDICATION RATIO (AMR)

The percentage of members ages 5–64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

The rates are stratified by the following age brackets:

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- Total.

AVOIDANCE OF ANTIBIOTIC TREATMENT IN ADULTS WITH ACUTE BRONCHITIS (AAB)

The percentage of adults ages 18–64 with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

B

BREAST CANCER SCREENING (BCS)

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

Exclusion: Women who have had a bilateral mastectomy are exempt from this measure. Diagnostic screenings are not compliant.

CPT	ICD-10 (for a history of bilateral mastectomy)
77061–77063, 77065–77067	Z90.13

C

CARDIOVASCULAR MONITORING FOR PEOPLE WITH CARDIOVASCULAR DISEASE AND SCHIZOPHRENIA (SMC)

The percentage of members ages 18–64 with schizophrenia or schizoaffective disorder and cardiovascular disease who had an LDL-C test during the measurement year.

CPT	CPT-CAT-II
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

CARE FOR OLDER ADULTS (COA)

The percentage of adults age 66 and older who had each of the following during the measurement year:

- Advance care planning.
- Medication review.
- Functional status assessment.
- Pain assessment.

Codes	CPT	CPT-CAT-11	HCPCS	ICD-10
Advance care planning	99497, 99483	1123F, 1124F, 1157F, 1158F	S0257	Z66
Medication review	90863, 99605, 99606, 99483	1159F, 1160F	G8427	
Functional status assessment	99483	1170F	G0438, G0439	
Pain assessment		1125F, 1126F		

CERVICAL CANCER SCREENING (CCS)

The percentage of women ages 21–64 who were screened for cervical cancer using either of the following criteria:

Criteria	CPT	HCPCS	ICD-10
Women ages 21–64 who had cervical cytology performed every 3 years.	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	
Women ages 30–64 who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years.	87620–87622, 87624, 87625	G0476	
Women who have had a hysterectomy without a residual cervix are exempt from this measure.	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552–58554, 58570–58573, 58575, 58951, 58953, 58954, 58956, 59135		Q51.5, Z90.710, Z90.712

CHILDHOOD IMMUNIZATION STATUS (CIS)

The percentage of children age two who received the required childhood immunization combination 10 vaccinations.

Note: Refer to the California Immunization Registry (CAIR) website at www.cairweb.org for information on tracking and submitting patient immunization records.

- **Combination 10.** The percentage of children age two who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

(continued)

CHILDHOOD IMMUNIZATION STATUS (CIS) (continued)

Codes	CPT	CVX	HCPCS
DTaP	90698, 90700, 90721, 90723	20, 50, 106, 107, 110, 120	
HiB	90644–90648, 90698, 90721, 90748	17, 46–51, 120, 148	
HepB	90723, 90740, 90744, 90747, 90748	08, 44, 45, 51, 110	G0010
IPV	90698, 90713, 90723	10, 89, 110, 120	
MMR	90704–90708, 90710	05, 03, 94, 04, 07, 06	
PCV	90670	133, 152	G0009
VZV	90710, 90716	21, 94	
HepA	90633	31, 83, 85	
Flu	90655, 90657, 90661, 90662, 90673, 90685–90688	88, 135, 140, 141, 150, 153, 155, 158, 161	G0008
RV (2 Dose Schedule)	90681	119	
RV (3 Dose Schedule)	90680	116, 122	

CHILDREN AND ADOLESCENTS' ACCESS TO PCP (CAP)

The percentage of members ages 12 months–19 years who had a visit with a PCP.

- **Children and Adolescents Access to PCP (12–24 months).** Children ages 12–24 months who had a visit with a PCP during the measurement year.
- **Children and Adolescents Access to PCP (25 months to 6 years).** Children ages 25 months–6 years who had a visit with a PCP during the measurement year.
- **Children and Adolescents Access to PCP (ages 7–11 years).** Children ages 7–11 who had a visit with a PCP during the measurement year or the year prior to the measurement year.
- **Children and Adolescents Access to PCP (ages 12–19 years).** Adolescents ages 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

CPT	HCPCS	ICD-10
99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99483	G0402, G0438, G0439, G0463, T1015	Z00.00, Z00.01, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0–Z02.6, Z02.71, Z02.79, Z02.81–Z02.83, Z02.89, Z02.9, Z76.1, Z76.2

CHLAMYDIA SCREENING IN WOMEN (CHL)

The percentage of women ages 16–24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

The rates are stratified by the following age brackets:

- 16–20 years.
- 21–24 years.
- Total.

