



# Benchmark Pay for Performance **Medi-Cal** Program Guidelines

---

2023 Program Year - Final Release

Click on [blue underlines](#) throughout to jump to relevant section

## Summary of Changes from First Release:

1. Full and partial credit benchmarks established for each quality metric set. See [Adult](#), [Family Practice](#), and [Pediatrics](#) sets.
2. Technical specifications removed for ADV – Annual Dental Visit, and AMR – Asthma Medication Ratio.
3. Technical specifications added for [CHA – Cognitive Health Assessment](#), a reporting-only metric for Adult and Family Practice tracks.

# Summary of Changes to 2023 Medi-Cal Program

## Important changes to program:

1. MY2023 data submission [deadlines](#) changed to 02/28/2024 for claims and 03/09/2024 for supplemental data files.
2. **Improvement targets for partial credit** added to program. Beginning MY2023, clinics can receive partial credit for any quality metric in which they improve performance by a minimum 10% “improvement on the negative” compared to prior year. For more information, see section on [Program Benchmarks](#) and below for examples:
  - Ex 1: If MY2022 rate = 10%, then MY2023 partial credit awarded at  $\geq 19\%$  (10% improvement on 90% noncompliance)
  - Ex 2: If MY2022 rate = 90%, then MY2023 partial credit awarded at  $\geq 91\%$  (10% improvement on 10% noncompliance)
3. **Encounter Threshold** retired as a payment-bearing quality metric for all program tracks. Clinics should continue to monitor utilization and engagement through the quarterly [Panel Engagement](#) special metric, which measures the proportion of members with at least one reported primary care encounter with assigned clinic over a rolling 12 months. Clinics can continue to earn bonuses of up to +30% additional capitation for high panel engagement.
4. Initial Health Assessment (**IHA**) renamed to “[Initial Health Appointment](#)”. As of 01/01/2023, the Staying Healthy Assessment (SHA) requirement is eliminated. An initial appointment within 90 days of panel assignment is still required and must include a history of the member’s physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.
5. Z-Coding for Social Determinants of Health (**SDoH**) reporting-only quality metric added. Clinics are encouraged to identify a social determinant of health (e.g. housing insecurity, food insecurity) of interest and priority to screen for presence among HPSM members and report using eligible z-codes. See [SDoH](#) for more information.

## Changes to quality metrics eligible for payment, by program track:

### **Adult** – Primary care panels with assigned members 18 and older

1. Comprehensive Diabetes Management (**CDM**) composite metric removed as a payment metric – now reporting-only.
2. Eye Exam for Patients with Diabetes (**EED**) added as a standalone payment metric. EED remains a component of the reporting-only Comprehensive Diabetes Management (CDM) composite metric.
3. Hemoglobin A1c Control  $<8.0\%$  (**HBD-1**) moved to reporting-only and replaced by Hemoglobin A1c Poor Control  $>9.0\%$  (HBD-2) as a payment metric. HBD-2 reports an inverse rate where a lower rate is “better”.

### **Family Practice** – Primary care panels with assigned members both adult and pediatric

1. Comprehensive Diabetes Management (**CDM**) composite metric removed as a payment metric – now reporting-only.
2. Eye Exam for Patients with Diabetes (**EED**) added as a standalone payment metric. EED remains a component of the reporting-only Comprehensive Diabetes Management (CDM) composite metric.
3. Hemoglobin A1c Control  $<8.0\%$  (**HBD-1**) moved to reporting-only and replaced by Hemoglobin A1c Poor Control  $>9.0\%$  (HBD-2) as a payment metric. HBD-2 reports an inverse rate where a lower rate is “better”.

### **Pediatrics** – Primary care panels with assigned members no older than 22

1. Initial Health Appointment (**IHA**) removed as a payment metric – now reporting-only.
2. Pediatric Weight Assessment (**WCC-BMI**) removed as a payment metric – now reporting-only.
3. Immunizations for Adolescents Combination 2 (**IMA-2**) added as payment metric.
4. Substance Misuse Screening (**SBIRT**) added as payment metric.

# Table of Contents

---

<b>Summary of Changes to 2023 Medi-Cal Program</b> .....	<b>2</b>
<b>I. Program Overview</b> .....	<b>5</b>
Provider Eligibility .....	5
Program Tracks .....	5
Quality Metric Selection .....	5
Program Benchmarks .....	6
Data Reports and Additional Coding Resources .....	6
Program Timeline .....	6
Incentive Payment Formula.....	7
<b>II. Adult Track Summary</b> .....	<b>8</b>
Adult Payment Quality Metric Set.....	8
Adult Reporting-Only Quality Metric Set.....	9
<b>III. Family Practice Track Summary</b> .....	<b>10</b>
Family Practice Payment Quality Metric Set.....	10
Family Practice Reporting-Only Quality Metric Set.....	11
<b>IV. Pediatric Track Summary</b> .....	<b>12</b>
Pediatric Payment Quality Metric Set.....	12
Pediatric Reporting-Only Quality Metric Set.....	13
<b>V. Panel Engagement – Capitation Bonuses and Corrective Action</b> .....	<b>14</b>
Panel Engagement Overview .....	14
Eligible primary care encounters that count towards patient engagement:.....	14
<b>VI. Quality Metric Specifications</b> .....	<b>15</b>
ACEs: Trauma Screening.....	15
AMB-ED: Ambulatory Emergency Care .....	16
Avoid-ED: Avoidable Emergency Department Visits.....	17
BCS: Mammogram for Breast Cancer Screening .....	18
BPD: Blood Pressure Control for Patients with Diabetes .....	19
CBP: Controlling High Blood Pressure .....	20
CCS: Cervical Cancer Screening.....	21
CDF: Depression Screening and Follow-Up (12 years and older) .....	24
CDM: Comprehensive Diabetes Management .....	26
CHA: Cognitive Health Assessment .....	27
CHL: Chlamydia Screening in Women (16-24 years old).....	29
CIS-10: Immunizations for Children – Combo 10 .....	30
DEV: Developmental Screening .....	32
EED: Eye Exam for Patients with Diabetes .....	33
FLU: Seasonal Influenza Vaccination .....	37
FVN: Fluoride Varnish .....	39

HBD-1: Hemoglobin A1c Control (<8.0%) for Patients with Diabetes.....	40
HBD-2: Hemoglobin A1c Control (>9.0%) for Patients with Diabetes.....	41
IHA: Initial Health Appointment.....	42
IMA-2: Immunization for Adolescents.....	47
KED: Kidney Health Evaluation for Patients with Diabetes.....	48
PCR: Plan All-Cause Readmissions.....	49
SBIRT: Substance Misuse Screening and Follow Up (12 years and older).....	50
SDoH: Z-Coding for Social Determinants of Health.....	51
TBC: Tobacco Use Screening and Cessation Intervention (12 years and older).....	53
WCC-BMI: Pediatric Weight Assessment.....	54
WCC-N: Weight Assessment & Nutrition Counseling for Children.....	55
WCC-PA: Weight Assessment & Physical Activity Counseling for Children.....	56
WCV: Well Child & Adolescent Visit (3-21 years old).....	57
W15: Well Child Visit (0-15 months old).....	59
W30: Well Child Visit (15-30 months old).....	61
<b>VII. Health Education Resources that Support P4P.....</b>	<b>62</b>
<b>VIII. Terms &amp; Conditions.....</b>	<b>62</b>

# I. Program Overview

Health Plan of San Mateo's Benchmark Pay for Performance ("Benchmark P4P") program offers performance bonus payments to in-network Medi-Cal providers for targeted quality metrics to improve population health outcomes for HPSM members. The program is also designed to share data with HPSM providers on care information for their assigned HPSM patients. The targeted quality performance metric set focuses on member access and preventive care services.

Questions about the Benchmark P4P program may be directed to HPSM Provider Services at [PSInquiries@hpsm.org](mailto:PSInquiries@hpsm.org).

## Provider Eligibility

Primary care providers participate at the clinic-level. All primary care clinics are automatically opted-in to P4P bonus payment eligibility if they meet all of the following criteria:

1. Clinic participates in HPSM primary care partial capitation;
2. Clinics must have a Medi-Cal primary care contract with HPSM active as of the measurement period start date through at least six months following the close of the measurement period;
3. Providers must have 100 HPSM Medi-Cal members assigned to their panel as of January 1<sup>st</sup>, 2023. If clinic assignment falls below 100 Medi-Cal members at any point during the measurement period, clinic may be asked to accept additional member assignment until the 100 minimum is achieved again in order to qualify for bonus.

## Program Tracks

All participating providers are eligible for percent increases to capitation payments based on [panel engagement](#).

Medi-Cal providers will be assigned one of three program sub-tracks based on the approximate age range of members assigned to their clinic(s):

- **Adult:** Assigned members 18 years and older (no maximum)
- **Family Practice:** Assigned members 0 years and older (no maximum)
- **Pediatrics:** Assigned members 0 – 18 years or similar ranges

## Quality Metric Selection

Quality metrics are selected for inclusion in the P4P program based on a number of factors, including:

- Baseline network performance
- Population health needs of HPSM members
- Regulatory requirements
- Strength of association between clinical process improvements and improved population health outcomes
- Provider input

## Program Benchmarks

### Standard Benchmarks

Benchmarks are derived from a combination of several factors, including:

- National performance benchmarks for HEDIS metrics;
- Prior year network performance;
- Critical mass thresholds for population health management.

Benchmarks may be retro-adjusted downward in the event no clinic meets the full credit benchmark. Decisions to adjust benchmarks are made during the payment calculation process after all data reconciliation activities and at the sole discretion of HPSM.

### Improvement Targets

Beginning MY2023, clinics can receive partial credit for any quality metric in which their performance improves by an established margin compared to MY2022. A minimum 10% improvement “on the negative” is required to earn partial credit if partial credit benchmark is not otherwise reached.

