HealthPlan OF SAN MATEO
Healthy is for everyone

Benchmark Pay for Performance

Medi-Cal Program Guidelines

2020 Program Year

We value your feedback

Help us improve the P4P program guidelines by sending us your questions or comments on this document

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Updated January 22, 2020

Table of Contents

General Program Guidelines

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 measures 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 measure set focuses on member access and preventive care services.

If you would like to participate in the program evaluation and update process in partnership with the Health Plan or if you have questions about the program, please contact the HPSM Provider Services Department at psinquiries@hpsm.org.

Provider Participation Eligibility

Providers must have an active Medi-Cal contract with HPSM and must have a specialty type designation as a primary care provider. The contract must be active as of the date of payment. Providers must have 100 HPSM Medi-Cal members assigned to their panel as of January 1st, 2020 to be eligible to participate.

Program Tracks

Providers will be assigned one of three program tracks: Pediatrics, Family Practice or Adult, based on their practice. Each provider will be assigned metrics based on this track. All program metrics will be assigned for payment if there are at least 30 members who qualify in the denominator of that metric.

Reports

Performance bonus payment in the Benchmark P4P program is contingent on meeting the specified measure benchmarks for assigned patients who meet the measure 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. The website for eReports login is: https://reports.hpsm.org.

If you are unsure whether your organization has access, who in your organization has access, or would like to set up a log in to access the HPSM eReports system, please contact the HPSM Provider Services Department Monday 1 p.m. to 5 p.m., or Tuesday through Friday, 8 a.m. to 5 p.m. at **650-616-2106**, or email psinquiries@hpsm.org. .

Payment Schedule

Final payment calculations for the Benchmark P4P program will be determined by April 30 following the program calendar year. The deadline for Benchmark P4P claims submission is March 31st following the program calendar year. This is to allow for a three month claims lag so that we capture as many encounters as possible to count towards meeting the quality benchmarks. Each participating provider will be eligible for performance bonuses calculated based on meeting benchmarks for assigned quality metrics in the program calendar year. Payment methodology is outlined in these guidelines. In addition to this, participating providers are eligible to receive the monthly engagement benchmark bonus payments made through capitation.

Payment Calculation

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

{(Member Points * $Benchmark P4P PMPM) + Full Credit Benchmark Bonus}
* # Assigned Metrics Factor Adjustment

Term Definitions

Member Points: Member Months * Composite Quality Score

Member Months: Total of all member months for members assigned to the Medi-Cal PCP panel for at least 9 months out of 12 during the calendar year. Does not require the 9 months of assignment to be continuous. *Members receiving hospice services are excluded from P4P performance and rate calculations.

Composite Quality Score: Average score for all earned quality points based on final April 1 progress report calculation following the program calendar year. For quality points to be attributed to an assigned measure the participating provider must have at least 30 patients who meet the denominator criteria.

$Benchmark P4P PMPM: Specific per member per month rate determined by HPSM no later than April 30 following the program calendar year. 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 all full credit quality benchmarks are met in the program calendar year.

Assigned Metrics Factor Adjustment: Adjustment made based on the number of assigned quality metrics for the program calendar year.

Benchmark Scorecard Summary

Performance Measure	Measure Source	Full Credit Benchmark - (2020)	Partial Credit Benchmark - (2020)	Full Credit Quality Score	Partial Credit Quality Score	Payment	Reporting
Adolescent Well-Care Visits	NCQA/HEDIS	68.1%	62.8%	2	1	F,P	
Ambulatory Care-ED Visits	NCQA/HEDIS	N/A	N/A	2	1		F, A
Asthma Medication Ratio	NCQA/HEDIS	71.6%	68.5%	2	1	F,A,P	
BMI Assessment-Adult	NCQA/HEDIS	95.9%	93.7%	2	1	F,A	
BMI Assessment-Pediatrics	NCQA/HEDIS	90.4%	85.2%	2	1	F,P	
Cervical Cancer Screening	NCQA/HEDIS	72%	66.3%	2	1		F,A
Chlamydia Screening	NCQA/HEDIS	71.6%	66.2%	2	1		F,A,P
Comprehensive Diabetes Care (at least one reported for all 4 above)	HPSM	60%	50%	4	2	F,A	
Controlling High Blood Pressure	NCQA/HEDIS	72.3%	66.9%	2	1	F,A	
Developmental Screening	HPSM	75%	60%	2	1		P
Depression Screening and Follow-up (12 y/o +)	MCAS	75%	60%	2	1	F,A,P	
Diabetes Blood Pressure Control	NCQA/HEDIS	77.2%	71.3%	2	1	A	
Diabetes A1c Testing	NCQA/HEDIS	92.9%	90.5%	2	1		F,A
Diabetes Retinal Eye Exam	NCQA/HEDIS	69.5%	64.7%	2	1		A
Diabetes HbA1c Control (<8.0%)	NCQA/HEDIS	60.8%	56%	2	1	F,A	
Diabetes Medical Attention for Nephropathy (including screening)	NCQA/HEDIS	93.4%	91.9%	2	1		A
Encounter Threshold	HPSM	1.75/member month/year	1.5/member month/year	2	1	P,A	F