CPT
87110, 87270, 87320, 87490–87492, 87810

COLORECTAL CANCER SCREENING (COL)

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

Exclusion: Patients who have a history of colon cancer or who have had a total colectomy are exempt from this measure.

Screenings	CPT	HCPCS	ICD-10
Colonoscopy	44388–44394, 44397, 44401–44408, 45355, 45378–45393, 45398	G0105, G0121	
CT colonography	74261–74263		
FIT-DNA test	81528		
Flexible sigmoidoscopy	45330–45335, 45337–45342, 45345–45347, 45349–45350	G0104	
Fecal occult blood test (FOBT)	82270, 82274	G0328	
Colorectal cancer		G0213, G0214, G0215, G0231	C18.0–C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total colectomy	44150–44153, 44155–44158, 44210–44212		

COMPREHENSIVE DIABETES CARE (CDC)

The percentage of members ages 18–75 with diabetes who had each of the following:

- **BP control (< 140/90 mm Hg).** The percentage of members ages 18–75 with diabetes (type 1 and type 2) who had BP control (< 140/90 mm Hg).

Codes	CPT	CPT-CAT-II	HCPCS
Outpatient	99201–99205, 99211–99215, 99241–99245, 99347–99350, 99381–99387, 99391–99397, 99401, 99404, 99411, 99412, 99429, 99455, 99456, 99483		G0402, G0438, G0439, G0463, T1015
Nonacute inpatient	99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337		
Remote blood pressure monitoring	93784, 93788, 93790, 99091		
Systolic < 130 mm Hg		3074F	
Systolic between 130–139 mm Hg		3075F	
Systolic ≥ 140 mm Hg		3077F	
Diastolic < 80 mm Hg		3078F	
Diastolic 80–89 mm Hg		3079F	
Diastolic ≥ 90 mm Hg		3080F	

- **Eye exam (retinal) performed.** The percentage of members ages 18–75 with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

Codes	CPT	CPT Modifier	CPT-CAT-II
Diabetic retinal screening with eye care professional	67028, 67030, 67031, 67036, 67039–67043, 67101, 67105, 67107, 67108, 67110–67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225–92228, 92230, 92235, 92240, 92250, 92260, 99203–99205, 99213–99215, 99242–99245		2022F, 2024F, 2026F, 3072F
Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifier Value Set).	65091, 65093, 65101, 65103, 65105, 65110, 65112, 65114	50	

- **Hemoglobin A1c (HbA1c) testing.** The percentage of members ages 18–75 with diabetes (type 1 and type 2) who had HbA1c testing.

Codes	CPT	CPT-CAT-II
HbA1c Tests	83036, 83037	
HbA1c tests and level less than 7.0%		3044F
HbA1c tests and level 7.0%-9.0%		3045F
HbA1c tests and level greater than 9.0%		3046F

- **HbA1c control (< 8.0%).** The percentage of members ages 18–75 with diabetes (type 1 and type 2) who had HbA1c control (< 8.0%).

CPT-CAT-II
3044F

We only included CPT II 3044F above because that effectively captures values < 8%. CPT II code 3045F indicates values between 7.0%–9.0%, but is not specific enough to capture values < 8%. For members with values between 7.0% and 8.0%, please submit supplemental data, such as lab results, to identify the actual value that indicates if the HbA1c result was < 8%.

HbA1c poor control (> 9.0%). The percentage of members ages 18–75 with diabetes (type 1 and type 2) who had HbA1c poor control (> 9%).

Note: A lower HbA1c poor control (> 9.0%) rate indicates better performance.

CPT-CAT-II
3046F

- **Medical attention for nephropathy.** The percentage of members ages 18–75 with diabetes (type 1 and type 2) who had medical attention for nephropathy.