- Ex 1: If MY2022 rate = 10%, then MY2023 partial credit awarded at  $\geq 19\%$  (10% improvement on 90% non-compliance)
- Ex 2: If MY2022 rate = 90%, then MY2023 partial credit awarded at  $\geq 91\%$  (10% improvement on 10% non-compliance)

## Data Reports and Additional Coding Resources

Performance bonus payment in the Benchmark P4P program is contingent on meeting the specified metric benchmarks for assigned patients who meet the metric criteria. Once the encounter information has been received and eligibility has been determined, providers will get credit towards the annual benchmark. Monthly member detail benchmark progress reports are available to providers through the HPSM eReports portal. Reports for the 2023 Program Year will be published **at the beginning of each month between May 2023 and April 2024**. The website for eReports login is: <https://reports.hpsm.org>. Additional resources, including an eReports User Guide, coding guidelines, and code lists are available at: <https://www.hpsm.org/provider/value-based-payment>.

## Program Timeline

Period	Dates (subject to change)	Description
<b>Program Year</b>	01/01/2023 – 12/31/2023	This is the anchor program year for all dates of service (DOS). For metrics with a lookback period of multiple years, count 2023 as year 1.
<b>Supplemental Data Submission Deadline</b>	03/08/2024	All supplemental data (EMR extracts, lab submissions) must be submitted by this date to ensure timely processing for bonus payments.
<b>Claims Submission Deadline</b>	02/28/2024	All HPSM claims and qualifying codes must be submitted by this date to ensure timely processing for bonus payments.

<b>Attestation Period</b>	04/02/2024 – 04/30/2024	Providers may manually attest for compliance in cases where the claims submission process has not captured all relevant data. Instructions for attestation will be distributed Spring 2024.
<b>Payment Finalization</b>	05/01/2024 – 06/30/2024	HPSM compiles all performance data and calculates bonus payment using the formula below. Bonus is distributed via lump sum as a single check mailed to the financial address on file.

## Incentive Payment Formula

Final Benchmark P4P total payments will be calculated using the following equation:

$$\text{(Eligible Member Months * Composite Quality Score * \$Benchmark P4P PMPM) + Full Credit Benchmark Bonus}$$

### Formula Term Definitions

*Eligible Member Months:* Total of all member months for CareAdvantage members assigned to the clinic/system for at least 9 months out of 12 during the calendar year. 9 months of assignment do NOT need to be continuous. 1 member month = 1 member assigned for every 1 month (i.e. 12 member months = 1 member assigned for 12 months or 12 members assigned for 1 month each). Members receiving hospice or palliative care services are excluded from all P4P rates, including eligible member months.

*Composite Quality Score:* Average score for all earned quality points based on final performance rate following the program calendar year. **For MY2023, earning full credit nets two (2) quality score points while partial credit nets one (1) point for all metrics.** For quality points to be attributed to an assigned metric, the participating provider must have at least fifteen eligible patient in the denominator. If eligible patients is zero, provider is considered ineligible for that assigned metric and it is excluded from their composite quality score calculation.

*\$Benchmark P4P PMPM:* Specific per member per month rate determined by HPSM. Allocations will be determined based on the pool of funds allocated for Benchmark P4P program and number of members covered by the program.

*Full Credit Benchmark Bonus:* Potential additional bonus amount added if clinic meets ALL full credit benchmarks for its assigned track's quality metric set in the program year.

## II. Adult Track Summary

Medi-Cal primary care clinics with an assigned panel of HPSM members 18 years of age and older (or a similar age range) report on the Adult quality metric set. These metrics are in addition to the special metric measuring panel engagement for quarterly capitation bonuses.

### Adult Payment Quality Metric Set

Clinics earn quality score points for each payment metric in which their performance meets or exceeds the full or partial credit benchmark for that metric. For all MY2023 payment metric, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit <sup>i</sup>
<b>BCS</b>	<a href="#">Mammogram for Breast Cancer Screening</a>	HEDIS	62 %	57 %
<b>BPD</b>	<a href="#">Blood Pressure Control for Patients with Diabetes</a>	HEDIS	57 %	45 %
<b>CBP</b>	<a href="#">Controlling High Blood Pressure</a>	HEDIS	70 %	57 %
<b>CCS</b>	<a href="#">Cervical Cancer Screening</a>	HEDIS	64 %	57 %
<b>CDF</b>	<a href="#">Depression Screening and Follow-Up (12 years and older)</a>	HPSM	60 %	46 %
<b>EED</b>	<a href="#">Eye Exam for Patients with Diabetes</a>	HEDIS	64 %	57 %
<b>FLU</b>	<a href="#">Seasonal Influenza Vaccine</a>	HPSM	71 %	62 %
<b>HBD-2*</b>	<a href="#">Hemoglobin A1c Control (&gt;9.0%) for Patients with Diabetes</a>	HEDIS	30 %	35 %
<b>IHA</b>	<a href="#">Initial Health Appointment</a>	HPSM	64 %	53 %
<b>SBIRT</b>	<a href="#">Substance Misuse Screening</a>	HPSM	55 %	41 %

\*HBD-2 is an inverted metric (a lower rate is better)

<b>Engagement</b>	<a href="#">Panel Engagement for Capitation Bonuses</a>	<b>HPSM</b>	<b>60%</b>	<b>50 - 59.99%</b>
-------------------	---	-------------	------------	--------------------

<sup>i</sup> Partial credit will also be awarded for 10% improvement “on the negative” compared to prior year. See [Improvement Targets](#).



## Adult Reporting-Only Quality Metric Set

HPSM collects and monitors performance data on “reporting-only” metrics, though these metrics are not included in payment calculations. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
<b>ACE</b>	<a href="#">Trauma Screening (Adverse Childhood Experiences)</a>	HPSM
<b>AMB-ED</b>	<a href="#">Ambulatory Emergency Department Visits</a>	HEDIS
<b>Avoid-ED</b>	<a href="#">Avoidable Emergency Department Visits</a>	HPSM
<b>CDM</b>	<a href="#">Comprehensive Diabetes Management</a>	HPSM
<b>CHA</b>	<a href="#">Cognitive Health Assessment</a>	HPSM
<b>CHL</b>	<a href="#">Chlamydia Screening in Women (16-24 years old)</a>	HEDIS
<b>Encounters</b>	Encounter Threshold – reported as average visits per member per year	HPSM
<b>HBD-1</b>	<a href="#">Hemoglobin A1c Control (&lt;8.0%) for Patients with Diabetes</a>	HEDIS
<b>PCR</b>	<a href="#">Plan All-Cause Readmissions</a>	HEDIS
<b>SDoH</b>	<a href="#">Z-Coding for Social Determinants of Health</a>	HPSM
<b>TBC</b>	<a href="#">Tobacco Use Screening and Cessation Intervention (12 years and older)</a>	HPSM

### III. Family Practice Track Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 999 years of age (no maximum) or a similar age range report on the Family Practice quality metric set. These metrics are in addition to the special metric measuring panel engagement for quarterly capitation bonuses.

#### Family Practice Payment Quality Metric Set

Providers earn quality score points for each payment metric in which their performance meets or exceeds the full or partial credit benchmark for that metric. For all MY2023 payment metrics, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metrics Name	Metrics Source	Performance Benchmarks	
			Full Credit	Partial Credit <sup>ii</sup>
<b>BCS</b>	<a href="#">Mammogram for Breast Cancer Screening</a>	HEDIS	62 %	57 %
<b>CBP</b>	<a href="#">Controlling High Blood Pressure</a>	HEDIS	64 %	50 %
<b>CCS</b>	<a href="#">Cervical Cancer Screening</a>	HEDIS	67 %	63 %
<b>CDF</b>	<a href="#">Depression Screening &amp; Follow Up (12 years and older)</a>	HEDIS	59 %	47 %
<b>EED</b>	<a href="#">Eye Exam for Patients with Diabetes</a>	HEDIS	64 %	57 %
<b>FLU</b>	<a href="#">Seasonal Influenza Vaccine</a>	HPSM	59 %	54 %
<b>HBD-2*</b>	<a href="#">Hemoglobin A1c Control (&gt;9.0%) for Patients with Diabetes</a>	HEDIS	31 %	36 %
<b>IHA</b>	<a href="#">Initial Health Appointment</a>	HEDIS	75 %	60 %
<b>W15</b>	<a href="#">Well Child Visit (0-15 months old)</a>	HEDIS	63 %	54 %
<b>WCV</b>	<a href="#">Well Child and Adolescent Visit (3 – 21 years old)</a>	HEDIS	56 %	50 %

\*HBD-2 is an inverted metric (a lower rate is better)

<b>Engagement</b>	<a href="#">Panel Engagement for Capitation Bonuses</a>	<b>HPSM</b>	<b>60%</b>	<b>50 - 59.99%</b>
-------------------	---	-------------	------------	--------------------

<sup>ii</sup> Partial credit will also be awarded for 10% improvement “on the negative” compared to prior year. See [Improvement Targets](#).

## Family Practice Reporting-Only Quality Metric Set

HPSM collects and monitors performance data on “reporting-only” metrics, though these metrics are not included in payment calculations. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
<b>ACE</b>	<a href="#">Trauma Screening (Adverse Childhood Experiences)</a>	HPSM
<b>AMB-ED</b>	<a href="#">Ambulatory Emergency Department Visits</a>	HEDIS
<b>Avoid-ED</b>	<a href="#">Avoidable Emergency Department Visits</a>	HPSM
<b>CDM</b>	<a href="#">Comprehensive Diabetes Management</a>	HPSM
<b>CHA</b>	<a href="#">Cognitive Health Assessment</a>	HPSM
<b>CHL</b>	<a href="#">Chlamydia Screening in Women (16 – 24 years old)</a>	HEDIS
<b>CIS-10</b>	<a href="#">Childhood Immunizations (Combination 10)</a>	HEDIS
<b>DEV</b>	<a href="#">Developmental Screening</a>	HPSM
<b>Encounters</b>	Encounter Threshold – reported as average visits per member per year	HPSM
<b>FVN</b>	<a href="#">Fluoride Varnish</a>	HPSM
<b>HBD-1</b>	<a href="#">Hemoglobin A1c Control (&lt;8.0%) for Patients with Diabetes</a>	HEDIS
<b>PCR</b>	<a href="#">Plan All-Cause Readmissions</a>	HEDIS
<b>SBIRT</b>	<a href="#">Substance Misuse Screening and Follow Up (12 years and older)</a>	HPSM
<b>SDoH</b>	<a href="#">Z-Coding for Social Determinants of Health</a>	HPSM
<b>TBC</b>	<a href="#">Tobacco Use Screening and Cessation Intervention (12 years and older)</a>	HPSM
<b>W30</b>	<a href="#">Well Child Visit (15-30 months)</a>	HEDIS
<b>WCC-BMI</b>	<a href="#">Pediatric BMI Assessment</a>	HEDIS
<b>WCC-N</b>	<a href="#">Nutrition Counseling for Children</a>	HEDIS
<b>WCC-PA</b>	<a href="#">Physical Activity Counseling for Children</a>	HEDIS

## IV. Pediatric Track Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 18 years of age (or similar ranges) report on the Pediatric quality metric set. These metrics are in addition to the special metric measuring panel engagement for quarterly capitation bonuses.