Performance Measure	Measure Source	Full Credit Benchmark - (2020)	Partial Credit Benchmark - (2020)	Full Credit Quality Score	Partial Credit Quality Score	Payment	Reporting
Fluoride Varnish	HPSM	90%	70%	2	1		P
Immunization for Adolescents - Combo 2	NCQA/HEDIS	47.2%	40.4%	2	1	P	F
Immunizations for Children - Combo 10	NCQA/HEDIS	49.3%	42%	2	1	P	F
Initial Health Assessments	DHCS	75%	60%	2	1	F,A,P	
Mammogram for breast cancer screening	NCQA/HEDIS	69.2%	64%	2	1	A	F
Panel Engagement	HPSM	60%	50%	30% cap	15% cap	F,A,P	
Plan All-Cause Readmissions	NCQA/HEDIS	20.6%	17.3%	2	1		F,A
Substance Misuse (SBIRT)	HPSM	75%	60%	2	1	A,P	F
Trauma Screening	HPSM	75%	60%				P
Well Child Visit (0-15 mo.)	NCQA/HEDIS	73.2%	69.8%	2	1	F,P	
Well Child Visit (3-6 y/o)	NCQA/HEDIS	83.9%	78.5%	2	1	F,P	

KEY: **F =** Family Practice Track **A =** Adult Track **P =** Pediatric Track

Panel Engagement

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 providers will be eligible to earn an additional 30% of capitation each month by meeting the engagement benchmark each quarter. The engagement benchmark is defined as follows:

- Full credit (30% additional capitation): Greater than or equal to 60% average panel engagement for continuously assigned members over a rolling 12 month timeline
- Partial credit (15% additional capitation): Greater than or equal to 50% and less than 60% average panel engagement for continuously assigned members over a rolling 12 month timeline
- No credit: Less than 50% average panel engagement for continuously assigned members over a rolling 12 month timeline

Patient engagement will be measured through our claims data.

Primary care visits 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**)
- AND telemedicine based on billable definitions
- AND capitated encounters
- AND telephone visits- **(98966, 98967, 98968, 99441, 99442, 99443)**

Participating providers will receive monthly reports showing the benchmark performance calculation and member list for how the benchmark performance is calculated. The engagement performance benchmark will be averaged over the quarter and capitation bonus payments will be based on the quarter performance benchmark average. Payments will be made prospectively for the quarter following the performance measurement period.

1. Adolescent Well-Care Visits (AWC)

Patient Eligibility: Members 12–21 years of age

Full Credit Benchmark: 68.1%

Partial Credit Benchmark: 62.8%

Measure Definition: The percentage of enrolled eligible members who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Services provided via telehealth do not count towards this measure.

Code	Definition	Code System
99381	Well-Care	CPT
99382	Well-Care	CPT
99383	Well-Care	CPT
99384	Well-Care	CPT
99385	Well-Care	CPT
99391	Well-Care	CPT
99392	Well-Care	CPT
99393	Well-Care	CPT
99394	Well-Care	CPT
99395	Well-Care	CPT
99461	Well-Care	CPT
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit (G0438)	HCPCS
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit (G0439)	HCPCS
Z00.00	[Z00.00] Encounter for general adult medical examination without abnormal findings	ICD10CM
Z00.01	[Z00.01] Encounter for general adult medical examination with abnormal findings	ICD10CM
Z00.110	[Z00.110] Health examination for newborn under 8 days old	ICD10CM
Z00.111	[Z00.111] Health examination for newborn 8 to 28 days old	ICD10CM
Z00.121	[Z00.121] Encounter for routine child health examination with abnormal findings	ICD10CM
Z00.129	[Z00.129] Encounter for routine child health examination without abnormal findings	ICD10CM

Code	Definition	Code System
Z00.5	[Z00.5] Encounter for examination of potential donor of organ and tissue	ICD10CM
Z00.8	[Z00.8] Encounter for other general examination	ICD10CM
Z02.0	[Z02.0] Encounter for examination for admission to educational institution	ICD10CM
Z02.1	[Z02.1] Encounter for pre-employment examination	ICD10CM
Z02.2	[Z02.2] Encounter for examination for admission to residential institution	ICD10CM
Z02.3	[Z02.3] Encounter for examination for recruitment to armed forces	ICD10CM
Z02.4	[Z02.4] Encounter for examination for driving license	ICD10CM
Z02.5	[Z02.5] Encounter for examination for participation in sport	ICD10CM
Z02.6	[Z02.6] Encounter for examination for insurance purposes	ICD10CM
Z02.71	[Z02.71] Encounter for disability determination	ICD10CM
Z02.82	[Z02.82] Encounter for adoption services	ICD10CM
Z76.1	[Z76.1] Encounter for health supervision and care of foundling	ICD10CM
Z76.2	[Z76.2] Encounter for health supervision and care of other healthy infant and child	ICD10CM

2. Ambulatory Care - ED Visits (AMB)

Patient Eligibility: All members excluding those in hospice.

Do not include ED visits that result in an inpatient stay. Exclude visits for mental health or chemical dependency.

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

Measure Definition: This measure summarizes utilization of ambulatory care in the following categories: ED 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.

3. Asthma Medication Ratio (AMR)

Patient Eligibility: Patients 5–64 years of age who were identified as having persistent asthma.

Full Credit Benchmark: 71.6%

Partial Credit Benchmark: 68.5%

Measure Definition: The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the calendar year.