A member who is being treated for nephropathy (on ACE/ARB), has evidence of end-stage renal disease (ESRD), stage 4 chronic kidney disease, has history of a kidney transplant, or is being seen by a nephrologist is compliant for this submeasure.

Codes	CPT	CPT-CAT-II
Urine protein tests	81000–81003, 81005, 82042–82044, 84156	3060F, 3061F, 3062F
Nephropathy treatment		3066F, 4010F

CONTROLLING HIGH BLOOD PRESSURE (CBP)

The percentage of members ages 18–85 who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90 mm Hg) during the measurement year.

Codes	CPT	CPT-CAT-II	HCPCS
Outpatient	99201–99205, 99211–99215, 99241–99245, 99341–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99429, 99455, 99456, 99483		G0402, G0438, G0439, G0463, T1015
Nonacute inpatient	99304–99310, 99315, 99316, 99318, 99324–99328, 99334–99337		
Remote blood pressure monitoring	93784, 93788, 93790, 99091		
Systolic < 130 mm Hg		3074F	
Systolic between 130–139 mm Hg		3075F	
Systolic ≥ 140 mm Hg		3077F	
Diastolic < 80 mm Hg		3078F	
Diastolic 80–89 mm Hg		3079F	
Diastolic ≥ 90 mm Hg		3080F	

D

DEPRESSION SCREENING AND FOLLOW-UP FOR ADOLESCENTS AND ADULTS (DSF)

The percentage of members age 12 and older who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.

- **Depression Screening.** The percentage of members who were screened for clinical depression using a standardized tool.
- **Follow-Up on Positive Screen.** The percentage of members who screened positive for depression and received follow-up care within 30 days.

Eligible screening instruments and thresholds for positive findings include:

- Patient Health Questionnaire (PHQ-9)® with total score ≥ 5.
- PRIME MD-PHQ2® with total score ≥ 3.
- Beck Depression Inventory-Fast Screen (BDI-FS)® with total score ≥ 4.
- Center for Epidemiologic Studies Depression Scale-Revised (CESD-R) with total score ≥ 10.
- PROMIS Depression with total T Score ≥ 52.5.

Exclusion: Members with any of the following:

- Bipolar disorder during the measurement period or the year prior to the measurement period.
- Depression during the year prior to the measurement period.
- In hospice or using hospice services during the measurement period.

DIABETES MONITORING FOR PEOPLE WITH DIABETES AND SCHIZOPHRENIA (SMD)

The percentage of members ages 18–64 with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Codes	CPT	CPT-CAT-II
HbA1c tests	83036, 83037	3044F, 3045F, 3046F
LDL-C tests	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS (SSD)

The percentage of members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Codes	CPT	CPT-CAT-II
HbA1c tests	83036, 83037	3044F, 3045F, 3046F
Glucose tests	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	

DISEASE-MODIFYING ANTIRHEUMATIC DRUG THERAPY FOR RHEUMATOID ARTHRITIS (ART)

The percentage of members age 18 and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying antirheumatic drug (DMARD).

HCPCS
J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, Q5103, Q5104

F

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

The percentage of discharges for members ages six and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.

- The percentage of discharges for which the member received follow-up within seven days after discharge.
- The percentage of discharges for which the member received follow-up within 30 days after discharge.

The rates are stratified by the following age brackets:

- 6–17 years.
- 18–64 years.
- 65 years and older.
- Total.

Visit Type	CPT	CPT Modifier	HCPCS	POS
An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255	95, GT		03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72
An outpatient visit (BH Outpatient Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)).	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, 99483	95, GT	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, M0064, T1015	
An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255	95, GT		52
An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/ Intensive Outpatient Value Set) with a mental health practitioner.			G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485	
A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255	95, GT		53
Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a mental health practitioner.	90870			24, 53, 52, 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72

(continued)

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH) (continued)

Visit Type	CPT	CPT Modifier	HCPCS	POS
A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255	95, GT		02
An observation visit (Observation Value Set) with a mental health practitioner.	99217–99220			
Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).	99495, 99496	95, GT		