### Pediatric Payment Quality Metric Set

Providers earn quality score points for each payment metric in which their performance meets or exceeds the full or partial credit benchmark for that metric. For all MY2023 payment metrics, earning full credit nets two (2) quality score points and partial credit nets one (1) point.

Shorthand	Payment Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit <sup>iii</sup>
<b>CDF</b>	<a href="#">Depression Screening and Follow Up (12 years and older)</a>	DHCS	75 %	61 %
<b>CIS-10</b>	<a href="#">Childhood Immunizations (Combination 10)</a>	HEDIS	55 %	44 %
<b>FLU</b>	<a href="#">Seasonal Influenza Vaccine</a>	HPSM	71 %	64 %
<b>IMA-2</b>	<a href="#">Immunizations for Adolescent (Combination 2)</a>	HEDIS	63 %	57 %
<b>SBIRT</b>	<a href="#">Substance Misuse Screening</a>	HEDIS	59 %	44 %
<b>TBC</b>	<a href="#">Tobacco Use Screening and Cessation Intervention (12 years and older)</a>	HPSM	58 %	41 %
<b>W15</b>	<a href="#">Well Child Visit (0-15 months old)</a>	HEDIS	64 %	55 %
<b>WCC-N</b>	<a href="#">Weight Assessment &amp; Nutrition Counseling for Children</a>	HEDIS	74 %	59 %
<b>WCC-PA</b>	<a href="#">Weight Assessment &amp; Physical Activity Counseling for Children</a>	HEDIS	71 %	54 %
<b>WCV</b>	<a href="#">Well Child and Adolescent Visit (3-21 years old)</a>	HEDIS	63 %	58 %

<b>Engagement</b>	<a href="#">Panel Engagement for Capitation Bonuses</a>	<b>HPSM</b>	<b>60%</b>	<b>50 - 59.99%</b>
-------------------	---	-------------	------------	--------------------

<sup>iii</sup> Partial credit will also be awarded for 10% improvement “on the negative” compared to prior year. See [Improvement Targets](#).

## Pediatric Reporting-Only Quality Metric Set

HPSM collects and monitors performance data on “reporting-only” metrics, though these metrics are not included in payment calculations. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Metric Name	Metric Source
<b>ACE</b>	<a href="#">Trauma Screening (Adverse Childhood Experiences)</a>	HPSM
<b>AMR</b>	<a href="#">Asthma Medication Ratio</a>	HEDIS
<b>Avoid-ED</b>	<a href="#">Avoidable Emergency Department Visit</a>	HPSM
<b>CHL</b>	<a href="#">Chlamydia Screening in Women (16-24 years old)</a>	HEDIS
<b>DEV</b>	<a href="#">Developmental Screening</a>	HPSM
<b>Encounters</b>	Encounter Threshold – reported as average visits per member per year	HPSM
<b>FVN</b>	<a href="#">Fluoride Varnish</a>	HPSM
<b>IHA</b>	<a href="#">Initial Health Appointment</a>	HPSM
<b>IMA-2</b>	<a href="#">Adolescent Immunizations (Combination 2)</a>	HEDIS
<b>SBIRT</b>	<a href="#">Substance Misuse Screening and Follow Up (12 years and older)</a>	HPSM
<b>SDoH</b>	<a href="#">Z-Coding for Social Determinants of Health</a>	HPSM
<b>W30</b>	<a href="#">Well Child Visit (15-30 months old)</a>	HEDIS

## V. Panel Engagement – Capitation Bonuses and Corrective Action

### Panel Engagement Overview

Access to primary care is a key driver for managing the health of our shared patient population and we want to recognize the work our providers do to engage assigned HPSM patients at their clinics/offices. Capitated clinics will be eligible to earn up to an additional 30% of capitation each month based on quarterly panel engagement:

- **30% additional capitation:** Clinic has had at least one eligible encounter with an average 60% or greater of continuously assigned members over a rolling 12 month timeline.
- **15% additional capitation:** Clinic has had at least one eligible encounter with an average 50-59.99% of continuously assigned members over a rolling 12 month timeline.
- **Base capitation only:** Clinic has had at least one eligible encounter with an average 35 - 49.99% of continuously assigned members over a rolling 12 month timeline.
- **Base capitation only with Corrective Action Plan:** Clinic has had at least one eligible encounter with an average 0 – 34.99% of continuously assigned members over a rolling 12 month timeline. Clinics with low panel engagement for two consecutive quarters may be placed on a Corrective Action Plan (CAP) and face sanctions including being temporarily placed on mandated Established Patients Only (EPO) status to prevent further member assignment, being temporarily transitioned to a fee-for-service reimbursement structure, or termination from the network.

### Eligible primary care encounters that count towards patient engagement:

- Any claims received from rendering providers at the assigned primary care clinic that fall into any of the following primary care specialty designations – general medicine, internal medicine, family medicine, geriatrics, pediatrics, certified nurse practitioner, and physician assistant
- AND preventive services billed by non-PCP specialty types at assigned clinic - (**99381-99387, 99391-99397, 99401-99429, G0402, G0438, G0439, S0612**);
- Codes for immunization: **99460-90749, G0008-G0010, Q2034-Q2039**;
- Encounters for COVID-19 immunization administered by assigned primary care clinic;
- AND telemedicine based on billable definitions and telephone visit codes - (**98966, 98967, 98968, 99441, 99442, 99443**);
- AND capitated encounters

Clinics receive monthly performance reports describing primary care engagement. The engagement performance benchmark is averaged over the quarter and capitation bonus payments will be based on the quarter performance benchmark average. Payments are made prospectively for the entire following quarter.

## VI. Quality Metric Specifications

### ACEs: Trauma Screening

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Reporting-Only

**Metric Source:** DHCS, under Proposition 56 directed payments.

**Patient Eligibility:** Members under age 21.

**Metric Definition:** Percentage of members under age 21 screened for ACEs (Adverse Childhood Experiences) using the PEARLS tool during the measurement year.

ACEs Trauma Screenings are not eligible for P4P payments or credit for the 2023 Program Year. However, eligible providers will continue to receive directed payments of \$35.67 per screening via Proposition 56 funds. To participate, providers must complete and attest to a free two-hour training on the science of ACEs and toxic stress. Providers may also earn CME/MOC credits through this training.

For more information, please visit <https://acesaware.org> or email [PSInquiries@hpsm.org](mailto:PSInquiries@hpsm.org).

### Trauma Screening Procedure Codes

Code	Definition	Code System
<b>G9919</b>	Trauma Screening	HCPCS
<b>G9920</b>	Trauma Screening	HCPCS

## AMB-ED: Ambulatory Emergency Care

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Reporting-Only

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** All members excluding those in hospice and palliative care.

**Exclusions:**

- ED visits that result in an inpatient stay.
- Visits for mental health or chemical dependency.

Full and partial credit benchmarks will not be applied for this metric. HPSM’s network rates will be reported back to providers.

**Metric Definition:** This metric summarizes utilization of ambulatory care for emergency department visits. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.



## Avoid-ED: Avoidable Emergency Department Visits

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Reporting-Only

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** Members 1 year and older who visited an emergency room.

**Exclusions:** Exclude members receiving hospice or palliative care during the measurement year.

**Metric Definition:** The percentage of avoidable ER visits among members 1 year of age and older. Avoidable visits are defined using the diagnosis codes referenced below.

Full and partial credit benchmarks will not be applied for this metric. HPSM's network rates will be reported back to providers.

Refer to <https://www.hpsm.org/provider/value-based-payment> for the complete list of qualifying ED diagnosis codes.

## BCS: Mammogram for Breast Cancer Screening

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Women age 50-74 years old who have not had a bilateral mastectomy.

**Exclusions:**

- Members 66 years of age and older by the end of the Measurement Period, with frailty AND advanced illness
- Members receiving palliative care

**Metric Definition:** The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

### Mammography Procedure Codes

Code	Definition	Code System
<b>77055</b>	Mammography	CPT
<b>77056</b>	Mammography	CPT
<b>77057</b>	Mammography	CPT
<b>77061</b>	Mammography	CPT
<b>77062</b>	Mammography	CPT
<b>77063</b>	Mammography	CPT
<b>77065</b>	Mammography	CPT
<b>77066</b>	Mammography	CPT
<b>77067</b>	Mammography	CPT
<b>G0202</b>	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed (G0202)	HCPCS
<b>G0204</b>	Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral (G0204)	HCPCS
<b>G0206</b>	Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral (G0206)	HCPCS
<b>3014F</b>	Screening mammography results documented and reviewed	CPT II

### Mammography Exclusion Code

Code	Definition	Code System
<b>3014F with Modifier 1P</b>	Screening mammography not performed for medical reasons	CPT II

## BPD: Blood Pressure Control for Patients with Diabetes

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

**Metric Source:** HEDIS metric of the same name (formerly Rate 6 of the retired HEDIS metric, CDC).

**Patient Eligibility:** Patients 18-75 years old with a diagnosis of diabetes (types 1 or 2).

**Exclusions:**

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

**Metric Definition:** The percent of diabetic patients who had a blood pressure reading and are in control for the most recent blood pressure reading. Must include both systolic and diastolic blood pressure results as documented through administrative data. To qualify, the most recent BP level (taken during the current calendar year) is <140/90 mm Hg, as documented through administrative data or medical record review.

