



Section 9

Quality Assessment and Improvement

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Introduction

The purpose of the Health Plan of San Mateo's (HPSM's) Quality Assessment and Improvement Program (QAIP) or Quality Program (QP) is to establish methods for systematically working to ensure that all HPSM members receive high quality health care and to help optimize their health status. Through the QP and in collaboration with HPSM providers, HPSM strives to continuously improve the structure, processes and outcomes of its health care delivery system.

HPSM's QP has a commitment to quality that relies on HPSM senior management oversight and accountability, and integrates the activities of all departments in meeting program goals and objectives. The QP involves members, participating providers, regulators, plan sponsors and evaluators in the development, evaluation, and planning of quality activities.

HPSM incorporates continuous quality improvement methodology that focuses on the specific needs of HPSM customers. It is organized to identify and analyze significant opportunities for improvement in care and services, to develop improvement strategies and to systematically track whether these strategies result in progress towards established benchmarks or goals. Focused QP activities are carried out on an ongoing basis to ensure that quality of care issues are identified and corrected. Quality studies and monitoring activities are reported through the quality committee structure to HPSM's governing body. The QAI Program Description is reviewed and updated annually and is posted on our website at: www.hpsm.org/documents/providers/Quality_Assessment_and_Improvement_Program.pdf Detailed information about the provider network, the quality initiatives, credentialing, site review statistics, and so forth, can be found in this document.

Provider Site and Medical Record Review

The purpose of the provider site and medical record review is to ensure that primary care providers, obstetricians/gynecologists (OB/GYN), and network referral providers are in compliance with applicable local, state, federal and HPSM standards. HPSM conducts provider site reviews for all new providers as a pre-contractual requirement prior to completion of initial credentialing. HPSM conducts provider site reviews triennially for Primary Care Providers and OB/GYN providers as a requirement of participation in the California Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications. This is a requirement of HPSM's contract with the State.

A full scope review is conducted utilizing the criteria and guidelines of the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (MMCD). The criteria is outlined in a 2002 Policy Letter¹ or updates, and summarized here. In addition to the criteria noted in the policy letter, supplemental criteria may be used by HPSM to address additional requirements applicable for quality studies. A full scope site review is not required automatically as a part of the re-credentialing process. Re-credentialing includes information from other sources pertinent to the credentialing process such as quality improvement criteria and may include medical record reviews.

Full Scope Facility Site Review

Initial Reviews

All primary care sites serving HPSM managed care members undergo an initial site review prior to completion of credentialing and assignment of members to the prospective provider. The schedule for performing a facility site review is determined by Quality Program staff and the prospective provider. It is based on the prospective credentialing date as well as the provider's availability and preference. A copy of the Site Review Survey Tool is mailed to each provider with notification of the review date. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

Recertification Reviews

Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with HPSM and Medi-Cal criteria and guidelines.

Moving to or Adding a New Site

Providers who move to a new site or open an additional office site must have a full scope site review at their new location. The site review must be completed as soon as

¹ (MMCD Policy Letter 03-02 Dated June 23, 2003, MMCD Policy Letter 02-03 Dated May 16, 2002, MMCD Policy Letter 02-02 Dated May 16, 2002 or superseding Policy Letter 96-6) Full Scope Site Review Survey and Medical Record Survey Tool.

possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), but no later than 30 calendar days after the date the new site was opened for business (or HPSM's notification date). The site review for relocated offices must be completed prior to the provider's re-credentialing date.

Adding a New Provider

Providers who move into an office which has a current site review will only require a medical record review to be credentialed.

When More Frequent Site Reviews May Be Necessary

HPSM reviews sites more frequently when it determines this to be necessary, based on findings from monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed pursuant to a request from the Peer Review Committee, the Quality Assessment and Improvement Committee, or the Commission. Additional reviews may also be done at the discretion of the Medical Director or the Quality Nurse, after discussion with the Medical Director, if patient safety or compliance with applicable standards is in question.

The Site Review Survey Tool is mailed to providers prior to an on-site audit. Relevant information is presented and shared with provider office staff at the time of the site review.

Medical Record Review

Ten (10) medical records are reviewed initially for each primary care provider as part of the initial site review process and every three years thereafter. During any medical record survey, reviewers have the option to request additional records for review. If additional records are reviewed, scores must be calculated as outlined below. Medical records of new providers are reviewed within 90 calendar days of the date on which members are first assigned to the provider. An extension of 90 calendar days may be allowed *only if* the new provider does not have sufficient HPSM members assigned to complete a review of 10 medical records. If there are still fewer than 10 records for assigned members at the end of six months, a medical record review is completed on the total number of records available and the scoring is adjusted according to the number of records reviewed.

Sites where documentation of patient care by multiple PCPs occurs in the same record are reviewed as a "shared" medical record system. Shared medical records are considered those that are not identifiable as "separate" records belonging to any specific PCP. A minimum of 10 records are reviewed if two to three PCPs share records, 20 records are reviewed for four to six PCPs, and 30 records are reviewed for seven or more PCPs.

Site Review Survey and Medical Record Scoring

A minimum passing score of 80% on **both** the Site Review Survey and Medical Record Review Survey is required. Scores are computed based on the following checklist of categories and assigned values:

Full Scope Site Reviews

Site Review Survey:

Access/Safety	29 points
Personnel	22 points
Office Management	25 points
Clinical Services	25 points
Preventive Services	13 points
Infection Control	27 points
Total	141 points

Medical Record Review Survey:

Format	80 points
Documentation	70 points
Continuity/Coordination	70 points
Pediatric Preventive (if applicable based on case mix)	50 or 100 points
Adult Preventive (if applicable based on case mix)	50 or 100 points
OB/CPSP Preventive (if applicable based on case mix)	50 points
Total	320 points

The Site Review survey is scored in the following manner:

1. Exempted Pass: 90% or above, *without* deficiencies in critical elements.
2. Conditional Pass: 80-89%, or 90% or above *with* deficiencies in critical elements.
3. Not Pass: below 80%

The Medical Record Survey is scored in the following manner:

1. Full Pass: 100%
2. Conditional Pass: 80-99%
3. Not Pass: below 80%

Critical Elements for Scoring

There are *nine critical elements* related to the potential for adverse effect on patient health or safety. These have a scored “weight” of two points. All other survey elements are weighted at one point. A full point is given if the scored element meets the applicable criterion. Zero points are given for any scored element that is considered only “partially” met by the reviewer. Zero points are given if an element does not meet criteria. The nurse reviewer determines the “not applicable” (N/A) status of each criterion based on the site-specific assessment. The reviewer must explain all criteria that are scored as zero or N/A.