Asthma Controller Medications

Generic Ingredient	Medication Name(s)	Description
beclomethasone	Qvar inhaler, Qvar Redihaler	*glucocorticoids, inhaled*
benralizumab	Fasenra syringe, Fasenra pen	*interleukin-5 (IL-5) receptor alpha antagonist, MAB*
budesonide	Pulmicort Flexhaler	*glucocorticoids, inhaled*
budesonide/formoterol	Budesonide-Formoterol inhaler, Symbicort inhaler	*beta-adrenergic and glucocorticoid combo, inhaled*
ciclesonide	Alvesco inhaler	*glucocorticoids, inhaled*

Generic Ingredient	Medication Name(s)	Description
flunisolide	Aerospan inhaler	*glucocorticoids, inhaled*
fluticasone	Arnuity Ellipta inhaler	*glucocorticoids, inhaled*
fluticasone/vilanterol	Breo Ellipta inhaler	*beta-adrenergic and glucocorticoid combo, inhaled*
fluticasone	Armonair Respiclick , Flovent (Diskus and HFA inhaler)	*glucocorticoids, inhaled*
fluticasone/salmeterol	Advair (Diskus and HFA inhaler), Airduo Respiclick , Fluticasone-Salmeterol inhaler, Wixela Inhub	*beta-adrenergic and glucocorticoid combo, inhaled*
mepolizumab	Nucala (vial, auto-injector, syringe)	*monoclonal antibody - interleukin-5 antagonists*
mometasone	Asmanex Inhaler, Asmanex Twisthaler	*glucocorticoids, inhaled*
mometasone/formoterol	Dulera inhaler	*beta-adrenergic and glucocorticoid combo, inhaled*
montelukast	Montelukast Sodium (tablet, granule, and chew) Singulair (tablet, granule, and chew)	*leukotriene receptor antagonists*
omalizumab	Xolair (vial and syringe)	*monoclonal antibodies to immunoglobulin E (IGE)*
reslizumab	Cinqair vial	*monoclonal antibody -*

Generic Ingredient	Medication Name(s)	Description
		interleukin-5 antagonists
theophylline	Elixophyllin Elixir, Theo-24 ER capsule, Theochron ER tablet, Theophylline (solution and ER tablets)	*xanthines*
zafirlukast	Accolate tablet, Zafirlukast tablet	*leukotriene receptor antagonists*
zileuton	Zileuton ER tablet, Zyflo filmtab, Zyflo CR tablet	*5-lipoxygenase inhibitors*

Asthma Reliever Medications

Generic Ingredient	Medication Name(s)	Description
albuterol	Albuterol HFA inhaler, ProAir Digihaler inhaler, ProAir HFA inhaler, ProAir Respiclick inhaler, Proventil HFA inhaler, Ventolin HFA inhaler	*short-acting, inhaled beta-2 agonists*
levalbuterol	Levalbuterol Tartrate HFA Inhaler, Xopenex HFA Inhaler	*short-acting, inhaled beta-2 agonists*

Asthma Diagnosis Codes

Definition	Code System
[**J45.20**] Mild intermittent asthma, uncomplicated	ICD10CM
[**J45.21**] Mild intermittent asthma with (acute) exacerbation	ICD10CM
[**J45.22**] Mild intermittent asthma with status asthmaticus	ICD10CM
[**J45.30**] Mild persistent asthma, uncomplicated	ICD10CM
[**J45.31**] Mild persistent asthma with (acute) exacerbation	ICD10CM
[**J45.32**] Mild persistent asthma with status asthmaticus	ICD10CM
[**J45.40**] Moderate persistent asthma, uncomplicated	ICD10CM

Definition	Code System
[**J45.41**] Moderate persistent asthma with (acute) exacerbation	ICD10CM
[**J45.42**] Moderate persistent asthma with status asthmaticus	ICD10CM
[**J45.50**] Severe persistent asthma, uncomplicated	ICD10CM
[**J45.51**] Severe persistent asthma with (acute) exacerbation	ICD10CM
[**J45.52**] Severe persistent asthma with status asthmaticus	ICD10CM
[**J45.901**] Unspecified asthma with (acute) exacerbation	ICD10CM
[**J45.902**] Unspecified asthma with status asthmaticus	ICD10CM
[**J45.909**] Unspecified asthma, uncomplicated	ICD10CM
[**J45.990**] Exercise induced bronchospasm	ICD10CM
[**J45.991**] Cough variant asthma	ICD10CM
[**J45.998**] Other asthma	ICD10CM

Criteria for identifying patients with persistent asthma

Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the current calendar year and the year prior to the current calendar year. Criteria need not be the same across both years.

- At least one ED visit, with a principal diagnosis of asthma.
- At least one acute inpatient encounter, with a principal diagnosis of asthma.
- At least one acute inpatient discharge, with a principal diagnosis of asthma.
- At least four outpatient visits, observation visits, telephone visits, or online assessments, on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller medication (Asthma Controller Medications List) or reliever medication. Visit type need not be the same for the four visits. Only three of the four visits may be an outpatient telehealth visit, a telephone visit or an online assessment
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that

year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor.