### Diabetes Blood Pressure Procedure Codes

Code	Definition	Code System
<b>3079F</b>	DIAST BP 80-89 MM HG	CPTII
<b>3080F</b>	DIAST BP >= 90 MM HG	CPTII
<b>3078F</b>	DIAST BP <80 MM HG	CPTII
<b>3077F</b>	SYST BP >= 140 MM HG	CPTII
<b>3074F</b>	SYST BP LT 130 MM HG	CPTII
<b>3075F</b>	SYST BP GE 130 - 139MM HG	CPTII

## CBP: Controlling High Blood Pressure

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Members 18-85 years old who had at least two visits and a diagnosis of hypertension in the year prior to the measurement year AND the first six months of the current measurement year.

**Exclusions:**

- Members 66-80 years old with both frailty AND advanced illness
- Members 81 years of age and older as of December 31 of the measurement year with frailty
- Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy, or kidney transplant on or prior to December 31 of the measurement year
- Members with a diagnosis of pregnancy during the measurement year
- Members who had a nonacute inpatient admission during the measurement year
- Members receiving palliative care

**Metric Definition:** The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. The representative BP reading is the most recent BP reading during the measurement year on or after the second diagnosis of hypertension.

### Hypertension Diagnosis Code

Code	Definition	Code System
<b>I10</b>	Essential (primary) hypertension	ICD10CM

### Blood Pressure Reading Codes

Code	Definition	Code System
<b>3079F</b>	Most recent diastolic blood pressure 80-89 mm Hg	CPT-CAT-II
<b>3080F</b>	Most recent diastolic blood pressure greater than or equal to 90 mm Hg	CPT-CAT-II
<b>3078F</b>	Most recent diastolic blood pressure less than 80 mm Hg	CPT-CAT-II
<b>3077F</b>	Most recent systolic blood pressure greater than or equal to 140 mm Hg	CPT-CAT-II
<b>3074F</b>	Most recent systolic blood pressure less than 130 mm Hg	CPT-CAT-II
<b>3075F</b>	Most recent systolic blood pressure 130-139 mm Hg	CPT-CAT-II

## CCS: Cervical Cancer Screening

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Women 21-64 years old.

**Exclusions:**

- Exclude members receiving hospice or palliative care during the measurement year.
- Members who have had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their history through December 31, 2021 may be excluded (see “[Cervical Cancer Exclusion Codes](#)”)

**Metric Definition:** The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed every 3 years (36 calendar months).
- Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years (72 calendar months).
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing every 5 years.

### Cervical Cancer Screening Procedure Codes

Code	Definition	Code System
88141	Cervical Cytology	CPT
88142	Cervical Cytology	CPT
88143	Cervical Cytology	CPT
88147	Cervical Cytology	CPT
88148	Cervical Cytology	CPT
88150	Cervical Cytology	CPT
88152	Cervical Cytology	CPT
88153	Cervical Cytology	CPT
88154	Cervical Cytology	CPT
88164	Cervical Cytology	CPT
88165	Cervical Cytology	CPT

<b>88166</b>	Cervical Cytology	CPT
<b>88167</b>	Cervical Cytology	CPT
<b>88174</b>	Cervical Cytology	CPT
<b>88175</b>	Cervical Cytology	CPT
<b>G0123</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision (G0123)	HCPCS
<b>G0124</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician (G0124)	HCPCS
<b>G0141</b>	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician (G0141)	HCPCS
<b>G0143</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision (G0143)	HCPCS
<b>G0144</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision (G0144)	HCPCS
<b>G0145</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision (G0145)	HCPCS
<b>G0147</b>	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision (G0147)	HCPCS
<b>G0148</b>	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening (G0148)	HCPCS
<b>P3000</b>	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision (P3000)	HCPCS
<b>P3001</b>	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician (P3001)	HCPCS
<b>Q0091</b>	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory (Q0091)	HCPCS
<b>3015F</b>	Cervical cancer screening results documented and reviewed	CPT II

## HPV Testing Codes

Code	Definition	Code System
<b>87620</b>	HPV detection by DNA or RNA, direct probe technique	CPT
<b>87621</b>	HPV detection by DNA or RNA, amplified probe technique	CPT
<b>87622</b>	HPV quantification	CPT
<b>87624</b>	Human Papillomavirus (HPV), high-risk types	CPT
<b>87625</b>	Human Papillomavirus (HPV)	CPT
<b>G0476</b>	Infectious agent detection by nucleic acid (dna or rna); human papillomavirus (hpv), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test (G0476)	HPCPS

## Cervical Cancer Screening Exclusion Codes

In order for patients to be excluded from the cervical cancer screening performance metric calculation HPSM must have documented evidence of a complete hysterectomy. For new patients, we do not always have this data. If you believe a patient is listed as eligible for this service in the P4P member detail report in error, then please submit one of the following diagnosis codes with the claim for the patient's next primary care visit:

Code	Definition	Code System
<b>Q51.5</b>	Agenesis and aplasia of cervix	ICD10CM
<b>Z90.710</b>	Acquired absence of both cervix and uterus	ICD10CM
<b>Z90.712</b>	Acquired absence of cervix with remaining uterus	ICD10CM
<b>0UTC0ZZ</b>	Resection of Cervix, Open Approach	ICD10PCS
<b>0UTC4ZZ</b>	Resection of Cervix, Percutaneous Endoscopic Approach	ICD10PCS
<b>0UTC7ZZ</b>	Resection of Cervix, Via Natural or Artificial Opening	ICD10PCS
<b>0UTC8ZZ</b>	Resection of Cervix, Via Natural or Artificial Opening Endoscopic	ICD10PCS
<b>3015F</b>	<b>Modifier 1P</b> Cervical cancer screening not performed for Medical Reasons	CPT II

## CDF: Depression Screening and Follow-Up (12 years and older)

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** Members 12 years old and up (patients who will turn 13 years of age as of December 31<sup>st</sup> of the measurement year) who had an outpatient visit during the measurement period.

**Exclusions:** Exclude members who have a documented active diagnosis of depression or bipolar disorder.

**Metric Definition:** The percentage of members 12 year of age and older who had an annual depression screening on the date of the encounter using a standard depression screening tool (including the HPSM Behavioral Health Screening tool available at: [hpsm.org/provider-forms](https://www.hpsm.org/provider-forms), which includes PHQ-2 standard screening questions):

- Screening must be documented in patient’s medical record
- If screening is positive, follow-up plan must be documented on the date of the positive screen

For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>. Note that for the Depression Screening metric, additional outpatient visit codes may apply in order to adequately capture maternal health and other visit types.

### Depression Screening Procedure Codes

Code	Definition	Code System
<b>96127</b>	Brief emotional/behavioral assessment with scoring and documentation using a standardized instrument	CPT
<b>G8431</b>	Screening for depression is documented as being positive and a follow-up plan is documented	HCPCS
<b>G8433</b>	Screening for clinical depression using a standardized tool not documented; patient not eligible/appropriate	HCPCS
<b>G0444</b>	Annual depression screening administration	HCPCS
<b>G8510</b>	Screening for depression is documented as negative, a follow-up plan is not required	HCPCS
<b>G8511</b>	Screening for depression documented as positive; follow-up plan is not documented and reason not given	CPT II
<b>3351F</b>	Negative screen for depressive symptoms as categorized by using a standardized depression assessment tool (MDD)	CPT II



<b>3352F</b>	No significant depressive symptoms as categorized by using a standardized depression assessment tool (MDD)	CPT II
<b>3353F</b>	Mild to moderate depressive symptoms as categorized by using a standardized depression/assessment tool (MDD)	CPT II
<b>3354F</b>	Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)	CPT II
<b>1220F</b>	Patient screened for depression (SUD)	CPT II
<b>0545F</b>	Plan for follow-up care for major depressive disorder documented (MDD ADOL)	CPT II

---

## CDM: Comprehensive Diabetes Management

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

**Metric Source:** HPSM internal metric (formerly known as CDC-Complete).

**Patient Eligibility:** Patients 18 years old and up with a diagnosis of diabetes.

**Exclusions:**

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

**Metric Definition:** Percent of assigned diabetic patients who had their most recent eligible result of hemoglobin A1c controlled ([HBD-1](#)), blood pressure controlled ([BPD](#)), retinal eye exam administered ([EED](#)), and kidney health evaluation performed ([KED](#)) in the relevant lookback period for each component metric.

## CHA: Cognitive Health Assessment

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

**Metric Source:** HPSM internal metric, directed by [APL 22-025](#).

**Patient Eligibility:** Medi-Cal members 65 and older.

**Metric Definition:** The percentage of members 65 and older who received an eligible cognitive health assessment in the measurement year.

In order to receive reimbursement for administering cognitive health assessments to Medi-Cal members not also receiving Medicare benefits, providers must complete and submit attestation of completion via Dementia Care Aware, a state-wide provider education and training program administered by the University of California, San Francisco. Visit [dementiacareaware.org](https://dementiacareaware.org) or email [PSInquiries@hpsm.org](mailto:PSInquiries@hpsm.org) for more information.

### Cognitive Health Assessment Procedure Codes

Code	Definition	Code System
<b>96116</b>	Neuropsychological testing	CPT
<b>96136</b>	Neuropsychological testing	CPT
<b>96138</b>	Neuropsychological testing	CPT
<b>96146</b>	Neuropsychological testing	CPT
<b>99483</b>	Neuropsychological testing	CPT
<b>71492-3</b>	Total Score, Saint Louis University Mental Status examination (SLUMS)	LOINC
<b>71947-6</b>	Saint Louis University Mental Status examination (SLUMS)	LOINC
<b>72088-8</b>	Clinical Dementia Rating (CDR)	LOINC
<b>72106-8</b>	Total Score, Mini-Mental State Examination (MMSE)	LOINC

<b>72107-6</b>	Mini-Mental State Examination (MMSE)	LOINC
<b>72133-2</b>	Montreal Cognitive Assessment [MoCA]	LOINC
<b>72172-0</b>	Total Score, Montreal Cognitive Assessment [MoCA]	LOINC
<b>72233-0</b>	Total Score, Mini-cog	LOINC
<b>72234-8</b>	Mini-cog	LOINC

---

## CHL: Chlamydia Screening in Women (16-24 years old)

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Reporting-Only

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Women 16-24 years old who are sexually active.