The nine critical elements are:

- 1) Exit doors and aisles are unobstructed and egress (escape) accessible.
- 2) Airway management equipment, appropriate to practice and populations served, are present on site.

- 3) Only qualified/trained personnel retrieve, prepare or administer medications.
- 4) Office practice procedures are utilized on-site that provide timely physician review and follow-up of referrals, consultation reports and diagnostic test results.
- 5) Only lawfully-authorized persons dispense drugs to patients.
- 6) Personal Protective Equipment (PPE) is readily available for staff use.
- 7) Needle stick safety precautions are practiced on-site.
- 8) Blood, other potentially infectious materials (specimens) and regulated wastes (sharps/biohazard non-sharps) are placed in appropriate, leak-proof, labeled containers for collection, processing, storage, transport or shipping.
- 9) Spore testing of autoclave/steam sterilizer is completed (at least monthly), with documented results.

An acceptable corrective action plan must be submitted within 10 business days of the survey date for any deficiencies found during any monitoring visits for any of these critical elements. This is regardless of the survey score attained. Corrections must be made within 30 calendar days of the survey date.

Corrective Action Plans (CAPs)

Sites that receive an Exempted Pass (90% or above, *without* deficiencies in critical elements) are not required to complete a corrective action plan (CAP) unless determined necessary by HPSM. However, all sites that receive a Conditional Pass (80-89%, or 90% and above with deficiencies in critical elements) must complete an acceptable CAP to address the cited deficiencies.

HPSM staff provides a written report of site survey findings that specifies any deficiencies for all critical and non-critical elements. For all critical and non-critical elements requiring immediate correction, providers must submit an acceptable CAP that attests that corrections were completed within 10 business days of the survey date. Within 30 days of the survey date, HPSM staff verifies corrections of critical elements and other survey deficiencies requiring immediate correction. For all other non critical deficiencies, providers must submit an acceptable CAP by 30 calendar days from the date of the written CAP request.

Providers' CAP documentation must identify the specific deficiency, an acceptable plan of corrective action(s) needed, projected and actual date(s) of the correction, re-evaluation timelines/dates, and responsible persons(s). HPSM staff, with oversight by HPSM's Medical Director, will review the CAP to determine if it is acceptable. HPSM's Peer Review Committee may be consulted for advice on standards of practice issues as necessary.

If the CAP cannot be verified and approved within 60 days from the date of the written CAP request, an on-site visit may be scheduled. If the CAP cannot be closed, the provider will be referred to the Medical Director. The reasons for a late CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

Providers may request a time-specific extension period to complete corrections if extenuating circumstances that prevented completion of corrections can be demonstrated, and if agreed to by HPSM. (This period may not exceed 90 calendar days from the survey findings report and CAP notification date unless a longer extension is approved by the State of California Department of Health Care Services.). HPSM will perform a focused review at any site that required an extension period beyond 90 calendar days to complete corrections prior to closing the CAP.

Once a CAP is approved, it will be reviewed by the Medical Director as part of the Credentialing Review process.

Non-Passing Providers

A pre-contractual provider who scores below 80% on the full scope site review survey will not be recommended for credentialing completion or contract approval until a passing score is achieved and correction of any missed critical elements is verified. Prior to being approved as a network provider, a non-passing provider must be re-surveyed and pass the full scope site review survey. After achieving a score of 80% or higher, a CAP must be completed as previously described.

Contracted providers who fail the site review upon recertification survey are notified of the survey score, all cited deficiencies and CAP requirements at the time of the failed survey. Providers who do not complete a CAP that addresses the deficiencies completely will be referred to the Medical Director for review and possible referral to the Peer Review Committee. The reasons for an unacceptable CAP will be reviewed with the Medical Director and other staff as appropriate to discuss the clinical significance of deficiencies, whether other actions are necessary to safeguard members, and determine the next steps.

HPSM may suspend any contracted provider with a non-passing score from the provider network. However, if a provider with a non-passing score is allowed to remain in the provider network, survey deficiencies must be corrected by the provider and verified by HPSM staff within the CAP timelines previously noted. New members will not be assigned to the provider until a score of 80% is achieved on a subsequent full scope site review and required corrections are verified and the CAP is closed.

Non-Compliant Provider

Any network provider who does not comply with survey criteria within the established timelines will be subject to Peer Review action and may be recommended for removal from the network. In such an instance, HPSM members will be re-assigned to other network providers following plan policies and procedures.

Provider Appeal Process

Providers removed from the network may appeal the decision. HPSM has a formal process to resolve grievances submitted by providers. Please refer to Section 5 - Provider Disputes and Grievances for additional information. If verified evidence of corrections is accepted by HPSM and the removal decision is reversed, a Site Survey may be repeated. If the current survey and CAP are accepted, the site will be re-

surveyed no later than 12 months following closure of the CAP. If HPSM does not reverse the decision, and the provider would like to again become an HPSM provider, he/she may re-apply through HPSM's application process. As previously noted, all applicants must undergo and pass an initial Full Scope Survey.

Facility Site Focused Review

Focused reviews may be used to monitor providers between full scope site review surveys, to investigate problems identified through monitoring activities, or to follow up on corrective actions. The focused review is a "targeted" audit of one or more specific site or medical record review survey areas and is not substituted for the full scope survey. Reviewers may use appropriate section(s) of site review and/or medical record review survey tools for the focused review, and/or other methods to investigate identified problems or situations. All deficiencies found in a focused review require the completion and verification of corrective actions according to CAP timelines previously described.

Facility Site Monitoring

HPSM staff monitors any contracted HPSM physician practice site between regularly scheduled full scope site review surveys. This may include visits for quality activities or follow up on member complaints. Indications of site deficiencies discovered through monitoring activities will require on-site inspection according to site review requirements. As a result, HPSM may schedule a full scope site review audit, conduct an additional focused onsite review, or conduct a medical record review. When non-compliance with the nine (9) Critical Elements is identified through monitoring processes, HPSM will determine the appropriate course of action to assure that problems are fully investigated and corrected in a timely manner.