Exclude members who had any of the following diagnoses at any time in their history through December 31 of the measurement year:

- Emphysema
- COPD
- Chronic Obstructive Bronchitis
- Chronic Respiratory Conditions due to Fumes or Vapors
- Cystic Fibrosis
- Acute Respiratory Failure

4. BMI Assessment Adult (ABA)

Patient Eligibility: Patients 18-74 years old who had an outpatient visit.

Exclude female members who have a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.

Full Credit Benchmark: 95.9%

Partial Credit Benchmark: 93.7%

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

BMI: Body mass index. A statistical measure of the weight of a person scaled according to height

BMI percentile: The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicate the relative position of a patient's BMI number among those of the same sex and age.

ICD-10 BMI Diagnosis Codes

18-19 years old

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

20+ years old

Code	Definition
Z68.1	[Z68.1] Body mass index (BMI) 19.9 or less, adult
Z68.20	[Z68.20] Body mass index (BMI) 20.0-20.9, adult
Z68.21	[Z68.21] Body mass index (BMI) 21.0-21.9, adult
Z68.22	[Z68.22] Body mass index (BMI) 22.0-22.9, adult
Z68.23	[Z68.23] Body mass index (BMI) 23.0-23.9, adult
Z68.24	[Z68.24] Body mass index (BMI) 24.0-24.9, adult
Z68.25	[Z68.25] Body mass index (BMI) 25.0-25.9, adult

Z68.26	[Z68.26] Body mass index (BMI) 26.0-26.9, adult
Z68.27	[Z68.27] Body mass index (BMI) 27.0-27.9, adult
Z68.28	[Z68.28] Body mass index (BMI) 28.0-28.9, adult
Z68.29	[Z68.29] Body mass index (BMI) 29.0-29.9, adult
Z68.30	[Z68.30] Body mass index (BMI) 30.0-30.9, adult
Z68.31	[Z68.31] Body mass index (BMI) 31.0-31.9, adult
Z68.32	[Z68.32] Body mass index (BMI) 32.0-32.9, adult
Z68.33	[Z68.33] Body mass index (BMI) 33.0-33.9, adult
Z68.34	[Z68.34] Body mass index (BMI) 34.0-34.9, adult
Z68.35	[Z68.35] Body mass index (BMI) 35.0-35.9, adult
Z68.36	[Z68.36] Body mass index (BMI) 36.0-36.9, adult
Z68.37	[Z68.37] Body mass index (BMI) 37.0-37.9, adult
Z68.38	[Z68.38] Body mass index (BMI) 38.0-38.9, adult
Z68.39	[Z68.39] Body mass index (BMI) 39.0-39.9, adult
Z68.41	[Z68.41] Body mass index (BMI) 40.0-44.9, adult
Z68.42	[Z68.42] Body mass index (BMI) 45.0-49.9, adult
Z68.43	[Z68.43] Body mass index (BMI) 50-59.9 , adult
Z68.44	[Z68.44] Body mass index (BMI) 60.0-69.9, adult
Z68.45	[Z68.45] Body mass index (BMI) 70 or greater, adult

5. BMI Assessment- Pediatrics (WCC)

For Nutrition & Physical Activity for Children/Adolescents

Patient Eligibility: Patients 3-17 years old

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

Full Credit Benchmark: 90.4%

Partial Credit Benchmark: 85.2%

Measure 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.

*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

BMI percentile: 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.

BMI Percentile Diagnosis Codes

Code	Definition
Z68.51	[Z68.51] Body mass index (BMI) pediatric, less than 5th percentile for age
Z68.52	[Z68.52] Body mass index (BMI) pediatric, 5th percentile to less than 85th percentile for age
Z68.53	[Z68.53] Body mass index (BMI) pediatric, 85th percentile to less than 95th percentile for age
Z68.54	[Z68.54] Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age

6. Cervical Cancer Screening (CCS)

Patient Eligibility: Women 21-64 years old

Full Credit Benchmark: 72%

Partial Credit Benchmark: 66.3%

Measure 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
88166	Cervical Cytology	CPT
88167	Cervical Cytology	CPT
88174	Cervical Cytology	CPT
88175	Cervical Cytology	CPT
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision (G0123)	HCPCS

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

HPV Test Codes

Code	Definition	Code System
87620	HPV detection by DNA or RNA, direct probe technique	CPT
87621	HPV detection by DNA or RNA, amplified probe technique	CPT
87622	HPV quantification	CPT

Code	Definition	Code System
87624	Human Papillomavirus (HPV), high-risk types	CPT
87625	Human Papillomavirus (HPV)	CPT
G0476	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)	HCPCS

Cervical Cancer Exclusion Codes

In order for patients to be excluded from the cervical cancer screening performance measure 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 please submit one of the following diagnosis codes with the claim for the patient's next primary care visit;

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

Members who meet any of the following criteria are excluded:

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, 2020 may be excluded.

7. Chlamydia Screening (CHL)

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

Full Credit Benchmark: 71.6%

Partial Credit Benchmark: 66.2%

Measure 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 measurement 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

8. Comprehensive Diabetes Care (CDC)

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

Exclusion Criteria:

- 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

Full Credit: 60%

Partial Credit: 50%

Measure Definition: Percent of assigned diabetic patients who had at least one HbA1c test and result submitted to HPSM, an eye exam, blood pressure reading, and medical attention for nephropathy or screening in the current program (calendar) year.