**Metric Definition:** The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the calendar year.

### Chlamydia Testing Codes

Code	Definition	Code System
87110	Chlamydia Test	CPT
87270	Chlamydia Test	CPT
87320	Chlamydia Test	CPT
87490	Chlamydia Test	CPT
87491	Chlamydia Test	CPT
87492	Chlamydia Test	CPT
87810	Chlamydia Test	CPT

## CIS-10: Immunizations for Children – Combo 10

Adult	Family Practice	Pediatrics
Not included	Reporting-Only	Payment

**Metric Source:** Combination 10 of the HEDIS metric CIS.

**Patient Eligibility:** Children who turn 2 years old during the current calendar year.

**Exclusions:** Exclude children who had a contraindication for a specific vaccine by their 2<sup>nd</sup> birthday from the denominator for all antigen rates and the combination rates.

**Metric Definition:** The percentage of children 2 years of age 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. The metric calculates a rate for each vaccine and nine separate combination rates.

### CIS Procedure Codes

Code	Definition	Code System
90700	DTaP Vaccine Procedure	CPT
90721	DTaP Vaccine Procedure	CPT
90723	DTaP Vaccine Procedure	CPT
90633		CPT
90644	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90645	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90646	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90647	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90648	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90698	Haemophilus Influenzae Type B (HiB) Vaccine Procedure/DTaP Vaccine Procedure	CPT
90721	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90748	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
B15.0	Hepatitis A with hepatic coma	ICD10CM
B15.9	Hepatitis A without hepatic coma	ICD10CM

<b>B16.0</b>	Acute hepatitis B with delta-agent with hepatic coma	ICD10CM
<b>B16.1</b>	Acute hepatitis B with delta-agent without hepatic coma	ICD10CM
<b>B16.2</b>	Acute hepatitis B without delta-agent with hepatic coma	ICD10CM
<b>B16.9</b>	Acute hepatitis B without delta-agent and without hepatic coma	ICD10CM
<b>B17.0</b>	Acute delta-(super) infection of hepatitis B carrier	ICD10CM
<b>B18.0</b>	Chronic viral hepatitis B with delta-agent	ICD10CM
<b>B18.1</b>	Chronic viral hepatitis B without delta-agent	ICD10CM
<b>B19.10</b>	Unspecified viral hepatitis B without hepatic coma	ICD10CM
<b>B19.11</b>	Unspecified viral hepatitis B with hepatic coma	ICD10CM
<b>Z22.51</b>	Carrier of viral hepatitis B	ICD10CM
<b>08</b>	hepatitis B vaccine, pediatric or pediatric/adolescent dosage	CVX
<b>90723</b>	Hepatitis B Vaccine Procedure	CPT
<b>90740</b>	Hepatitis B Vaccine Procedure	CPT
<b>90744</b>	Hepatitis B Vaccine Procedure	CPT
<b>90747</b>	Hepatitis B Vaccine Procedure	CPT
<b>90748</b>	Hepatitis B Vaccine Procedure	CPT
<b>G0010</b>	Administration of hepatitis b vaccine	HCPCS
<b>3E0234Z</b>	Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach	ICD10PCS
<b>90670</b>	Pneumococcal Conjugate Vaccine Procedure	CPT
<b>G0009</b>	Administration of pneumococcal vaccine	HCPCS
<b>90681</b>	Rotavirus Vaccine (2 Dose Schedule) Procedure	CPT
<b>90680</b>	Rotavirus Vaccine (3 Dose Schedule) Procedure	CPT
<b>B06.00</b>	Rubella with neurological complication, unspecified	ICD10CM
<b>B06.01</b>	Rubella encephalitis	ICD10CM
<b>B06.02</b>	Rubella meningitis	ICD10CM
<b>B06.09</b>	Other neurological complications of rubella	ICD10CM
<b>B06.81</b>	Rubella pneumonia	ICD10CM
<b>B06.82</b>	Rubella arthritis	ICD10CM
<b>B06.89</b>	Other rubella complications	ICD10CM
<b>B06.9</b>	Rubella without complication	ICD10CM
<b>90706</b>	Rubella Vaccine Procedure	CPT

## DEV: Developmental Screening

Adult	Family Practice	Pediatrics
Not included	Reporting-Only	Reporting-Only

**Metric Source:** DHCS, under Proposition 56 directed payments.

**Patient Eligibility:** Children 30 months of age.

**Metric Definition:** Percentage of children 30 months of age who have received developmental screening by 9 months, 18 months and 30 months of age.

Developmental Screenings are not eligible for P4P payments or credit for the 2022 Program Year. However, providers will continue to receive directed payments via Proposition 56 funds. Providers receive \$73.68 for each eligible developmental screening performed and reported using the CPT code 96110. **Note:** FQHCs are excluded from Prop 56 directed payments. For more information, please refer to the DHCS guidance at:

<https://www.dhcs.ca.gov/provgovpart/Prop-56/Pages/Prop56-Screenings-Developmental.aspx>

Providers must use a validated and age-appropriate screening instrument and document results in the medical record. The following tools are currently approved by DHCS:

- Ages and Stages Questionnaire (ASQ) - 4 months to age 5
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

### Developmental Screening Procedure Code

Code	Definition	Code System
96110	Developmental screening with scoring and documentation, per standardized instrument	CPT



## EED: Eye Exam for Patients with Diabetes

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

**Metric Source:** HEDIS metric of the same name (formerly Rate 4 of the retired HEDIS metric, CDC).

**Patient Eligibility:** Patients 18 -75 years old with a diagnosis of diabetes (types 1 or 2).

### Exclusions:

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

**Metric Definition:** Percent of diabetic patients who had screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the current calendar year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the current calendar year.
- Bilateral eye enucleation anytime during the member’s history through December 31 of the current calendar year.

## Diabetic Retinal Eye Exam Procedure Codes

Code	Definition	Code System
67028	Diabetic Retinal Screening	CPT
67030	Diabetic Retinal Screening	CPT
67031	Diabetic Retinal Screening	CPT
67036	Diabetic Retinal Screening	CPT
67039	Diabetic Retinal Screening	CPT
67040	Diabetic Retinal Screening	CPT
67041	Diabetic Retinal Screening	CPT
67042	Diabetic Retinal Screening	CPT
67043	Diabetic Retinal Screening	CPT
67101	Diabetic Retinal Screening	CPT
67105	Diabetic Retinal Screening	CPT

<b>67107</b>	Diabetic Retinal Screening	CPT
<b>67108</b>	Diabetic Retinal Screening	CPT
<b>67110</b>	Diabetic Retinal Screening	CPT
<b>67113</b>	Diabetic Retinal Screening	CPT
<b>67121</b>	Diabetic Retinal Screening	CPT
<b>67141</b>	Diabetic Retinal Screening	CPT
<b>67145</b>	Diabetic Retinal Screening	CPT
<b>67208</b>	Diabetic Retinal Screening	CPT
<b>67210</b>	Diabetic Retinal Screening	CPT
<b>67218</b>	Diabetic Retinal Screening	CPT
<b>67220</b>	Diabetic Retinal Screening	CPT
<b>67221</b>	Diabetic Retinal Screening	CPT
<b>67227</b>	Diabetic Retinal Screening	CPT
<b>67228</b>	Diabetic Retinal Screening	CPT
<b>92002</b>	Diabetic Retinal Screening	CPT
<b>92004</b>	Diabetic Retinal Screening	CPT
<b>92012</b>	Diabetic Retinal Screening	CPT
<b>92014</b>	Diabetic Retinal Screening	CPT
<b>92018</b>	Diabetic Retinal Screening	CPT
<b>92019</b>	Diabetic Retinal Screening	CPT
<b>92134</b>	Diabetic Retinal Screening	CPT
<b>92225</b>	Diabetic Retinal Screening	CPT
<b>92226</b>	Diabetic Retinal Screening	CPT
<b>92227</b>	Diabetic Retinal Screening	CPT
<b>92228</b>	Diabetic Retinal Screening	CPT
<b>92230</b>	Diabetic Retinal Screening	CPT
<b>92235</b>	Diabetic Retinal Screening	CPT
<b>92240</b>	Diabetic Retinal Screening	CPT

<b>92250</b>	Diabetic Retinal Screening	CPT
<b>92260</b>	Diabetic Retinal Screening	CPT
<b>99203</b>	Diabetic Retinal Screening	CPT
<b>99204</b>	Diabetic Retinal Screening	CPT
<b>99205</b>	Diabetic Retinal Screening	CPT
<b>99213</b>	Diabetic Retinal Screening	CPT
<b>99214</b>	Diabetic Retinal Screening	CPT
<b>99215</b>	Diabetic Retinal Screening	CPT
<b>99242</b>	Diabetic Retinal Screening	CPT
<b>99243</b>	Diabetic Retinal Screening	CPT
<b>99244</b>	Diabetic Retinal Screening	CPT
<b>99245</b>	Diabetic Retinal Screening	CPT
<b>S0620</b>	Diabetic Retinal Screening	HCPCS
<b>S0621</b>	Diabetic Retinal Screening	HCPCS
<b>S3000</b>	Diabetic Retinal Screening	HCPCS
<b>3072F</b>	Diabetic Retinal Screening Negative	CPT II
<b>2022F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>2023F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>2024F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>2025F</b>	Diabetic Retinal Screening With Eye Care Professional	CPTII
<b>2026F</b>	Diabetic Retinal Screening With Eye Care Professional	CPTII
<b>2033F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>65091</b>	Unilateral Eye Enucleation	CPT
<b>65093</b>	Unilateral Eye Enucleation	CPT
<b>65101</b>	Unilateral Eye Enucleation	CPT
<b>65103</b>	Unilateral Eye Enucleation	CPT
<b>65105</b>	Unilateral Eye Enucleation	CPT
<b>65110</b>	Unilateral Eye Enucleation	CPT

<b>65112</b>	Unilateral Eye Enucleation	CPT
<b>65114</b>	Unilateral Eye Enucleation	CPT
<b>08B10ZX</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B10ZZ</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B13ZX</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B13ZZ</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B1XZX</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B1XZZ</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B00ZX</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B00ZZ</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B03ZX</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B03ZZ</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B0XZX</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B0XZZ</b>	Unilateral Eye Enucleation Right	ICD10PCS

## FLU: Seasonal Influenza Vaccination

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** All members 6 months and older.