Healthcare Effectiveness Data and Information Set (HEDIS)

HPSM is required by the State of California Department of Health Care Services (DHCS) to perform quality measure studies for our Medi-Cal line of business and by the State Managed Risk Medical Insurance Board (MRMIB) for Healthy Families. The Centers for Medicare and Medicaid Services (CMS) require HPSM to perform quality studies for HPSM's CareAdvantage program as well. In addition, as the Third Party Administrator for the Access to Care for Everyone (ACE) program, San Mateo County's indigent care program, and insurer for the county's Healthy Kids program, HPSM collects quality measures for these programs also. The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to ensure that purchasers and consumers of health care services have the information they need to compare the performance of managed health care plans. DHCS, MRMIB and CMS use HEDIS measures as one way to assess how well HPSM is providing quality services for our members. The funders of Healthy Kids and ACE have asked that we use select HEDIS measures to demonstrate level of quality of care for these

populations as well.

There are two phases to each HEDIS study. HPSM's data analysts perform the first phase by examining HPSM's administrative data (e.g. claims data and enrollment information). This type of information may not fully reflect the actual care provided to our members when the services are capitated and not separately billed to HPSM. In phase two, HPSM staff, or contracted vendor staff, undertakes an extensive examination of the relevant members' medical records in provider offices. In these ways, data is collected that provides information to DHCS, MRMIB, CMS and San Mateo County about the level of clinical care, preventive care, access to care and utilization of services that HPSM members receive, based on claims and chart review data, in specific areas.

Clinical Practice Guidelines and Best Practices

Clinical practice guidelines help to improve the quality of care for our members by providing HPSM physicians with systematically developed, evidence-based best practice guidelines to assist both physicians and patients in decision-making regarding appropriate health care for specific clinical circumstances.

The practice guidelines used by HPSM are evidence-based; they have been developed using nationally recognized scientific evidence as published in peer reviewed journals, released by Specialty Societies or Academies or promulgated by national advisory committees.

The National Guidelines Clearinghouse (NGC) is the primary source of HPSM's guidelines. The NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, and was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America's Health Insurance Plans [AHIP]). By using guidelines from the NGC, HPSM ensures the "pedigree" and thus, the validity/reliability of the guidelines we promote to our providers.

The guideline topics and resources are evaluated and updated at least annually, with the input of HPSM's Physician Advisory Group (PAG), the Quality Assessment and Improvement Committee (QAIC) and any other interested HPSM provider. These are then disseminated to providers via HPSM's website and its provider newsletter.

The Clinical Practice Guidelines are listed on HPSM's website at www.hpsm.org and are as follows:

HPSM Clinical Guidelines:

Asthma guidelines

Decision making tools from HPSM and Institute for Clinical Systems Improvement

- Algorithm: Asthma Diagnosis and Outpatient Management
www.guideline.gov/algorithm/4295/NGC-4295.html
- Table: Approaching Asthma Diagnosis and Treatment
Source: www.hpsm.org/Documents/Providers/Approach%20to%20patients%20with%20asthma.pdf

Chronic obstructive pulmonary disease (COPD) guidelines

Decision making tool from the Institute for Clinical Systems Improvement

- Algorithm: COPD Diagnosis and Treatment
Source: www.guideline.gov/algorithm/4744/NGC-4744.html

Diabetes guidelines

Guidelines and notes developed by the California Diabetes Program

- Basic Guidelines for Diabetes Care and Notes
Source: www.hpsm.org/documents/providers/2005-06BasicGuidelinesandExplanatoryNotes.pdf

Heart disease guidelines

Recommendations from the National Heart Lung and Blood Institute

- Guidelines and tools: Detection, Evaluation, and Treatment of High Blood Cholesterol
Source: www.nhlbi.nih.gov/guidelines/cholesterol/index.htm
- Algorithm: Stages of Development of Heart Failure and Recommended Therapy
Source: www.hpsm.org/Documents/Providers/algorithm.ppt

High blood pressure guidelines

Recommendations from the National Heart Lung and Blood Institute

- Reference card: Detection, Evaluation, and Treatment of High Blood Pressure
Source: www.nhlbi.nih.gov/guidelines/hypertension/phycard.pdf
- Guidelines from the Institute for Clinical Systems Improvement
www.guideline.gov/summary/summary.aspx?doc_id=13481

Immunization guidelines

Recommended vaccination schedules from the Centers for Disease Control

- Table: Adult 2010 Immunization Schedule
Source: www.hpsm.org/documents/providers/Immunizations-Recommended Adult Schedule 2010.pdf
- Table: Child 0-6 Years Old Immunization 2010 Schedule
Source: www.hpsm.org/documents/providers/Immunizations-Recommended Schedule Child 0-6 2010.pdf
- Table: Child 7-18 Years Old Immunization 2010 Schedule

Source: www.hpsm.org/documents/providers/Immunizations-Recommended_Schedule_Child_7-18_2010.pdf

- Catch up Immunization 2010 Schedule for ages 4 months to 18 Years Old
Source: www.hpsm.org/documents/providers/Immunizations-Recommended_Catchup_Schedule_4mo-18_2010.pdf
- Immunization Updates from the Centers for Disease Control
Source: www.cdc.gov/vaccines/

Obesity guidelines for adults and children

Recommendations from the National Heart Lung and Blood Institute

Clinical Guidelines: Identification, Evaluation, and Treatment of Obesity in Adults

Source: www.nhlbi.nih.gov/guidelines/obesity/ob_exsum.htm

Tools for Calculating Body Mass Index

- Table: Body Mass Index for Adults
Source: www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm
- Calculator for Adults: Measuring Body Mass Index
Source: www.nhlbisupport.com/bmi/bmicalc.htm
- Calculator for Children: Ages 2 to 20: Measuring Body Mass Index
Source: www.shapeup.org/oap/entry.php

Sexually transmitted infections: guidelines and reporting form

- CDC Sexually Transmitted Disease Treatment Guidelines
Source: www.cdc.gov/std/treatment/default.htm
- Confidential Morbidity Report for STDs in San Mateo County
Source: www.co.sanmateo.ca.us/Attachments/health/pdfs/Public%20Health/cd_program/CMR/CMR_12_09.pdf
- San Mateo County STD Quarterly Report
Source: www.hpsm.org/documents/providers/STD-HIV_Quarterly_Report.pdf

Additional resources

National Guidelines Clearinghouse: www.guidelines.gov/

National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov/guidelines/index.htm

United States Preventive Services Task Force: www.ahrq.gov/clinic/uspstfix.htm

Quality Committees

HPSM has multiple avenues for physicians to contribute to its quality program. The most important way is through providing high quality and preventive care to HPSM members. Without our providers, HPSM could not offer services to our members. HPSM's Medical Directors and Provider Services Manager have an "open door" policy. Contact information is freely available to physicians. When any physician has a quality

improvement suggestion or a quality concern, they are encouraged to contact these or any other HPSM staff to share their thoughts, via phone, e-mail or letter.