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

- **Initiation Phase.** The percentage of members ages 6–12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Visit Type	CPT	HCPCS	POS
An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255		03, 05, 07, 09, 11–20, 22, 33, 49, 50, 71, 72
An outpatient visit (BH Outpatient Value Set).	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99510, 99483	G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013–H2020, M0064, T1015	
An observation visit (Observation Value Set).	99217–99220		
A health and behavior assessment/ intervention (Health and Behavior Assessment/ Intervention Value Set).	96150–96154		
An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255		52
An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/ Intensive Outpatient Value Set).		G0410, G0411, H0035, H2001, H2012, S0201, S9480, S9484, S9485	
A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876, 99221–99223, 99231–99233, 99238, 99239, 99251–99255		53

- **Continuation and Maintenance (C&M) Phase.** The percentage of members ages 6–12 as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

(continued)

Continuation and Maintenance (C&M) Phase (continued)

Visit Type	CPT	CPT Modifier	POS
Only one of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) or a telehealth visit.	98966–98968, 99441–99443		
Identify follow-up visits using the code combinations above; then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim.		95, GT	02

H

HOSPITALIZATIONS FOR POTENTIALLY PREVENTABLE COMPLICATIONS (HPC)

For members age 67 and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.

This measure is based on a calculation and there are no codes associated.

I

IMMUNIZATIONS FOR ADOLESCENTS (IMA)

The percentage of adolescents age 13 who received the required combination 1 and combination 2 vaccinations.

Note: Refer to the California Immunization Registry (CAIR) website at www.cairweb.org for information on tracking and submitting patient immunization records.

- **Combination 1.** The percentage of adolescents age 13 who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine.

Combo 1	CPT	CVX
Meningococcal vaccine	90734	108, 114, 136, 147, 167
Tdap vaccine	90715	115

- **Combination 2.** The percentage of adolescents age 13 who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and the complete human papillomavirus (HPV) vaccine series by their 13th birthday.

Combo 2	CPT	CVX
Meningococcal vaccine	90734	108, 114, 136, 147, 167
Tdap vaccine	90715	115
HPV vaccine	90649–90651	62, 118, 137, 165

INITIATION & ENGAGEMENT OF ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE TREATMENT (IET)

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD Treatment.** Initiated dependence treatment within 14 days of their diagnosis.
- **Engagement of AOD Treatment**. Continued treatment with two or more additional services within 34 days of the initiation visit.

The rates are stratified by the following age brackets:

- 13–17 years.
- 18+ years.
- Total.

For the follow-up treatments, include an ICD-10 diagnosis for alcohol or other drug dependence from the Mental, Behavioral and Neurodevelopmental Disorder Section of ICD-10 along with a procedure code for the preventive service, evaluation and management consultation or counseling service.

(continued)

INITIATION & ENGAGEMENT OF ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE TREATMENT (IET) (continued)

Visit Type	CPT	CPT Modifier	HCPCS	POS	ICD-10
IET standalone visits	98960–98962, 99078, 99201–99205, 99211–99215, 99241–99245, 99341–99345, 99347–99350, 99384–99387, 99394–99397, 99401–99404, 99408–99409, 99411, 99412, 99483, 99510	95, GT	G0155, G0176, G0177, G0396, G0397, G0409–G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034–H0037, H0039, H0040, H0047, H2000, H2001, H2010–H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015		Refer to the current ICD-10 manual for the appropriate IET codes.
IET group 1 visits	90791, 90792, 90832–90834, 90836–90840, 90845, 90847, 90849, 90853, 90875, 90876	95, GT		02, 03, 05, 07, 09, 11–20, 22, 33, 49, 50, 52, 53, 57, 71, 72	Refer to the current ICD-10 manual for the appropriate IET codes.
IET group 2 visits	99221–99223, 99231–99233, 99238, 99239, 99251–99255	95, GT		02, 52, 53	
Observation visit	99217–99220				
Telephone visit	98966–98968, 99441–99443				
Online assessment	98969, 99444				
Alcohol and other drug medication treatment			H0020, H0033, J0571–J0575, J2315, S0109		

L

LEAD SCREENING IN CHILDREN (LSC)

The percentage of children age two who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

CPT
83655

M

MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA (MMA)

The percentage of members ages 5–64 during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.