**Exclusions:** Exclude women with a diagnosis of pregnancy during the measurement period.

**Metric Definition:** The percentage of members 6 months and older receiving a seasonal flu vaccination July 1, 2023 through March 31, 2024.

**Numerator:** Assigned members (6 months and older) with flu vaccine administered July of the measurement year through March of the following calendar year *OR* evidence of flu vaccine from CAIR Registry administered July of the measurement year through March of the following calendar year.

**Denominator:** All assigned members (6 months and older) who had at least one in-person outpatient encounter with provider during July through December of the measurement year.

For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>

### Flu Vaccine Procedure Codes

Code	Definition	Code System
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	CPT
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	CPT
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	CPT
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	CPT
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	CPT
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	CPT
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	CPT
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	CPT
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT

<b>90674</b>	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
<b>90682</b>	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
<b>90685</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
<b>90686</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
<b>90687</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	CPT
<b>90688</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	CPT
<b>90689</b>	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use	CPT
<b>90694</b>	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	CPT
<b>90756</b>	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
<b>Q2034</b>	Influenza virus vaccine, split virus, for intramuscular use (agriflu)	HCPCS
<b>Q2035</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)	HCPCS
<b>Q2036</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)	HCPCS
<b>Q2037</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)	HCPCS
<b>Q2038</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)	HCPCS
<b>Q2039</b>	Influenza virus vaccine, not otherwise specified	HCPCS
<b>G0008</b>	Administration of influenza virus vaccine	HCPCS

## FVN: Fluoride Varnish

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Reporting-Only

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** Members ages 0-5.

**Metric Definition:** Percentage of members ages 0-5 who have received fluoride varnish at least two times during the measurement period.

### Fluoride Varnish Procedure Codes

Code	Definition	Code System
<b>99188</b>	Topical application of fluoride varnish	CPT
<b>D1206</b>	Topical application of fluoride varnish	HCPCS

## HBD-1: Hemoglobin A1c Control (<8.0%) for Patients with Diabetes

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

**Metric Source:** Rate 1 of the HEDIS metric of the same name (formerly Rate 3 of the retired HEDIS metric, CDC).

**Patient Eligibility:** Members 18 -75 years old with a diagnosis of diabetes (types 1 or 2).

### Exclusions:

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

**Metric Definition:** Percent of diabetic members whose most recent HbA1c level (performed during the current calendar year) is <8.0% as identified by automated laboratory data or administrative data if laboratory data is not received.

Laboratories who currently send data directly to HPSM on a monthly basis:

- Chinese Hospital
- San Mateo Medical Center
- LabCorp
- Quest
- North East Medical Services
- Stanford
- Sutter

\*Note that lab data sent directly to HPSM by the sources listed above might still not be 100% complete. It is important to check your monthly reports and follow up with the lab provider to obtain any results for your patients.

### Diabetes HbA1c Procedure Codes

Code	Definition	Code System
<b>3044F</b>	HbA1c Level Less Than 7.0	CPT II
<b>3051F</b>	HbA1c Level greater than or equal to 7.0% and less than 8.0%	CPT II
<b>3045F</b>	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (DM)	CPTII
<b>3046F</b>	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT II
<b>3052F</b>	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	CPT II

\*To get credit towards this performance metric lab data must be received directly or a CPT Category II Code must be submitted by the participating provider office once the lab result has been reviewed and documented in the patient's medical record.



## HBD-2: Hemoglobin A1c Control (>9.0%) for Patients with Diabetes

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

**Metric Source:** Rate 2 of the HEDIS metric of the same name (formerly Rate 2 of the retired HEDIS metric, CDC).

**Patient Eligibility:** Members 18 -75 years old with a diagnosis of diabetes (types 1 or 2).

### Exclusions:

- Members who have not had a diagnosis of diabetes AND had a diagnosis of gestational diabetes or steroid-induced diabetes during the current or prior measurement year
- Members 66 years and older as of December 31 of the measurement year with frailty AND advanced illness
- Members receiving palliative care

**Metric Definition:** Percent of diabetic members whose most recent HbA1c level (performed during the current calendar year) is <8.0% as identified by automated laboratory data or administrative data if laboratory data is not received.

Laboratories who currently send data directly to HPSM on a monthly basis:

- Chinese Hospital
- San Mateo Medical Center
- LabCorp
- Quest
- North East Medical Services
- Stanford
- Sutter

\*Note that lab data sent directly to HPSM by the sources listed above might still not be 100% complete. It is important to check your monthly reports and follow up with the lab provider to obtain any results for your patients.

### Diabetes HbA1c Procedure Codes

Code	Definition	Code System
<b>3044F</b>	HbA1c Level Less Than 7.0	CPT II
<b>3051F</b>	HbA1c Level greater than or equal to 7.0% and less than 8.0%	CPT II
<b>3045F</b>	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (DM)	CPTII
<b>3046F</b>	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT II
<b>3052F</b>	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	CPT II

\*To get credit towards this performance metric lab data must be received directly or a CPT Category II Code must be submitted by the participating provider office once the lab result has been reviewed and documented in the patient's medical record.

## IHA: Initial Health Appointment

Adult	Family Practice	Pediatrics
Payment	Payment	Reporting-Only

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** Newly enrolled HPSM members (within 120 days of Health Plan enrollment AND 90 days of assignment to primary care panel).

**Metric Definition:** Percent of newly enrolled and assigned members who had an Initial Health Appointment within 120 days of HPSM enrollment (generally within 90 days of panel assignment) or the submission of an IHA procedure code listed below in the 12 months prior to re-enrollment with HPSM. The Active Engagement report sent monthly through the HPSM eReports system can help conduct outreach to newly enrolled HPSM members who are newly assigned to your panel.

A complete IHA must:

1. Be completed by a provider within the primary care medical setting;
2. Be performed in a way that is culturally and linguistically considerate;
3. Be documented in a member's medical record;
4. Include:
  - A history of the member's physical and mental health;
  - An identification of risks;
  - An assessment of need for preventive screens or services;
  - The diagnosis and plan for treatment of any diseases;
  - Any additional health education provided.

Providers may track outreach attempts to attest to members who receive at least three outreach attempts during the measurement year for partial P4P credit. Providers must document date and modality of outreach attempts and share copies of scripting or other outreach materials with HPSM.

### IHA Procedure Codes

Code	Definition	Code System
99201	Office/Outpt E&M New Minor 10	CPT
99202	Office/Outpt E&M New Low-Mod	CPT
99203	Office/Outpt E&M New Mod Seve	CPT
99204	Office/Outpt E&M New Mod-Hi 4	CPT
99205	Office/Outpt E&M New Mod-Hi 6	CPT

<b>99211</b>	Office/Outpt E&M Estab 5 Min	CPT
<b>99212</b>	Office/Outpt E&M Estab Minor	CPT
<b>99213</b>	Office/Outpt E&M Estab Low-Mo	CPT
<b>99214</b>	Office/Outpt E&M Estab Mod-Hi	CPT
<b>99215</b>	Office/Outpt E&M Estab Mod-Hi	CPT
<b>99241</b>	Office Cons New/Estab Minor 1	CPT
<b>99242</b>	Office Cons New/Est Lo Sever	CPT
<b>99243</b>	Office Cons New/Estab Mod 40	CPT
<b>99244</b>	Office Cons New/Estab Mod-Hi	CPT
<b>99245</b>	Office Cons New/Estab Mod-Hi	CPT
<b>99304</b>	Nursing Facility Care Init	CPT
<b>99305</b>	Nursing Facility Care Init	CPT
<b>99306</b>	Nursing Facility Care Init	CPT
<b>99307</b>	Nursing Fac Care Subseq	CPT
<b>99308</b>	Nursing Fac Care Subseq	CPT
<b>99309</b>	Nursing Fac Care Subseq	CPT
<b>99310</b>	Nursing Fac Care Subseq	CPT
<b>99315</b>	Nurs Facil D/C Da Mgmt; 30 M	CPT
<b>99316</b>	Nurs Facil D/C Da Mgmt; > 30	CPT
<b>99318</b>	Annual Nursing Fac Assessmnt	CPT
<b>99324</b>	Domicil/R-Home Visit New Pat	CPT
<b>99325</b>	Domicil/R-Home Visit New Pat	CPT
<b>99326</b>	Domicil/R-Home Visit New Pat	CPT
<b>99327</b>	Domicil/R-Home Visit New Pat	CPT
<b>99328</b>	Domicil/R-Home Visit New Pat	CPT
<b>99334</b>	Domicil/R-Home Visit Est Pat	CPT
<b>99335</b>	Domicil/R-Home Visit Est Pat	CPT