There are also formalized ways for HPSM providers to participate in quality activities with the plan. These are through the San Mateo Health Commission quality advisory groups.

Physician Advisory Group (PAG)/Peer Review Committee (PRC)

Purpose/Responsibilities

- Serves in an advisory capacity to HPSM, providing community physician insight and feedback on the quality initiatives of the plan.
- Reviews areas in need of quality improvement identified via HEDIS or other comparable measurements and assists HPSM in developing potential interventions.
- After quality improvement initiatives are developed, provides feedback on the tools, materials, incentives, etc. that are developed to implement the initiative.
- As HPSM practicing physicians, provide real-world feedback on how they, their colleagues and their patients are accepting/participating in HPSM's quality initiatives, to help HPSM continuously improve its efforts and outcomes.
- The PRC meets regularly to review all HPSM credentialing recommendations, and to address HPSM credentialing concerns (e.g. when a potential provider does not appear to meet or no longer appears to meet HPSM credentialing requirements). The PRC meets confidentially to provide a peer-based resource for reviewing provider issues related to credentialing, quality of care issues or similar concerns.
- Where indicated, the PRC makes recommendations (e.g. regarding sanctions) to the San Mateo Health Commission for final decision-making. Any sanctions or actions affecting individual providers are protected by Evidence Code 1157.

Membership

- Committee membership is reflective of the provider network. It includes a physician member of the San Mateo Health Commission, a physician of the San Mateo Medical Center, a maximum of nine HPSM contracting physicians, the majority of whom are primary care physicians from the adult and pediatric community (representing care of adults and children) and at least three

specialists representing different disciplines.

Quality Assessment and Improvement Committee (QAIC)

Purpose/Responsibilities

- Serves in an advisory capacity to the Commission on the overall functions of the quality assessment and improvement process to ensure that activities are consistent with the purposes of the program.
- Reviews and makes recommendations about best practice clinical guidelines for quality of medical care and services.
- Provides input and feedback on the ongoing development and implementation of a systematic, comprehensive and integrated program for quality improvement activities, including review of the QP work plan and associated documents as applicable.
- Reviews quality activities, measurements, results, and follow-up related to quality improvement initiatives, assisting with the assessment of the overall impact of these efforts and identifying additional opportunities to improve care.
- Uses clinical and administrative experiences in their practice settings to advise the QP on ways to optimize quality activities internally at HPSM and externally in the provider network.

Membership

- Committee members include a physician member of the Commission, a public/consumer member of the Commission, a physician provider of the San Mateo Medical Center, a pharmacist, at least four additional physicians representative of the primary care physician community in San Mateo County, and two specialty physicians.

San Mateo Health Commission

Purpose/Responsibilities

- Delegates management of the QP to HPSM's Executive Director while retaining overall authority and responsibility for program implementation, continuity and effectiveness.
- Monitors QP strategies and activities outlined in HPSM's QP Annual Report/Evaluation and Work Plan, and at the time of any substantive revision.

- Monitors and reviews HEDIS results and establishes activities/opportunities for improvement
- Reviews the identification of Quality of Care issues and development of Quality Improvement Projects to establish interventions/activities
- Reviews quarterly reports about monitoring and evaluation activities performed as a result of the QP implementation, discusses these reports as necessary, raises any issues of concern and requests follow-up as indicated.
- Identifies opportunities to improve care and service, directs action to be taken, or resolves problems when indicated, independent of any other quality activities.

Membership

- Members are appointed by the San Mateo County Board of Supervisors and include: two members of the San Mateo County Board of Supervisors; the San Mateo County Manager or his/her designee; an HPSM contracted physician; a public representative of senior and/or minority communities in San Mateo County; a representative beneficiary served by the commission; a San Mateo County hospital staff physician; an HPSM contracted pharmacist, and a member of the public at large.

Quality Improvement Projects

HPSM is required by the State of California to conduct and/or participate in at least two Quality Improvement Projects (QIPs) annually. These projects may be based on HEDIS measures or other measures that have been identified by HPSM that require intervention to improve quality. Of the required QIPs, HPSM may choose plan specific measures, but must participate in a state-wide collaborative.

The Center for Medicare and Medicaid Services (CMS) requires HPSM to conduct a quality improvement project yearly as well. CMS dictates that each QIP run for three consecutive years and consist of three phases: baseline assessment, intervention, and evaluation.

Even when QIPs focus on member activities, they cannot succeed without our provider network participation, so HPSM always appreciates provider input and feedback on the QIPs. All QIPs are presented at the Physician Advisory Group and Quality Assessment and Improvement Committee meetings, as well, to ensure that the tools and interventions planned appear feasible and useful from a provider perspective.

A few of our ongoing QIPs are summarized below. A full description of HPSM's current QIPs is available on HPSM's website at <http://www.hpsm.org/providers/quality-programs/default.aspx>.

Reducing Avoidable Emergency Room Visits

HPSM is participating in the Medi-Cal Managed Care Division's collaborative to reduce avoidable ER visits. This collaborative, among the State of California and all 22 California Medi-Cal managed health care plans, will continue through 2011. Since 80% of ER use by Medi-Cal beneficiaries is for non-emergency health conditions and most of these avoidable visits are for URI-related symptoms in children, the campaign focuses on educating families on appropriate ER use by children less than nine years of age with URIs. The "Not Sure It's An Emergency?" brochures and posters, available in English and Spanish to all HPSM providers for their patients, advises patients to talk with their doctor about when to go to the emergency room and what to do if the doctor's office is closed. For brochures and posters, please contact Provider Services at (650) 616-2106.

A second component of the campaign involves HPSM partnering with a local contracted hospital to share data on avoidable ER visits of health plan members. The project explores whether notifying the member's primary care physician (PCP) and intervening with the member after an avoidable ER visit reduces avoidable visits. This is an ongoing project, and we hope to expand this pilot to other hospitals in San Mateo County in the future.

HPSM has also been piloting a Nurse Advice Line (NAL) for members who have San Mateo Medical Center clinics as their primary care provider. This effort is another intervention to try and reduce avoidable ER visits, with the hope that members will call the NAL for common problems when their clinic is closed instead of just going to the ER.