- The percentage of members who remained on an asthma controller medication for at least 50% of the treatment period.
- The percentage of members who remained on an asthma controller medication for at least 75% of the treatment period.

The rates are stratified by the following age brackets:

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- Total.

MEDICATION RECONCILIATION POST DISCHARGE (MRP)

The percentage of discharges from January 1–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).

CPT	CPT-CAT-II
99495, 99496, 99483	1111F

METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS (APM)

The percentage of children and adolescents ages 1–17 who had two or more antipsychotic prescriptions and had metabolic testing.

The rates are stratified by the following age brackets:

- 1–5 years.
- 6–11 years.
- 2–17 years.
- Total.

Both of the following are needed to be compliant:

- Blood glucose or HbA1c testing.
- LDL-C or cholesterol testing.

Test Types	CPT	CPT-CAT-II
HbA1c	83036, 83037	3044F, 3045F, 3046F
Glucose	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951	
LDL-C	80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F
Cholesterol	82465, 83718, 84478	

N

NON-RECOMMENDED CERVICAL CANCER SCREENING IN ADOLESCENT FEMALES (NCS)

The percentage of adolescent females ages 16–20 who were screened unnecessarily for cervical cancer.

Note: A lower rate indicates better performance.

Test Types	CPT	HCPCS
Cervical cytology	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175	G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001, Q0091
HPV tests	87620–87622, 87624, 87625	G0476

NON-RECOMMENDED PSA-BASED SCREENING IN OLDER MEN

The percentage of men age 70 and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening.

CPT	CPT-CAT-II
99495, 99496, 99483	1111F

O

OSTEOPOROSIS MANAGEMENT WOMEN WHO HAD A FRACTURE (OMW)

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

Test Types	CPT	HCPCS
Bone mineral density tests	76977, 77078, 77080–77082, 77085, 7706	G0130
Osteoporosis medications		J0630, J0897, J1740, J3110, J3489
Long-acting osteoporosis medications during an inpatient stay.		J0897, J1740, J3489

P

PERSISTENCE OF BETA-BLOCKER TREATMENT AFTER A HEART ATTACK (PBH)

The percentage of members age 18 and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge. This measure is based on a calculation and there are no codes associated.

PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION (PCE)

The percentage of chronic obstructive pulmonary disease (COPD) exacerbations for members age 40 and older who had an acute inpatient discharge or emergency department (ED) visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications.

- Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
- Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

There are no codes for numerator compliance; this is the reason why the list of bronchodilator medications was the only information in previous QRGs.

PLAN ALL-CAUSE READMISSION (PCR)

For members age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator).
- Count of Observed 30-Day Readmissions (numerator).
- Count of Expected 30-Day Readmissions.

Note: For Medicaid, report only members ages 18–64.

This measure is based on a calculation and there are no codes associated.

PRENATAL AND POSTPARTUM CARE (PPC)

The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- **Timeliness of Prenatal Care.** The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.

Codes	CPT	CPT-CAT-II	HCPCS	ICD-10
Standalone prenatal visits	99500	0500F, 0501F, 0502F,	H1000–H1004,Z1036, Z6400, Z6402, Z6404, Z6410, Z6412	
Prenatal visits	99201–99205, 99211–99215, 99241–99245, 99483		G0463, T1015, Z1000, Z1020, Z1022, Z1032, Z1034, Z5904, Z5906, Z5908, Z6200, Z6202, Z6204, Z6206, Z6300, Z6304, Z6306, Z6406, Z6408, Z6500	

PRENATAL AND POSTPARTUM CARE (PPC) (continued)

Codes	CPT	CPT-CAT-II	HCPCS	ICD-10
Obstetric panel	80055, 80081			
Prenatal ultrasound	76801, 76805, 76811, 76813, 76815–76821, 76825–76828			
Pregnancy diagnosis				Refer to the current ICD-10 manual for the appropriate pregnancy diagnosis codes.
Toxoplasma antibody	86777–86778			
Rubella antibody	86762			
Cytomegalovirus antibody	86644			
Herpes simplex antibody	86694–86696			
Rubella antibody and ABO	86762 & 86900			
Rubella antibody and Rh test	86762 & 86901			