9. Controlling High Blood Pressure (CBP)

Patient Eligibility: Members 18-85 years old who had at least two visits and a diagnosis of hypertension during the measurement year or the year prior to the measurement year.

Exclusion criteria:

- 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.

Full Credit: 72.3%

Partial Credit: 66.9%

Measure 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.

Representative BP The most recent BP reading during the measurement year on or after the second diagnosis of hypertension

ICD10 Diagnosis Code for Hypertension

Code	Definition	Code System
I10	[I10] Essential (primary) hypertension	ICD10CM

Codes for Blood Pressure Reading

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

3075F	Most recent systolic blood pressure 130-139 mm Hg	CPT-CAT-II

10. Developmental Screening

Patient Eligibility: Children 30 months of age

Full Credit: 75%

Partial Credit: 60%

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

Developmental Screening Procedure Code

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

11. Depression Screening and Follow-up (ages 12+) (CDF)

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

A patient is not eligible if they have a documented active diagnosis or depression or bipolar disorder.

Full Credit: 75%

Partial Credit: 60%

Measure Definition: The percentage of patients 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 HPSM Behavioral Health Screening tool available at: hpsm.org/p4p, 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

Depression Screening Procedure Codes

Code	Definition	Code System

96127	Brief emotional/behavioral assessment with scoring and documentation using as standardized instrument	CPT
G8431	Screening for depression is documented as being positive and a follow-up plan is documented (G8431)	HCPCS
G8433	Screening for clinical depression using a standardized tool not documented patient not eligible/appropriate	HCPCS
G0444	Annual depression screening administration	HCPCS
G8510	Screening for depression is documented as negative, a follow-up plan is not required (G8510)	HCPCS
G8511	Screening for depression documented as positive, follow-up plan not documented, reason not given (G8511)	HCPCS
3351F	Negative screen for depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)	CPT II
3352F	No significant depressive symptoms as categorized by using a standardized depression assessment tool (MDD)	CPT II
3353F	Mild to moderate depressive symptoms as categorized by using a standardized depression /assessment tool (MDD)	CPT II
3354F	Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)	CPT II
1220F	Patient screened for depression (SUD)	CPT II
0545F	Plan for follow-up care for major depressive disorder documented (MDD ADOL)	CPT II

ICD-10 Depressive Disorder Diagnosis Codes

Code	Definition	Code System
F32.0	Major depressive disorder, single episode, mild	ICD-10
F32.1	Major depressive disorder, single episode, moderate	ICD-10
F32.2	Major depressive disorder, single episode, severe without psychotic features	ICD-10
F32.3	Major depressive disorder, single episode, severe with psychotic features	ICD-10
F32.4	Major depressive disorder, single episode, in partial remission	ICD-10
F32.5	Major depressive disorder, single episode, in full remission	ICD-10
F32.8	Other depressive episodes (eg, atypical depression, post-schizophrenic depression)	ICD-10
F32.9	Major depressive disorder, single episode, unspecified	ICD-10
F33.0	Major depressive disorder, recurrent, mild	ICD-10

F33.1	Major depressive disorder, recurrent, moderate	ICD-10
F33.2	Major depressive disorder, recurrent severe without psychotic features	ICD-10
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms	ICD-10
F33.40	Major depressive disorder, recurrent, in remission, unspecified	ICD-10
F33.41	Major depressive disorder, recurrent, in partial remission	ICD-10
F33.42	Major depressive disorder, recurrent, in full remission	ICD-10
F33.8	Other recurrent depressive disorders	ICD-10
F33.9	Major depressive disorder, recurrent, unspecified	ICD-10
F34.1	Dysthymic disorder (depressive personality disorder, dysthymia neurotic depression)	ICD-10
F39	Mood (affective) disorder, unspecified	ICD-10
Z13.89	Encounter for screening for other (eg, depression, anxiety) disorder	ICD-10

12. Diabetes Blood Pressure Control (CDC)

Patient Eligibility: Patients 18-75 years old with a diagnosis of diabetes

Exclusion Criteria:

- 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

Full Credit: 77.2%

Partial Credit: 71.3%

Measure 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.

BP Control <140/90 mm Hg	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
3079F	DIAST BP 80-89 MM HG	CPTII
3080F	DIAST BP >/= 90 MM HG	CPTII
3078F	DIAST BP <80 MM HG	CPTII
3077F	SYST BP >/= 140 MM HG	CPTII
3074F	SYST BP LT 130 MM HG	CPTII
3075F	SYST BP GE 130 - 139MM HG	CPTII

13. Diabetes HbA1c Testing (CDC)

Patient Eligibility: Patients 18-75 years old with a diagnosis of diabetes

Exclusion Criteria:

- 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

Full Credit: 92.9%

Partial Credit: 90.5%

Measure Definition: The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing.