The Living Healthy Women's Program

The Living Healthy Women's Program supports women's efforts to stay healthy. The Living Healthy Women's Program provides the following services to HPSM's female members:

- Information and education about routine breast and cervical cancer screening exams
- Reminders if the member is overdue for a screening test
- Help in finding an HPSM gynecologist
- Emotional support and motivation
- A \$15 Target gift card incentive when a member has received a verified Pap test and/or mammogram

For Living Healthy Women's Program brochures or more information about the program call the Health Promotion Specialist at (650) 616-2173 or (800) 750-4776.

Improving Diabetes Management

Our diabetes management quality improvement program (QIP) aims to both assist providers as they work to achieve better health outcomes for HPSM members with diabetes as well as support diabetic members in managing their disease. The provider component of this initiative includes providing up-to-date clinical guidelines on diabetes management on the HPSM provider website, and also offering opportunities for provider input on tools for diabetes care at our Physician Advisory Group and Quality Assessment and Improvement Committee meetings. In January 2008, we instituted a new provider outreach and education campaign that includes a Pay for Performance (P4P) component for six key HEDIS-based diabetes care measures: retinal eye exam, kidney function test, hemoglobin A1c and LDL cholesterol tests, hemoglobin A1c test value of 8% or less, and LDL cholesterol test value of 100 or less. Our Medi-Cal P4P program is discussed in detail later in this chapter. Our hope is that in working together with providers, we can improve the comprehensiveness and timeliness of care that HPSM members with diabetes receive.

The member education component for improved diabetes management includes promoting free individual counseling and group diabetes self-management classes for HPSM members through our community partners, and sending targeted mailings of focused educational materials on diabetes to members with a diagnosis of diabetes.

Immunization Registry Program

HPSM is collaborating with the San Mateo County Health Department to facilitate the participation of providers in the Bay Area Regional Immunization Registry (BARR). BARR serves as a single population-based data source on immunizations for all health care providers in the Bay Area. The registry significantly reduces staff time by providing immediate access to complete immunization histories, even when shots were administered by different providers. It can be used to print out yellow cards as well as produce various vaccination reports. It also has an algorithm that will calculate and recommend the immunizations that are due at each visit.

Our goal is to have all San Mateo County children fully immunized by age two. HPSM has implemented a reminder system to support this goal. Providers who are participating in the registry receive a monthly list of their 18 month old patients who are past due for immunizations and are asked to follow up. These patients also receive a reminder postcard from HPSM. Additionally, HPSM has included participation in the registry as an incentive in our Medi-Cal Pay for Performance program.

Asthma Program

HPSM's Asthma Program has multiple components aimed toward increasing asthma control and decreasing morbidity of this chronic disease among our children and adult members with asthma. One component of our asthma program is to increase the use of inhaled corticosteroids (ICS) and decrease the use of/reliance on short-acting beta

agonist medications for members with persistent asthma. We identify members based on pharmacy claims data. If a member has received four or more refills of a short-acting beta agonist over the past year and has no history of ICS use, his/her assigned PCP is notified. PCPs receive a prescription form pre-printed with our preferred controller medication (QVAR) along with an asthma toolkit that contains provider tools and patient education materials.

To further expand our asthma program and improve clinical outcomes, we have developed an asthma registry that identifies our high risk members. If a member falls in our high risk classification, which is based on hospitalizations, ER visits, and medication usage, the assigned provider will receive a report that he/she can use to follow up with these members. Providers will also receive a packet of patient education materials and a referral slip if they would like HPSM's Health Educator to also follow up with the patient. We expect this level of care management with the provider to help improve health outcomes for our members. Additionally, completion of Asthma Action Plans is another important measure in our Pay for Performance program. We hope that this will encourage more comprehensive asthma care, and improve the self-management skills of our members.

Prenatal Care

HPSM's Prenatal Care QIP aims at improving the health of pregnant women and their babies. These outcomes are measured through the HEDIS timeliness of early entry into prenatal care, and the rate of post-partum visits. The program also has provider and member incentives to help achieve these outcomes. Providers can receive P4P incentives for meeting the HEDIS measures and members can receive gifts from the Prenatal Care Program for starting care within the first trimester, attending regular prenatal visits and completing the post-partum visit in the required timeframe (21-56 days after delivery).

Prenatal Care Program

The Prenatal Care Program encourages HPSM members to receive early and regular prenatal care. When the member's doctor has confirmed her prenatal care visits she will receive the following gifts.

- After the first prenatal care visit within the first 12 weeks of pregnancy, she will receive a \$15 gift card to Target.
- After three (3 months) of confirmed prenatal care visits she will receive the book, "What to Do When You're Having a Baby".
- After six (6) months of confirmed prenatal care visits she will receive a \$50 Target gift card.
- After a confirmed visit between 3-8 weeks after the birth (post-partum visit) she will receive a \$40 gift card to Safeway.

Prenatal Social Marketing Campaign-Go Before You Show

HPSM, the San Mateo County Family Health Services Department of the San Mateo County Health System and the Prenatal Social Marketing Committee, have collaborated on developing the Go Before You Show campaign. The committee looked at HEDIS data on timely entry into prenatal care and saw that a disparity existed in Latina, African

American and Pacific Islander communities in comparison to Caucasian women. This led to the development of the social marketing campaign, Go Before You Show (GBYS). The goal of the campaign is to create materials that reflect the culture and language of the women in these ethnic groups and in turn increase their early entry into prenatal care. A brochure and variety of posters were developed and available for display. The brochure and website include information on how to access Presumptive Eligibility (PE, or temporary Medi-Cal) so that women can access care as soon as they think they are pregnant.

For more information or to request materials please contact Liliana Ramirez at 650-616-2170.

You can view more information on the website: www.gobeforeyoushowsanmateo.org

Individual Health Assessment (IHA)

An IHA is a comprehensive assessment that is completed during a patient's initial encounter(s) with his/her PCP. HPSM is required by the California Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), the Centers for Medicare and Medicaid and funders of Healthy Kids to ensure that new members receive an Initial Health Assessment (IHA) within 120 days of becoming an HPSM member. HPSM encourages providers to use the DHCS Staying Healthy Assessment (SHA) tool to receive an additional incentive, and help meet this requirement (see below).

Assessment Components

The IHA consists of a comprehensive history, physical, mental status assessment and where age appropriate, developmental exam, diagnosis and plan of care, preventive services and the Individual Health Education Behavioral Assessment.

Staying Healthy Assessment (SHA) Tool

The Staying Healthy Assessment (SHA) Tool assists PCPs in:

- identifying and tracking individual health risks and behaviors
- targeting health education counseling interventions
- providing referral and follow-up.