<b>99336</b>	Domicil/R-Home Visit Est Pat	CPT
<b>99337</b>	Domicil/R-Home Visit Est Pat	CPT
<b>99341</b>	Home Visit E&M New Pt Lo Sev	CPT
<b>99342</b>	Home Visit E&M New Pt Mod Se	CPT
<b>99343</b>	Home Visit E&M New Pt Mod-Hi	CPT
<b>99344</b>	Home Visit E&M New Pt Hi Sev	CPT
<b>99345</b>	Home Visit E&M New Pt Unstbl	CPT
<b>99347</b>	Home Visit E&M Estab Minor-1	CPT
<b>99348</b>	Home Visit E&M Estab Low-Mod	CPT
<b>99349</b>	Home Visit E&M Estab Mod-Hi	CPT
<b>99350</b>	Home Visit E&M Estab Mod-Hi	CPT
<b>99354</b>	Prolong Md Serv Outpt W/Pt;	CPT
<b>99355</b>	Prolong Md Serv Outpt W/Pt;	CPT
<b>99381</b>	Init Preven Meds E&M New Pt;	CPT
<b>99382</b>	Init Preven Meds E&M New Pt;	CPT
<b>99383</b>	Init Preven Meds E&M New Pt;	CPT
<b>99384</b>	Init Preven Meds E&M New Pt;	CPT
<b>99385</b>	Init Preven Meds E&M New Pt;	CPT
<b>99386</b>	Init Preven Meds E&M New Pt;	CPT
<b>99387</b>	Init Preven Meds E&M New Pt;	CPT
<b>99391</b>	Preven Meds E&M Estab Pt; In	CPT
<b>99392</b>	Preven Meds E&M Estab Pt; 1-	CPT
<b>99393</b>	Preven Meds E&M Estab Pt; 5-	CPT
<b>99394</b>	Preven Meds E&M Estab Pt; 12	CPT
<b>99395</b>	Preven Meds E&M Estab Pt; 18	CPT
<b>99396</b>	Preven Meds E&M Estab Pt; 40	CPT
<b>99397</b>	Preven Meds E&M Estab Pt; 65	CPT

<b>99401</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99402</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99403</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99404</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99411</b>	Preven Med Counsl Grp (Sep P	CPT
<b>99412</b>	Preven Med Counsl Grp (Sep P	CPT
<b>99420</b>	Admin/Intrpt Health Risk Ass	CPT
<b>99429</b>	Unlisted Preven Meds Serv	CPT
<b>99444</b>	Online E/M By Phys	CPT
<b>99446</b>	Interprof Phone/Online 5-10	CPT
<b>99447</b>	Interprof Phone/Online 11-2	CPT
<b>99448</b>	Interprof Phone/Online 21-3	CPT
<b>99449</b>	Interprof Phone/Online 31/>	CPT
<b>99450</b>	Basic Life &/Or Disability E	CPT
<b>99455</b>	Work Relat/Disabl Exam-Treat	CPT
<b>99456</b>	Work Relat/Disabl Exam-Not T	CPT
<b>G0402</b>	Initial Preventive Exam	HCPCS
<b>G0438</b>	Ppps Initial Visit	HCPCS
<b>G0439</b>	Ppps Subseq Visit	HCPCS
<b>G0463</b>	Hospital Outpt Clinic Visit	HCPCS
<b>T1015</b>	Clinic Service	HCPCS

## IHA Diagnosis Codes

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>Z00.00</b>	Encounter for general adult medical examination without abnormal findings	ICD10CM
<b>Z00.01</b>	Encounter for general adult medical examination with abnormal findings	ICD10CM
<b>Z00.121</b>	Encounter for routine child health examination with abnormal findings	ICD10CM

<b>Z00.129</b>	Encounter for routine child health examination without abnormal findings	ICD10CM
<b>Z00.5</b>	Encounter for examination of potential donor of organ and tissue	ICD10CM
<b>Z00.8</b>	Encounter for other general examination	ICD10CM
<b>Z02.0</b>	Encounter for examination for admission to educational institution	ICD10CM
<b>Z02.1</b>	Encounter for pre-employment examination	ICD10CM
<b>Z02.2</b>	Encounter for examination for admission to residential institution	ICD10CM
<b>Z02.3</b>	Encounter for examination for recruitment to armed forces	ICD10CM
<b>Z02.4</b>	Encounter for examination for driving license	ICD10CM
<b>Z02.5</b>	Encounter for examination for participation in sport	ICD10CM
<b>Z02.6</b>	Encounter for examination for insurance purposes	ICD10CM
<b>Z02.71</b>	Encounter for disability determination	ICD10CM
<b>Z02.79</b>	Encounter for issue of other medical certificate	ICD10CM
<b>Z02.81</b>	Encounter for paternity testing	ICD10CM
<b>Z02.82</b>	Encounter for adoption services	ICD10CM
<b>Z02.83</b>	Encounter for blood-alcohol and blood-drug test	ICD10CM
<b>Z02.89</b>	Encounter for other administrative examinations	ICD10CM
<b>Z02.9</b>	Encounter for administrative examinations, unspecified	ICD10CM

## IMA-2: Immunization for Adolescents

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Payment

**Metric Source:** Combination 2 rate of the HEDIS metric IMA.

**Patient Eligibility:** Adolescents who turn 13 years of age during the current calendar year.

**Exclusions:** Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates.

**Metric Definition:** The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

### IMA Procedure Codes

Code	Definition	Code System
90649	HPV Vaccine Administered	CPT
90650	HPV Vaccine Administered	CPT
90651	HPV Vaccine Administered	CPT
90734	Meningococcal Vaccine Administered	CPT
90715	Tdap Vaccine Administered	CPT

## KED: Kidney Health Evaluation for Patients with Diabetes

Adult	Family Practice	Pediatrics
Reporting-Only <i>(as a standalone measure and a component of CDM)</i>	Reporting-Only <i>(as a standalone measure and a component of CDM)</i>	Not included

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Members 18-85 years of age with a diagnosis of diabetes (types 1 or 2).

**Exclusions:**

- Members with documented evidence of end-stage renal disease (ESRD) or dialysis at any time during the member’s history
- Members receiving palliative care
- Members with diagnoses of frailty AND advanced illness

**Metric Definition:** The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. Note that this metric corresponds to the HEDIS metric KED (Kidney Health Evaluation).

Full and partial credit benchmarks will not be applied for this metric. HPSM’s network rates will be reported back to providers.

### eGFR and uACR Procedure Codes

Code	Code System
80047	CPT
80048	CPT
80050	CPT
80053	CPT
80069	CPT
82565	CPT
82043	CPT
82570	CPT



## PCR: Plan All-Cause Readmissions

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Not Included

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Members 18 and older.

**Exclusions:**

- Exclude hospital stays for any of the following reasons from the denominator:
  - The member died during the stay.
  - Female members with a principal diagnosis of pregnancy
  - A principal diagnosis for a condition originating in the perinatal period
- Exclude hospital stays for any of the following reasons from the numerator:
  - Female members with a principal diagnosis of pregnancy
  - A principal diagnosis for a condition originating in the perinatal period
  - Planned admissions using any of the following:
    - A principal diagnosis of maintenance chemotherapy
    - A principal diagnosis of rehabilitation
    - An organ transplant
    - A potentially planned procedure without a principal acute diagnosis

**Metric Definition:** For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

## SBIRT: Substance Misuse Screening and Follow Up (12 years and older)

Adult	Family Practice	Pediatrics
Payment	Reporting-Only	Payment

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** Members 12 years and older.

**Metric Definition:** The percentage of members 12 years and older who had an outpatient visit and received a substance misuse screening in the current calendar year.

### SBIRT Procedure Codes

Code	Definition	Code System
<b>99408</b>	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	CPT
<b>99409</b>	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	CPT
<b>G0396</b>	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min	HCPCS
<b>G0397</b>	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min	HCPCS
<b>G0442</b>	Prevention: Screening for alcohol misuse in adults including pregnant women once per year.	HCPCS
<b>G0443</b>	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS
<b>H0001</b>	Alcohol and/or Drug Assessment	HCPCS
<b>H0003</b>	Alcohol and/or Drug Screening; Laboratory analysis of specimens for presence of alcohol and/or drugs	HCPCS
<b>H0049</b>	Alcohol and/or drug screening	HCPCS
<b>3016F</b>	Substance misuse screening	CPT CAT II

## SDoH: Z-Coding for Social Determinants of Health

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Reporting-Only

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** All assigned members.

**Metric Definition:** The percentage of assigned members who had at least one eligible z-code reported during the measurement year.

HPSM understands that medical care and healthcare services are one of many complex factors that influences members' health status. In order to create more holistic member profiles that consider other non-medical and environmental indicators of health, HPSM requests that providers assist in our collection of data on social determinants of health through select z-coding. HPSM uses z-codes to identify health inequities, determine eligibility for CalAIM services, and develop tailored interventions with community partners.

25 eligible z-codes for this metric capture factors relating to illiteracy, homelessness or housing insecurity, food or water insecurity, social exclusion or loneliness, domestic conflict, or incarceration are sourced from the Department of Health Care Services' (DHCS) list of priority z-codes for CalAIM's Population Health Management (PHM) initiative. For more information, see [All Plan Letter 21-009](#). An additional nine z-codes are eligible for this metric to capture factors relating to reduced physical mobility or dependence on durable medical equipment (DME).

### SDoH Eligible Z-Codes

Z-Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support

Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z73.6	Limitation of activities due to disability
Z74.0	Reduced mobility
Z74.01	Bed confinement status
Z74.09	Other Reduced Mobility
Z99.0	Dependence on aspirator
Z99.1	Dependence on respirator
Z99.2	Dependence on renal dialysis
Z99.3	Dependence on wheelchair
Z99.8	Dependence on other enabling machines and devices

---

## TBC: Tobacco Use Screening and Cessation Intervention (12 years and older)

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Payment

**Metric Source:** HPSM internal metric.

**Patient Eligibility:** Assigned members 12 years and older.

**Metric Definition:** Percentage of patients 12 years and older who were screened for tobacco use using a validated screening tool (i.e. CRAFFT, S2BI, etc.) at least once during the measurement year AND who received tobacco cessation intervention if identified as a tobacco user.

**Denominator:** All assigned members 12 years and older with at least one preventive encounter OR two outpatient encounters between January 1, 2022 – December 31, 2022.

**Numerator:** Patients who meet the denominator criteria and have evidence of tobacco screening and cessation intervention (if identified as a tobacco user) performed during the measurement year (January 1, 2022 – December 31, 2022) using procedure codes 99406, 99407, 4004F, 1036F.

### Tobacco Screening Procedure Codes

Screening Result	Code	Definition	Code System
<b>Tobacco Use Present</b>	<b>99406</b>	Smoking and tobacco use cessation counseling visit; intermediate, between 3-10 minutes	CPT
	<b>99407</b>	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	CPT
	<b>4004F</b>	Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user	CPT
<b>Tobacco Use NOT Present</b>	<b>1036F</b>	Current tobacco non-user <u>OR</u> Tobacco Screening not Performed <u>OR</u> Tobacco Cessation Intervention not Provided for Medical Reasons	CPT-II

Please visit <https://www.hpsm.org/provider/value-based-payment> for a list of covered tobacco cessation services, including medications covered by Medi-Cal Rx.