Diabetes HbA1c Testing Codes

83036	HbA1c Lab Test	**CPT**
83037	HbA1c Lab Test	CPT
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)	CPT-CAT-II
3045F	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (DM)	CPT-CAT-II
3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT-CAT-II
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	CPT-CAT-II
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	CPT-CAT-II

14. Diabetes Eye Exam (CDC)

Patient Eligibility: Patients 18 -75 years old with a diagnosis of diabetes

Exclusion Criteria:

- 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

Full Credit: 69.5%

Partial Credit: 64.7%

Measure 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

Code	Definition	Code System
67107	Diabetic Retinal Screening	CPT
67108	Diabetic Retinal Screening	CPT
67110	Diabetic Retinal Screening	CPT
67113	Diabetic Retinal Screening	CPT
67121	Diabetic Retinal Screening	CPT
67141	Diabetic Retinal Screening	CPT
67145	Diabetic Retinal Screening	CPT
67208	Diabetic Retinal Screening	CPT
67210	Diabetic Retinal Screening	CPT
67218	Diabetic Retinal Screening	CPT
67220	Diabetic Retinal Screening	CPT
67221	Diabetic Retinal Screening	CPT
67227	Diabetic Retinal Screening	CPT
67228	Diabetic Retinal Screening	CPT
92002	Diabetic Retinal Screening	CPT
92004	Diabetic Retinal Screening	CPT
92012	Diabetic Retinal Screening	CPT
92014	Diabetic Retinal Screening	CPT
92018	Diabetic Retinal Screening	CPT
92019	Diabetic Retinal Screening	CPT
92134	Diabetic Retinal Screening	CPT
92225	Diabetic Retinal Screening	CPT
92226	Diabetic Retinal Screening	CPT
92227	Diabetic Retinal Screening	CPT
92228	Diabetic Retinal Screening	CPT
92230	Diabetic Retinal Screening	CPT
92235	Diabetic Retinal Screening	CPT

Code	Definition	Code System
92240	Diabetic Retinal Screening	CPT
92250	Diabetic Retinal Screening	CPT
92260	Diabetic Retinal Screening	CPT
99203	Diabetic Retinal Screening	CPT
99204	Diabetic Retinal Screening	CPT
99205	Diabetic Retinal Screening	CPT
99213	Diabetic Retinal Screening	CPT
99214	Diabetic Retinal Screening	CPT
99215	Diabetic Retinal Screening	CPT
99242	Diabetic Retinal Screening	CPT
99243	Diabetic Retinal Screening	CPT
99244	Diabetic Retinal Screening	CPT
99245	Diabetic Retinal Screening	CPT
S0620	Diabetic Retinal Screening	HCPCS
S0621	Diabetic Retinal Screening	HCPCS
S3000	Diabetic Retinal Screening	HCPCS
3072F	Diabetic Retinal Screening Negative	CPT II
2022F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2023F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2024F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2025F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2026F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2033F	Diabetic Retinal Screening With Eye Care Professional	CPT II
65091	Unilateral Eye Enucleation	CPT
65093	Unilateral Eye Enucleation	CPT
65101	Unilateral Eye Enucleation	CPT
65103	Unilateral Eye Enucleation	CPT

Code	Definition	Code System
65105	Unilateral Eye Enucleation	CPT
65110	Unilateral Eye Enucleation	CPT
65112	Unilateral Eye Enucleation	CPT
65114	Unilateral Eye Enucleation	CPT
08B10ZX	Unilateral Eye Enucleation Left	ICD10PCS
08B10ZZ	Unilateral Eye Enucleation Left	ICD10PCS
08B13ZX	Unilateral Eye Enucleation Left	ICD10PCS
08B13ZZ	Unilateral Eye Enucleation Left	ICD10PCS
08B1XZX	Unilateral Eye Enucleation Left	ICD10PCS
08B1XZZ	Unilateral Eye Enucleation Left	ICD10PCS
08B00ZX	Unilateral Eye Enucleation Right	ICD10PCS
08B00ZZ	Unilateral Eye Enucleation Right	ICD10PCS
08B03ZX	Unilateral Eye Enucleation Right	ICD10PCS
08B03ZZ	Unilateral Eye Enucleation Right	ICD10PCS
08B0XZX	Unilateral Eye Enucleation Right	ICD10PCS
08B0XZZ	Unilateral Eye Enucleation Right	ICD10PCS

15. Diabetes HbA1c Control (CDC)

Patient Eligibility: Patients 18 -75 years old with a diagnosis of diabetes

Exclusion Criteria:

- 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

Full Credit: 60.8%

Partial Credit: 56%

Measure Definition: Percent of diabetic patients 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.

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

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

*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
3044F	HbA1c Level Less Than 7.0	CPT II
3051F	HbA1c Level greater than or equal to 7.0% and less than 8.0%	CPT II
3045F	Most recent hemoglobin A1c (HbA1c) level 7.0-9.0% (DM)	CPTII
3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)	CPT II
3052F	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 measure 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.

16. Diabetes Medical Attention for Nephropathy (CDC)

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

Exclusion Criteria:

- 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

Full Credit: 93.4%

Partial Credit: 91.9%

Measure Definition: Percent of diabetic patients for whom a nephropathy screening or monitoring test during the current calendar year **or** evidence of nephropathy during the current calendar year, as documented through administrative data.

A nephropathy screening or monitoring test **or** evidence of nephropathy, as documented through administrative data includes diabetics who had one of the following during the current calendar year:

- A nephropathy screening or monitoring test
- Evidence of treatment for nephropathy or ACE/ARB therapy
- Evidence of stage 4 chronic kidney disease
- Evidence of ESRD or dialysis
- Evidence of nephrectomy or kidney transplant
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted)
- At least one ACE inhibitor or ARB dispensing event

Download Nephropathy Procedure Codes (PDF Document, 287 kbs.)