The SHA tool should become a permanent part of the member's medical record and be referred to annually. When potentially high risk health behaviors are identified, PCPs are expected to ask appropriate follow-up assessment questions to identify patient's health education needs and facilitate focused educational counseling that addresses health behavior changes. If providers identify concerns that need additional evaluation, referrals to resources such as behavioral health, substance treatment, other specialty providers, etc should be made.

Facilitating health education intervention

Information provided on the Staying Healthy Assessment tool combined with the patient's medical history, conditions, problems, testing results, and other related factors, can help a provider recommend appropriate health education interventions. If a member is in need of a health education service that is not outlined in the HPSM provider manual, or quarterly list of Health Education Community Classes and Resources, the provider is encouraged to contact the Health Education Unit at (650) 616-2165 for information about other community resources.

Provider Incentive: Completing the IHA and the Assessment Tool Pay for Performance (P4P)

The Initial Health Assessment incentive is available for completing the IHA visit and administering the SHA tool within 120 days for Medi-Cal, Healthy Kids, Healthy Families and HealthWorx new members only.

HPSM will reimburse a flat amount (currently \$90.00) under these conditions:

- (a) The IHA is rendered within the first 120 days of a member becoming eligible for HPSM, and

- (b) An IHA has not been completed by another PCP within the last year for the same member.

New members are identified on the top of your case management list with an asterisk. *Please be aware that HPSM may not be able to notify you that you have a new member and verify the member's eligibility until 30 days after they have become eligible with HPSM. Thus, you would have 90 days after this notification to complete the IHA visit and SHA tool.*

To receive the P4P incentive, you need to bill using procedure (CPT) codes based on the member's age

(initial comprehensive preventive medicine):

- Code 99381: Under age 1
- Code 99382: Age 1-4 years
- Code 99383: Age 5 -11 years
- Code 99384: Age 12 -17 years
- Code 99385: Age 18 -39 years
- Code 99386: Age 40 -64 years
- Code 99387: Age 65 and older

Preventive care visits are not separately reimbursable for HPSM Medi-Cal PCPs

Subsequent preventive medical office visits for Medi-Cal members, including review and updating of the SHA, are an expected part of clinical care that a primary care provider renders, **and are reimbursed overall by the monthly capitation a provider receives.** The only exceptions are when additional services (such as an annual adolescent visit) are performed because these services are separately payable beyond the capitated amount providers receive monthly, as P4P incentives.

Who to contact for questions:

Staying Healthy Assessment (SHA) Tool - Liliana Ramirez, (650) 616-2170
Individual Health Assessment and P4P – Nicole Ford (650) 616 -2169
General Provider Questions - Provider Services (650) 616 – 2106

Adolescent Annual Well Visit Incentive

HPSM encourages adolescents ages 12-18 to receive an **annual** well visit once a year with his/her Primary Care Provider (PCP). Adolescents who receive a verified annual well visit from their PCP can get two free movie tickets to Century Theaters.

Please note: this is *in addition to* the periodic visits determined by CHDP. Do **NOT** confuse this incentive with CHDP. This annual incentive occurs in accordance with the periodicity guidelines of the American Academy of Pediatrics. Thus, providers should schedule these annual visits and the incentive **WILL BE PAID** if billed correctly to HPSM, separate from CHDP.

Components of a Well Visit

- Assessment of interval history, what has occurred since the previous well check-up with an evaluation of physical, behavioral and emotional growth and development
- Complete physical exam
- Age specific anticipatory guidance
- Medically necessary lab testing and immunizations
- Completion/review of age appropriate SHA tool (see above)

Provider Incentive for Annual Adolescent Well Visits

HPSM will reimburse \$90 for an annual adolescent well visit. Providers should bill using procedure (CPT) codes (comprehensive preventive medicine) based on the member's age:

- Code 99384 for a new patient, age 12-17
- Code 99385 for a new patient age 18
- Code 99394 for an established patient age 12-17
- Code 99395 for an established patient age 18

HPSM has helpful tools to assist the primary care provider in delivering teen-centered care, including bookmarks with HEADSS tips, health guidance folders for teens, etc. If you would like these materials, please call Health Education Services at 650-616-2165.

3 to 6 Year Old Well Child Annual Well Visit Incentive

HPSM encourages children ages 3 to 6 to receive a well visit once a year with his/her

Primary Care Provider (PCP). Children who receive a verified annual well visit from their PCP can get a \$15 Target gift card.

Please note: this is *in addition to* the periodic visits determined by CHDP. Do NOT confuse this incentive with CHDP. This annual incentive occurs in accordance with the periodicity guidelines of the American Academy of Pediatrics. Thus, providers should schedule these annual visits and the incentive WILL BE PAID if billed correctly to HPSM, separate from CHDP.

The components of a well child exam are the same as those listed above for adolescents. HPSM will reimburse \$90 for a well child exam for 3 to 6 year olds. To receive reimbursement, providers must bill with the appropriate CPT code and one of the associated ICD-9 codes below:

- CPT code:
 - 3-4 years: 99382 for new patients
99392 for established patients
 - 5-6 years: 99283 for new patients
99393 for established patients
- ICD-9 code: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

CareAdvantage Initial Health Assessments

HPSM is required to have each member complete an initial health assessment survey within 90 days of enrolling in CareAdvantage. The survey helps determine the member's health risk and whether the member should be enrolled into HPSM's Care Coordination programs. A PCP's members who are determined to be high risk based on the member's survey responses are referred to HPSM's Care Coordination Unit for admission into the Case Management program. HPSM contacts the PCP about this enrollment and notifies the member to make an appointment with the PCP as soon as possible, if there has not been a recent visit with the PCP. For members identified as moderate risk, HPSM contacts both the PCP and the member and recommends the member see his/her PCP within 30 days. For members identified as low risk, HPSM contacts the PCP and the member and recommends the member see his/her PCP within 60 days. The PCP is expected to appropriately case manage the member based on the risk assignment in conjunction with other information available to them.

Medi-Cal Pay for Performance (P4P) Program

In January of 2008, HPSM initiated the Pay for Performance (P4P) program to help focus its Medi-Cal primary care physicians' involvement on quality of care activities. The program replaced the former "risk surplus sharing" program, and financially aligns HPSM's interest in quality of care services and outcomes for our members with

physicians' commitment to quality of care in an ever-busy and demanding office practice environment.

Only Primary Care Providers (PCPs), Obstetricians (OBs) and Gynecologists (Gyns) contracted with HPSM's Medi-Cal line of business, where specified, are eligible to participate in the P4P program. The incentives apply to services performed for enrolled Medi-Cal members (including dual eligible Medi-Cal/Medicare members). Please contact the P4P Project Specialist at P4Phelp@hpsm.org or (650) 616-2169 for any P4P-related inquires.