- **Postpartum Care.** The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Codes	CPT	CPT-CAT-II	HCPCS	ICD-10
Postpartum visits	57170, 58300, 59430, 99501	0503F	G0101, Z1026, Z1038	Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Cervical cytology	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175		G0123, G0124, G0141, G0143–G0148, P3000, P3001, Q0091	

S

STATIN THERAPY FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC)

The percentage of males ages 21–75 and females ages 40–75 during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy.*

- **Received Statin Therapy.** Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.*
- **Statin Adherence 80 percent.** Members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period.*

** There are no codes for numerator compliance, just that the member be on a high- or moderate-intensity statin medication during the MY.*

STATIN THERAPY FOR PATIENTS WITH DIABETES (SPD)

The percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria.*

- **Received Statin Therapy:** Members who were dispensed at least one statin medication of any intensity during the measurement year.*
- **Statin Adherence 80 percent:** Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period.*

** There are no codes for numerator compliance, just that the member be on a statin medication during the MY.*

USE OF HIGH RISK MEDICATIONS IN ELDERLY (DAE)

- The percentage of Medicare members age 66 and older who had at least one dispensing event for a high-risk medication.
- The percentage of Medicare members age 66 and older who had at least two dispensing events for the same high-risk medication.
- For both rates, a lower rate represents better performance.

Measure is based on a calculation of medication and number of dispensing events.

USE OF IMAGING STUDIES FOR LOW BACK PAIN (LBP)

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Codes	CPT	ICD-10
Imaging study	72020, 72052, 72100, 72110, 72114, 72120, 72131–72133, 72141–72142, 72146–72149, 72156, 72158, 72200, 72202, 72220	

Codes	CPT	ICD-10
Uncomplicated low back pain		M47.26–M47.28, M47.816–M47.818, M47.896–M47.898, M48.06, M48.061–M48.062, M48.07, M48.08, M51.16–M51.17, M51.26–M51.27, M51.36–M51.37, M51.86–M51.87, M53.2X6–M53.2X8, M53.3, M53.86–M53.88, M54.16–M54.18, M54.30–M54.32, M54.40–M54.42, M54.5, M54.89, M54.9, M99.03–M99.04, M99.23, M99.43, M99.53, M99.63, M99.73, M99.83, M99.84, S33.100A, S33.100D, S33.100S, S33.110S, S33.110D, S33.110S, S33.120A, S33.120D, S33.120S, S33.130A, S33.130D, S33.130S, S33.140A, S33.140D, S33.140S, S33.5XXA, S33.6XXA, S33.8XXA, S33.9XXA, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.092A, S39.092D, S39.092S, S39.82XA, S39.82XD, S39.82XS, S39.92XA, S39.92XD, S39.92XS

USE OF MULTIPLE CONCURRENT ANTIPSYCHOTICS IN CHILDREN AND ADOLESCENTS (APC)

The percentage of children and adolescents ages 1–17 who were treated with antipsychotic medications and were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.

The rates are stratified by the following age brackets:

- 1–5 years.
- 6–11 years.
- 12–17 years.
- Total.

Note: A lower rate indicates better performance.

W

WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (WCC)

The percentage of members ages 3–17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- **BMI percentile.** (BMI Percentile Value Set) during the measurement year.
- **Counseling for nutrition.** (Nutrition Counseling Value Set) during the measurement year.
- **Counseling for physical activity.** Counseling for physical activity (Physical Activity Value Set) during the measurement year.

Codes	CPT	HCPCS	ICD-10
BMI percentile documentation			Z68.51–Z68.54
Nutrition counseling	97802–97804	G0270, G0271, G0447, S9449, S9452, S9470	Z71.3
Physical activity counseling		G0447, S9451	Z02.5, Z71.82

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE (W15)

The percentage of members who turned 15 months old during the measurement year and who had six comprehensive well-child visits with a PCP during their first 15 months of life.