## WCC-BMI: Pediatric Weight Assessment

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Reporting-Only

**Metric Source:** Rate 1 of the HEDIS metric WCC.

**Patient Eligibility:** Members 3-17 years old.

**Exclusions:** Exclude female members who have a diagnosis of pregnancy during the measurement year.

**Metric Definition:** The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year. For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>.

The percentile ranking based on the CDC’s BMI-for-age growth charts, which indicates the relative position of the patient’s BMI number among others of the same gender and age. Because BMI norms for youth vary with age and gender, this metric evaluates whether BMI percentile is assessed rather than an absolute BMI value.

### BMI Percentile Diagnosis Codes

Code	Definition	Code System
<b>Z68.51</b>	Body mass index (BMI) pediatric, less than 5th percentile for age	ICD10CM
<b>Z68.52</b>	Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age	ICD10CM
<b>Z68.53</b>	Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age	ICD10CM
<b>Z68.54</b>	Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age	ICD10CM

## WCC-N: Weight Assessment & Nutrition Counseling for Children

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Payment

**Metric Source:** Rate 2 of the HEDIS metric WCC.

**Patient Eligibility:** Members 3-17 years old who had evidence of BMI percentile documentation during the calendar year.

**Exclusions:** Exclude female members who have a diagnosis of pregnancy during the measurement year.

**Metric Definition:** The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of nutrition counseling based on their BMI percentile. For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>.

### Nutrition Counseling Procedure Codes

Code	Definition	Code System
97802		CPT
97803		CPT
97804		CPT
G01270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	HCPCS
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	HCPCS
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS
S9449	Weight management classes, non-physician provider, per session	HCPCS
S9452	Nutrition classes, non-physician provider, per session	HCPCS
S9470	Nutritional counseling, dietitian visit	HCPCS
Z71.3	Dietary counseling and surveillance	ICD10CM

## WCC-PA: Weight Assessment & Physical Activity Counseling for Children

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Payment

**Metric Source:** Rate 3 of the HEDIS metric WCC.

**Patient Eligibility:** Members 3-17 years old who had evidence of BMI percentile documentation during the calendar year.

**Exclusions:** Exclude female members who have a diagnosis of pregnancy during the measurement year.

**Metric Definition:** The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of physical activity counseling based on their BMI percentile. For a complete list of outpatient visit codes, please refer to <https://www.hpsm.org/provider/value-based-payment>.

### Physical Activity Counseling Procedure Codes

Code	Definition	Code System
<b>G0447</b>	Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS
<b>S9451</b>	Exercise classes, non-physician provider, per session	HCPCS
<b>Z02.5</b>	Encounter for examination for participation in sport	HCPCS
<b>Z71.82</b>	Exercise counseling	ICD10CM



## WCV: Well Child & Adolescent Visit (3-21 years old)

Adult	Family Practice	Pediatrics
Not Included	Payment	Payment

**Metric Source:** HEDIS metric of the same name.

**Patient Eligibility:** Members age 3-21 years old during the calendar year.

**Metric Definition:** The percentage of members 3–21 years of age who had one or more well-child visits with a PCP during the current calendar year.

Annual well child visit for patients 3-21 years old must include:

- A health, physical developmental, and mental developmental history
- Complete physical exam
- Anticipatory guidance and health education
- Complete the SHA Tool and Instruction Guide found here: [hpsm.org/provider-forms](https://hpsm.org/provider-forms)

### WCV Well Child & Adolescent Visit Procedure Codes

Code	Definition	Code System
99381		CPT
99382	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient: early childhood (age 1-4 years)	CPT
99383	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient: late childhood (age 5-11 years)	CPT
99384		CPT
99385		CPT
99391		CPT
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1-4 years)	CPT
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5-11 years)	CPT

<b>99394</b>		CPT
<b>99395</b>		CPT
<b>99461</b>		CPT
<b>G0438</b>	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	HCPCS
<b>G0439</b>	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	HCPCS
<b>S0302</b>	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service) (S0302)	HCPCS
<b>Z00.00</b>	Encounter for general adult medical examination without abnormal findings	ICD10CM
<b>Z00.01</b>	Encounter for general adult medical examination with abnormal findings	ICD10CM
<b>Z00.110</b>	Health examination for newborn under 8 days old	ICD10CM
<b>Z00.111</b>	Health examination for newborn 8 to 28 days old	ICD10CM
<b>Z00.121</b>	Encounter for routine child health examination with abnormal findings	ICD10CM
<b>Z00.129</b>	Encounter for routine child health examination without abnormal findings	ICD10CM
<b>Z00.2</b>	Encounter for examination for period of rapid growth in childhood	ICD10CM
<b>Z00.3</b>	Encounter for examination for adolescent development state	ICD10CM
<b>Z02.0</b>	Encounter for examination for admission to educational institution	ICD10CM
<b>Z02.5</b>	Encounter for examination for participation in sport	ICD10CM
<b>Z02.6</b>	Encounter for examination for insurance purposes	ICD10CM
<b>Z76.1</b>	Encounter for health supervision and care of foundling	ICD10CM
<b>Z76.2</b>	Encounter for health supervision and care of other healthy infant and child	ICD10CM

## W15: Well Child Visit (0-15 months old)

Adult	Family Practice	Pediatrics
Not Included	Payment	Payment

**Metric Source:** Rate 1 of the HEDIS metric W30.

**Patient Eligibility:** Members who turned 15 months old during the measurement year.

**Metric Definition:** The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

Annual well child visit for patients 0-15 months old must include:

- A health, physical developmental, and mental developmental history
- Complete physical exam
- Anticipatory guidance and health education

Note that children cannot become Medi-Cal enrolled until the end of the first month of life. In order to properly capture all well visits completed in the first month of life and mitigate the need for data linkage, providers are encouraged to wait until the infant has received their own Medi-Cal member ID independent of the mother before submitting well visit procedure codes to HPSM.

### W15 & W30 Well Child Visit Procedure Codes

Code	Definition	Code System
99381		CPT
99382		CPT
99383		CPT
99384		CPT
99385		CPT
99391		CPT
99392		CPT
99393		CPT
99394		CPT
99395		CPT
99461		CPT
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	HCPCS

<b>G0439</b>	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	HCCPS
<b>S0302</b>	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service	HCCPS
<b>Z00.00</b>	Encounter for general adult medical examination without abnormal findings	ICD10CM
<b>Z00.01</b>	Encounter for general adult medical examination with abnormal findings	ICD10CM
<b>Z00.110</b>	Health examination for newborn under 8 days old	ICD10CM
<b>Z00.111</b>	Health examination for newborn 8 to 28 days old	ICD10CM
<b>Z00.121</b>	Encounter for routine child health examination with abnormal findings	ICD10CM
<b>Z00.129</b>	Encounter for routine child health examination without abnormal findings	ICD10CM
<b>Z00.2</b>	Encounter for examination for period of rapid growth in childhood	ICD10CM
<b>Z00.3</b>	Encounter for examination for adolescent development state	ICD10CM
<b>Z02.5</b>	Encounter for examination for participation in sport	ICD10CM
<b>Z76.1</b>	Encounter for health supervision and care of foundling	ICD10CM
<b>Z76.2</b>	Encounter for health supervision and care of other healthy infant and child	ICD10CM

## W30: Well Child Visit (15-30 months old)

Adult	Family Practice	Pediatrics
Not Included	Reporting-Only	Reporting-Only

**Metric Source:** Rate 2 of the HEDIS metric W30.

**Patient Eligibility:** Members who turned 30 months old during the measurement year.

**Metric Definition:** The percentage of members who turned 30 months old during the measurement year and who had two or more well-child visits with a PCP between the child's 15-month birthday plus one day and 30-month birthday.

A well child visit for patients 15-30 months old must include:

- A health, physical developmental, and mental developmental history
- Complete physical exam
- Anticipatory guidance and health education

[\\*See procedure code list for W15 and W30 above](#)

## VII. Health Education Resources that Support P4P

Some patients may benefit from additional health education support or information regarding health education topics or lifestyle changes in order to achieve health related goals and improve outcomes. We recognize that some health education topics or self-management education may require time and resources beyond what you may be able to cover in a clinic visit, especially when it comes to health topics such as obesity and weight management, diabetes self-management, controlling hypertension or other lifestyle influenced health conditions. HPSM's Health Education Guide online offers a wide variety of health information and tips for staying healthy. Members can access our Health Education Guide online at <https://www.hpsm.org/health-information>. Members who would benefit from health education resources or programs around topics such as maternal and child health, tobacco cessation services, and diabetes self-management can also call our Health Education line at **650-616-2165**.

If you need any other health education resources to support the care you provide to our members, please send us a request via email at [healtheducationrequest@hpsm.org](mailto:healtheducationrequest@hpsm.org). We appreciate working in partnership with you in caring for our members.

## VIII. Terms & Conditions

Participation in HPSM's P4P program, as well as acceptance of performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between HPSM and participating providers. There is no guarantee of future funding or payment under any HPSM P4P performance bonus program. HPSM's P4P program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at HPSM's sole discretion.

In consideration of HPSM's offering of its P4P program, provider agrees to fully and forever release and discharge HPSM from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by HPSM of the P4P Program.

Any monies paid under the P4P program for services deemed inappropriately submitted will be recouped from future payment. All cases of suspected fraud or abuse will be investigated thoroughly and reported to the appropriate authorities.

HPSM reserves the right to audit medical records to validate services have been completed as billed. If there is evidence of fraud, waste, or abuse, HPSM can recoup P4P payments found to be invalidly billed and the provider could lose privileges to participate in future HPSM P4P programs.

Participating providers must be in good standing with all contract and compliance requirements in order to receive HPSM P4P program payments. If any participating providers are not in good standing P4P program payments will not be made until such time that providers are meeting all contract and compliance requirements.