Pay for Performance Incentives:

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Encounter Forms	<p>Bill each office visit with an HPSM member on the appropriate claim form.</p> <p>Note: Even though the member is capitated, send in a claim for this visit to get the incentive.</p>	<p>An incentive of \$3.00 per paper claim submitted</p> <p>An incentive of \$5.00 per electronic claim submitted</p>
Extended Office Hours	Offer extended hours in accordance with the requirements of the Medi-Cal PCP Contract.	An incentive of 10% of your monthly capitation payment.
Patient Auto-Assignment	Accept auto-assignment of patients in accordance with the requirements of the Medi-Cal PCP Contract.	An incentive of 20% of your monthly capitation payment.
Initial Health Assessment	<ol style="list-style-type: none"> 1. Perform an initial health assessment (IHA) of new members within 120 days of HPSM enrollment. (See <i>Components of an IHA</i> above) 2. Complete the Staying Healthy Assessment (SHA) Tool (or history form with approval from HPSM's Medical Director). 3. Bill the visit with the appropriate CPT code for a new visit. Coding tip sheet for IHA visits available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx 	An incentive of \$90 per claim .

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Annual Child Well Visit	<ol style="list-style-type: none"> 1. Perform an annual well visit for children <u>ages 3-6 years old</u>. 2. Complete the SHA Tool (or history form with approval from HPSM's Medical Director). 3. Bill the visit with the appropriate CPT code for a child well visit. Coding tip sheet for child well visits available at http://www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx 	<p>An incentive of \$90 per claim.</p> <p>Available once per eligible member per year.</p>
Annual Teen Visit	<ol style="list-style-type: none"> 1. Perform an annual well visit for adolescents ages 12-18 years old. (See <i>Components of a Well Visit</i> above) 2. Complete the SHA tool (or history form with approval from HPSM's Medical Director). 3. Bill the visit with the appropriate CPT code for an teen well visit. Coding tip sheet for teen well visits available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx 	<p>An incentive of \$90 per claim.</p> <p>Available once per eligible member per year.</p>
Women's Health Exam	<p>For Women 20-64 years old:</p> <ol style="list-style-type: none"> 1. Perform each of the following: <ol style="list-style-type: none"> a. Cervical (Pap smear) or vaginal cancer screening b. Full pelvic exam c. Clinical breast exam 2. Bill HPSM with procedure (HCPCS) code G0101 and an appropriate diagnosis code 	<p>An incentive of \$90 per claim.</p> <p>Available to you once per eligible member per year.</p>

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Asthma Action Plan	<ol style="list-style-type: none"> 1. Complete an asthma action plan (AAP) annually for any asthma patient with <u>persistent</u> asthma (adult or child) 2. Fax the completed AAP to HPSM at (650) 829-2071. 3. Bill HPSM with CPT code 99411 and modifier AP <p>Note: AAP forms available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx</p>	<p>An incentive of \$25 per AAP claim.</p> <p>Available once per eligible member per year.</p>
Body Mass Index (BMI)	<ol style="list-style-type: none"> 1. Measure the BMI of each of your patients (adult or child). 2. Complete a BMI form annually, provided by HPSM. 3. Fax the completed BMI form to HPSM at (650) 829-2009. <p>Bill HPSM with CPT code , modifier WT and the appropriate diagnosis code – see below for billing codes</p> <p>Note: BMI forms (Adult / Child) available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx For PCPs who see pediatric patients, growth charts are also available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx BMI wheels are available by contacting the P4P Project Specialist at (650) 616-2169 or P4Phelp@hpsm.org.</p>	<p>An incentive of \$25 per BMI claim.</p> <p>Available once per eligible member per year.</p>

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Referrals by PCP to OB physicians	<ol style="list-style-type: none"> 1. Identify pregnant women as early in pregnancy as possible. 2. Refer the pregnant woman to an OB provider immediately. 3. Help the pregnant woman make an appointment with an OB provider in the woman's first trimester. 4. Complete the HPSM OB referral verification form. 5. Fax the verification form to HPSM at (650) 829-2009. <p>Note: Verification forms available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx</p>	An incentive of \$50 for each verification form received.
OB Visit by OB physician	<ol style="list-style-type: none"> 1. See HPSM pregnant women as early in pregnancy as possible. 2. Accept referrals from PCPs or other entities to see HPSM pregnant women in their first trimester. 3. Complete the HPSM OB visit verification form. 4. Fax the verification form to HPSM at (650) 829-2009. <p>Note: Verification forms available at www.hpsm.org/providers/provider-resources/medi-cal-p4p.aspx</p>	An incentive of \$100 for each verification form received documenting a prenatal assessment occurred in the first trimester.
Postpartum exam by OB/Gyn physician	<ol style="list-style-type: none"> 1. Perform a postpartum exam for HPSM members within 21 to 56 days after delivery. 2. Bill HPSM with CPT code 59430, modifier PP and indicate the date of delivery in the remarks section of the claim. 	An incentive of \$50 per postpartum exam claim.

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Diabetes Program	1. Order and ensure completion of annual recommended tests/check-ups: HbA1C, LDL-C, retinal eye screening by an eye specialist, and nephropathy screening .	Receive an incentive for each test per patient once a year when HPSM receives lab results, clinical notes or claims, evidence that these tests have been completed, <ul style="list-style-type: none"> • HbA1C = \$30 • LDL-C = \$30 • Nephropathy screening = \$30 • Retinal eye exam = \$30

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
<p>Diabetes Program cont.</p>	<p>2. Monitor test results and achieve the following range:</p> <p><u>HbA1C</u></p> <p>Adults: < 8%</p> <p>Pediatric: Ages < 6: ≤ 8.5%;</p> <p style="padding-left: 40px;">Ages 6-12: ≤ 8%;</p> <p style="padding-left: 40px;">Ages 13-19: ≤ 7.5%</p> <p><u>LDL-C < 100</u></p> <p>Note - Blood and Urine Tests/Results: HPSM is working diligently to get lab results directly from our hospital labs and the most utilized private outpatient labs. This is an ongoing project.</p> <p>Note - Other Evidence of Nephropathy Screening: Treatment with an ACE or ARB inhibitor is considered de facto evidence of nephropathy screening. A chart note* or copy of a prescription* of these medications faxed to HPSM at (650) 829-2009 serves as evidence of this component.</p> <p>Note - Evidence of Ophthalmology Screening: If a patient's ophthalmology consultant bills HPSM for a retinal eye exam, that will be sufficient evidence of the screening. Documentation in the patient's chart of a consult note from the specialist indicating this test was done and faxed to HPSM at (650) 829-2009 also serves as evidence of this component.*</p>	<p>Receive an incentive for each result per patient once a year when HPSM receives lab results have the HbA1C and LDL-C in the desired ranges,</p> <p>HbA1C result = \$65</p> <p>LDL-C result = \$65</p> <p>*Any lab results, chart notes or prescriptions faxed to HPSM must be signed and dated to be eligible for the incentive.</p>