Documentation in the medical record must include evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

CPT	HCPCS	ICD-10
99381, 99382, 99391, 99392, 99461	G0438, G0439	Z00.110, Z00.111, Z00.121, Z00.129, Z00.8, Z02.0, Z02.71, Z02.82, Z00.5

WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE (W34)

The percentage of members ages 3–6 who had one or more well-child visits with a PCP during the measurement year.

Documentation in the medical record must include evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

CPT	HCPCS	ICD-10
99382, 99383, 99392, 99393	G0438, G0439	Z00.121, Z00.129, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.82

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Effectiveness of Care Measure

Breast Cancer Screening

Health Net®

Breast cancer is the most common type of cancer, and the second leading cause of cancer-related deaths among women in the United States. Approximately 237,000 cases of breast cancer are diagnosed in women, and about 41,000 women die each year of breast cancer.[1] Mammography is an effective screening tool for early detection of breast cancer and reduction of breast cancer mortality.

Health Net* wants to help your practice increase Healthcare Effectiveness Data and Information Set (HEDIS®) rates. This tip sheet outlines key details of the Breast Cancer Screening (BCS) measure, its codes and guidance for documentation.

Measure

Women ages 50–74 who had a mammogram to screen for breast cancer in the past two years.[2]

Exclusions:

- Patients who meet the following criteria anytime during the measurement year:
  - Medicare patients ages 66 and older enrolled in an institutional special needs plans (I-SNP) or living long-term in an institution.
  - Patients ages 66 and older with frailty and advanced illness.
  - Patients in hospice.
- Patients with bilateral mastectomy. Any of the following meet the criteria for bilateral mastectomy:
  - Bilateral mastectomy or history.
  - Unilateral mastectomy with a bilateral modifier.
  - Two unilateral mastectomies without a modifier with service dates 14 days or more apart.
  - A unilateral mastectomy without a modifier and a left mastectomy with service dates 14 days or more apart.
  - A unilateral mastectomy without a modifier and a right mastectomy with service dates 14 days or more apart.
  - Absence of the left breast and absence of the right breast on the same or different dates of service.
  - Both of the following (on the same or different dates of service):
    - » Unilateral mastectomy with a left-side modifier (same visit).
    - » Unilateral mastectomy with a right-side modifier (same visit).

(continued)

PROVIDER COMMUNICATIONS

[1]Centers for Disease Control and Prevention. Basic Information. Retrieved from www.cdc.gov/cancer/breast/basic_info/index.htm, August 24, 2018.

[2]NCQA. HEDIS 2019 Technical Specifications for Health Plans, Volume 2, Washington, D.C., 2018.

Coverage for every stage of life™

Exclusion codes		
CPT	**ICD-10-PCS**	**ICD-10-PCM**
• Bilateral modifier: 50 • Left modifier: LT • Right modifier: RT • Unilateral mastectomy: 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307	• Bilateral mastectomy: 0HTV0ZZ • Unilateral mastectomy left: 0HTU0ZZ • Unilateral mastectomy right: 0HTT0ZZ	• History of bilateral mastectomy: Z90.13 • Absence of left breast: Z90.12 • Absence of right breast: Z90.11

Best practices	Mammography codes	
• Need date of mammogram along with proof of completion. Providing results or findings would indicate screening was performed and not merely ordered. • All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) meet the numerator compliance. Do not count biopsies, breast ultrasounds or MRIs. • Educate patients on the importance of routine screening (at least once every 24 months) and remind patients that preventive screenings are covered under health care reform. Depending on risk factors, mammograms may be administered more frequently. • Develop standing orders along with automated referrals (if applicable) for women ages 50–74. • Refer women to local mammography imaging centers. Follow up to verify completion.	CPT	77061, 77062, 77063, 77065, 77066, 77067
	UBREV	0401, 0403

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Improve Patient Care and Quality of Life

Health Net®

Use these tips and recommendations to guide discussions with your patients about their health.

What is the Health Outcomes Survey (HOS)?

- ✔ An annual survey administered from April through July to a random sample of Medicare patients. The same patients are surveyed again two years later to assess change in health status.
- ✔ It measures patients' perception of their physical and mental health and overall quality of life.
- ✔ Survey results impact Centers for Medicare & Medicaid Services (CMS) Star Ratings.