17. Fluoride Varnish

Patient Eligibility: Ages 0-5

Full Credit: 90%

Partial Credit: 70%

Measure Definition: Percentage of patients 0-5 who have received fluoride varnish at least 2 times during the measurement period.

Fluoride Varnish Procedure Codes

Code	Definition	Code System
99188	Topical application of fluoride varnish	CPT
D1206	Topical application of fluoride varnish	HCPCS

18. Encounter Threshold

Patient Eligibility: All age ranges

Full Credit: 1.75 encounters per member month per year

Partial Credit: 1.5 encounters per member month per year

Measure Definition: Average number of total primary care encounters* for eligible members during the measurement period.

Example: 5 patients assigned to your practice for the month of January = 5 'member months'

> ***Primary care encounter definition:**
>
> Jump to Engagement Benchmark primary care visit definition

19. Immunization for Adolescents (IMA) – Combo 2

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

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

Full Credit Benchmark: 47.2%

Partial Credit Benchmark: 40.4%

Measure 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.

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

20. Immunizations for Children (CIS)– Combo 10

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

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. The exclusion must have occurred by the member's second birthday. Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Full Credit: 49.3 %

Partial Credit: 42 %

Measure 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 measure calculates a rate for each vaccine and nine separate combination rates.

Vaccine Procedure Codes

Code	Definition	Code System
90698	DTaP Vaccine Procedure	CPT
90700	DTaP Vaccine Procedure	CPT
90721	DTaP Vaccine Procedure	CPT
90723	DTaP Vaccine Procedure	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	CPT
90721	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90748	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
B15.0	[B15.0] Hepatitis A with hepatic coma	ICD10CM

Code	Definition	Code System
B15.9	[B15.9] Hepatitis A without hepatic coma	ICD10CM
90633		CPT
B16.0	[B16.0] Acute hepatitis B with delta-agent with hepatic coma	ICD10CM
B16.1	[B16.1] Acute hepatitis B with delta-agent without hepatic coma	ICD10CM
B16.2	[B16.2] Acute hepatitis B without delta-agent with hepatic coma	ICD10CM
B16.9	[B16.9] Acute hepatitis B without delta-agent and without hepatic coma	ICD10CM
B17.0	[B17.0] Acute delta-(super) infection of hepatitis B carrier	ICD10CM
B18.0	[B18.0] Chronic viral hepatitis B with delta-agent	ICD10CM
B18.1	[B18.1] Chronic viral hepatitis B without delta-agent	ICD10CM
B19.10	[B19.10] Unspecified viral hepatitis B without hepatic coma	ICD10CM
B19.11	[B19.11] Unspecified viral hepatitis B with hepatic coma	ICD10CM
Z22.51	[Z22.51] Carrier of viral hepatitis B	ICD10CM
08	hepatitis B vaccine, pediatric or pediatric/adolescent dosage	CVX
90723	Hepatitis B Vaccine Procedure	CPT
90740	Hepatitis B Vaccine Procedure	CPT
90744	Hepatitis B Vaccine Procedure	CPT
90747	Hepatitis B Vaccine Procedure	CPT
90748	Hepatitis B Vaccine Procedure	CPT
G0010	Administration of hepatitis b vaccine (G0010)	HCPCS
3E0234Z	Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach	ICD10PCS
90670	Pneumococcal Conjugate Vaccine Procedure	CPT
G0009	Administration of pneumococcal vaccine (G0009)	HCPCS
90681	Rotavirus Vaccine (2 Dose Schedule) Procedure	CPT
90680	Rotavirus Vaccine (3 Dose Schedule) Procedure	CPT
B06.00	[B06.00] Rubella with neurological complication, unspecified	ICD10CM
B06.01	[B06.01] Rubella encephalitis	ICD10CM
B06.02	[B06.02] Rubella meningitis	ICD10CM
B06.09	[B06.09] Other neurological complications of rubella	ICD10CM
B06.81	[B06.81] Rubella pneumonia	ICD10CM
B06.82	[B06.82] Rubella arthritis	ICD10CM

Code	Definition	Code System
B06.89	[B06.89] Other rubella complications	ICD10CM
B06.9	[B06.9] Rubella without complication	ICD10CM
90706	Rubella Vaccine Procedure	CPT

21. Initial Health Assessments (IHA)

Patient Eligibility: Newly enrolled HPSM member (within 120 days of Health Plan enrollment)

Full Credit: 75%

Partial Credit: 60%

Measure Definition: Percent of newly enrolled and assigned patients who had an initial health assessment 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.