PAY FOR PERFORMANCE MEASURES	REQUIREMENTS	INCENTIVE
Immunization Registry	<p>1. Any PCP caring for pediatric patients needs to join the San Mateo County Immunization Registry. Contact Daisy Liu at (650) 616-2156.</p> <p>2. After a practice is signed up and trained, each patient's record must be entered and updated in the registry with each new immunization administered.</p> <p>Note: The \$500 startup payment is a onetime incentive.</p>	<p>After your practice is signed up, trained, on board, and actively using the registry for at least 2 months, you will get an incentive of \$500.</p> <p>Once you are actively updating patient records, you will get an incentive of \$1.00 for every HPSM Medi-Cal member ages 0-19 years old per month.</p>

Incentive Billing Summary

Below are tables of the procedure (CPT) and diagnosis (ICD-9) codes necessary to bill for some of the P4P incentives.

P4P Incentive Billing Procedure Codes:

Incentive	CPT Code	Modifier	Description	Pay
Body Mass Index (BMI)	99411	WT	Incentive payment for completing and submitting BMI forms to HPSM	\$25
Asthma Action Plan (AAP)	99411	AP	Incentive payment for completing and submitting AAP forms to HPSM	\$25
Postpartum Exam	59430	PP	Incentive payment for providing a postpartum exam within 21- 56 days after delivery. Indicate the date of delivery in the remarks section of the claim.	\$50
Child Well Visit	99392	—	Established Patient, Child (Age 3 - 4 years) – Well Visit	\$90
	99393	—	Established Patient, Child (Age 5 - 6 years) –Well Visit	\$90
Teen Well Visit	99394	—	Established Patient, Adolescent (Age 12-17 years) – Well Adolescent Visit	\$90
	99395	—	Established Patient, use for 18-21 year olds – Well Visit	\$90
Initial Health Assessment (IHA)	99381	—	Initial Comprehensive Preventive Visit (Under 1 year of age) – 1 st Well Baby Visit	\$90
	99382	—	New Patient, Early Childhood (Age 1 - 4 years) – Well Baby Visit	\$90
	99383	—	New Patient, Late Childhood (Age 5 - 11 years) – Well Child Visit	\$90
	99384	—	New Patient, Adolescent (Age 12 - 17 years) – Well Adolescent Visit	\$90
	99385	—	New Patient, Adult (Age 18 - 39) – Well Adult Visit	\$90
	99386	—	New Patient, Adult (Age 40 - 64) – Well Adult Visit	\$90
	99387	—	New Patient, Adult (Age 65+) – Well Adult Visit	\$90

Body Mass Index (BMI) diagnosis (ICD-9) codes:

ADULT Body Mass Index (BMI)

BMI adult codes are for use for persons **over 20 years old** and **some require 5 digit specificity.**

BMI	ICD-9 Code
< 19	V85.0
19-24	V85.1
25.0-25.9	V85.21
26.0-26.9	V85.22
27.0-27.9	V85.23
28.0-28.9	V85.24
29.0-29.9	V85.25
30.0-30.9	V85.30
31.0-31.9	V85.31
32.0-32.9	V85.32
33.0-33.9	V85.33
34.0-34.9	V85.34
35.0-35.9	V85.35
36.0-36.9	V85.36
37.0-37.9	V85.37
38.0-38.9	V85.38
39.0-39.9	V85.39
40+	V85.4

PEDIATRIC Body Mass Index (BMI)

Note: BMI pediatric codes are for **persons 2-20 years old**. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC) All diagnosis codes **require 5 digit specificity.**

BMI Percentile	ICD-9 Code
< 5th % for age	V85.51
5% to < 85% for age	V85.52
85% to < 95% for age	V85.53
≥ 95% for age	V85.54

Diagnosis Codes to use with IHA and Adolescent Well Visits:

ICD-9 Code	Definition
V20.2	<ul style="list-style-type: none"> • Routine infant or child health check • Developmental testing of infant or child • Immunizations appropriate for age • Routine vision and hearing testing
V70.0	<input type="checkbox"/> Routine general medical examination at a health care facility
V70.3	<ul style="list-style-type: none"> • Other medical examination for administrative purposes • General medical examination for: <ul style="list-style-type: none"> ○ Adoption ○ School admission ○ Sports competition ○ Camp ○ Driver's license ○ Immigration and naturalization ○ Insurance certification ○ Marriage
V70.5	<ul style="list-style-type: none"> • Health examination of defined subpopulations <ul style="list-style-type: none"> ○ Preschool children ○ School children ○ Students ○ Inhabitants of institutions • Occupational health examinations • Pre-employment screening • Armed forces personnel
V70.6	<ul style="list-style-type: none"> • Health examination in population surveys
V70.8	<ul style="list-style-type: none"> • Other specified general medical examinations • Examination of potential donor of organ or tissue
V70.9	<ul style="list-style-type: none"> • Unspecified general medical examination

Pay for Performance Reports

Each quarter, PCPs receive a P4P report that details their progress in the program. The report indicates how much money they have received in incentives and how much money they can still earn within the calendar year. The report also includes lists of members whom the provider has billed or submitted a form/documentation for the incentive as well as lists of members who are still eligible for incentives that calendar year.

These reports serve as a “registry” in each area of the quality initiatives for providers. They inform HPSM’s physicians participating in the P4P program of 1)who your patients are with a particular diagnosis (e.g. asthma, diabetes); 2)which members have had a particular intervention and who have not (e.g. received an asthma action plan or had a HbA1c) OR whether or not you have billed HPSM for something you have done (e.g. BMI).

This information helps to provide you with a plan of action so that you know which of your health plan members have specific conditions, and so you can better manage your patients with specific chronic conditions.

If you have any comments, suggestions or ideas for how to improve HPSM’s P4P

program, please contact our P4P Project Specialist at P4Phelp@hpsm.org or (650) 616-2169.