Each measure addresses a different aspect of patient care and patient-provider interaction. There are five Star HOS measures you can directly impact.

Improving or maintaining physical health

This Star measure assesses the percentage of patients whose physical health was the same or better after two years.

RECOMMENDATIONS	DISCUSSION TIPS...
• Assess your patient's pain and functional status using standardized tools. • Provide interventions to improve physical health, such as disease management, pain management, physical therapy, or care management. • Promote self-management support strategies, such as goal-setting, action planning, problem solving, and follow-up to help patients take an active role in improving their health.	***Ask patients:*** • How far they can walk. • If they have trouble with stairs. • If they are able to shop and cook their own food. • If pain limits activity.

Improving or maintaining mental health

This Star measure assesses the percentage of patients whose behavioral health was the same or better after two years.

RECOMMENDATIONS	DISCUSSION TIPS...
• Assess your patient's symptoms of depression with the PHQ-2 and, when appropriate, PHQ-9. • Refer patients to behavioral health services or manage depression and anxiety treatment as indicated. • Promote web-based programs, such as myStrength.com, that provide a range of evidence-based behavioral health self-care resources. • Use motivational interviewing to improve treatment engagement and behavioral and physical health outcomes.	***Ask patients:*** • To describe their energy level. • If they get out to socialize. • If alcohol use causes personal problems.

(continued)

PROVIDER COMMUNICATIONS

19-286
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Monitoring physical activity

This Star measure assesses the percentage of patients who discussed exercise with their doctor or other health care provider and were advised to start, increase or maintain their physical activity within the year.

RECOMMENDATIONS	DISCUSSION TIPS...
• Assess your patient's current physical activity level. • Discuss health benefits and advise patients to start, maintain or increase physical activity as appropriate for their individual health status. • Develop physical activity plans with patients that match their abilities. Use the Let's Get Active Rx pad to provide written activity guidelines. • Refer patients with limited mobility to physical therapy to learn safe and effective exercises. • Encourage participation in a gym, fitness and exercise programs and local community resources.	***Ask patients:*** • About daily level of workouts. • What activities they enjoy. • If they feel better when they are more active. Discuss the benefits of aerobic activities (walking, jogging or swimming) and strength training (bodyweight exercises, weightlifting, tai chi, or gardening).

Reducing risk of falling

This Star measure assesses the percentage of patients with falling, walking or balance problems who discussed these topics with their providers and received treatment within the year.

RECOMMENDATIONS	DISCUSSION TIPS...
• Assess fall risk by asking patients about falling, gait and balance problems. Document discussion on the My Wellness and Prevention Checklist. • Provide fall prevention interventions, such as promoting regular exercise, strengthening and balance activities (tai chi, yoga), promoting regular eye exams, and providing appropriate educational materials. • Promote home safety, such as: – Removal of throw rugs and clutter to reduce tripping. – Installing handrails on stairs and grab bars in the bathrooms. – Use of non-slip mats in the tub or shower. – Use of night lights to keep halls well lit.	***Ask patients:*** • If they had a fall in the past year. • About circumstances of the fall. • How they think a fall could have been prevented. • If they felt dizzy, or had problems with balance or walking in the past year. • About vision problems and if they have had a recent eye exam.

Improving bladder control

This Star measure assesses the percentage of patients with urinary incontinence (UI) who discussed the problem and treatment options with their health care providers.

RECOMMENDATIONS	DISCUSSION TIPS...
• Assess problems with UI in the last six months and document discussion on the My Wellness and Prevention Checklist. • Assess the severity of the condition and the impact of UI on the patient's quality of life. Involve patients in decisions about treatment options that best work for them. These options include behavioral (such as bladder training and pelvic muscle rehabilitation), pharmacological and surgical therapies. • Have informative brochures and materials visible and available as discussion starters.	***Ask patients:*** • If they have had leakage in the past six months. • How often and when the leakage problem occurs. • If UI has affected their daily life (such as social withdrawals, depression or sleep deprivation).

Contact QI for more tools at
CQI_Medicare@healthnet.com.