IHAs must utilize the Staying Healthy Assessment (SHA) Tool. See the tool and Instruction Guide found here: hpsm.org/providers-forms

Procedure Codes

Code	System	Definition
99201	CPT	Office/Outpt E&M New Minor 10
99202	CPT	Office/Outpt E&M New Low-Mod
99203	CPT	Office/Outpt E&M New Mod Seve
99204	CPT	Office/Outpt E&M New Mod-Hi 4
99205	CPT	Office/Outpt E&M New Mod-Hi 6
99211	CPT	Office/Outpt E&M Estab 5 Min
99212	CPT	Office/Outpt E&M Estab Minor
99213	CPT	Office/Outpt E&M Estab Low-Mo
99214	CPT	Office/Outpt E&M Estab Mod-Hi
99215	CPT	Office/Outpt E&M Estab Mod-Hi
99241	CPT	Office Cons New/Estab Minor 1
99242	CPT	Office Cons New/Est Lo Sever
99243	CPT	Office Cons New/Estab Mod 40
99244	CPT	Office Cons New/Estab Mod-Hi
99245	CPT	Office Cons New/Estab Mod-Hi

Code	System	Definition
99304	CPT	Nursing Facility Care Init
99305	CPT	Nursing Facility Care Init
99306	CPT	Nursing Facility Care Init
99307	CPT	Nursing Fac Care Subseq
99308	CPT	Nursing Fac Care Subseq
99309	CPT	Nursing Fac Care Subseq
99310	CPT	Nursing Fac Care Subseq
99315	CPT	Nurs Facil D/C Da Mgmt; 30 M
99316	CPT	Nurs Facil D/C Da Mgmt; > 30
99318	CPT	Annual Nursing Fac Assessmnt
99324	CPT	Domicil/R-Home Visit New Pat
99325	CPT	Domicil/R-Home Visit New Pat
99326	CPT	Domicil/R-Home Visit New Pat
99327	CPT	Domicil/R-Home Visit New Pat
99328	CPT	Domicil/R-Home Visit New Pat
99334	CPT	Domicil/R-Home Visit Est Pat
99335	CPT	Domicil/R-Home Visit Est Pat
99336	CPT	Domicil/R-Home Visit Est Pat
99337	CPT	Domicil/R-Home Visit Est Pat
99341	CPT	Home Visit E&M New Pt Lo Sev
99342	CPT	Home Visit E&M New Pt Mod Se
99343	CPT	Home Visit E&M New Pt Mod-Hi
99344	CPT	Home Visit E&M New Pt Hi Sev
99345	CPT	Home Visit E&M New Pt Unstbl
99347	CPT	Home Visit E&M Estab Minor-1
99348	CPT	Home Visit E&M Estab Low-Mod
99349	CPT	Home Visit E&M Estab Mod-Hi

Code	System	Definition
99350	CPT	Home Visit E&M Estab Mod-Hi
99354	CPT	Prolong Md Serv Outpt W/Pt;
99355	CPT	Prolong Md Serv Outpt W/Pt;
99381	CPT	Init Preven Meds E&M New Pt;
99382	CPT	Init Preven Meds E&M New Pt;
99383	CPT	Init Preven Meds E&M New Pt;
99384	CPT	Init Preven Meds E&M New Pt;
99385	CPT	Init Preven Meds E&M New Pt;
99386	CPT	Init Preven Meds E&M New Pt;
99387	CPT	Init Preven Meds E&M New Pt;
99391	CPT	Preven Meds E&M Estab Pt; In
99392	CPT	Preven Meds E&M Estab Pt; 1-
99393	CPT	Preven Meds E&M Estab Pt; 5-
99394	CPT	Preven Meds E&M Estab Pt; 12
99395	CPT	Preven Meds E&M Estab Pt; 18
99396	CPT	Preven Meds E&M Estab Pt; 40
99397	CPT	Preven Meds E&M Estab Pt; 65
99401	CPT	Preven Med Counsl (Sep Pro);
99402	CPT	Preven Med Counsl (Sep Pro);
99403	CPT	Preven Med Counsl (Sep Pro);
99404	CPT	Preven Med Counsl (Sep Pro);
99411	CPT	Preven Med Counsl Grp (Sep P
99412	CPT	Preven Med Counsl Grp (Sep P
99420	CPT	Admin/Intrpt Health Risk Ass
99429	CPT	Unlisted Preven Meds Serv
99444	CPT	Online E/M By Phys
99446	CPT	Interprof Phone/Online 5-10

Code	System	Definition
99447	CPT	Interprof Phone/Online 11-2
99448	CPT	Interprof Phone/Online 21-3
99449	CPT	Interprof Phone/Online 31/>
99450	CPT	Basic Life &/Or Disability E
99455	CPT	Work Relat/Disabl Exam-Treat
99456	CPT	Work Relat/Disabl Exam-Not T
G0402	HCPCS	Initial Preventive Exam
G0438	HCPCS	Ppps Initial Visit
G0439	HCPCS	Ppps Subseq Visit
G0463	HCPCS	Hospital Outpt Clinic Visit
T1015	HCPCS	Clinic Service

ICD-10 IHA Diagnosis Codes

Code	System	Definition
Z00.00	ICD10CM	Encounter for general adult medical examination without abnormal findings
Z00.01	ICD10CM	Encounter for general adult medical examination with abnormal findings
Z00.121	ICD10CM	Encounter for routine child health examination with abnormal findings
Z00.129	ICD10CM	Encounter for routine child health examination without abnormal findings
Z00.5	ICD10CM	Encounter for examination of potential donor of organ and tissue
Z00.8	ICD10CM	Encounter for other general examination
Z02.0	ICD10CM	Encounter for examination for admission to educational institution
Z02.1	ICD10CM	Encounter for pre-employment examination
Z02.2	ICD10CM	Encounter for examination for admission to residential institution
Z02.3	ICD10CM	Encounter for examination for recruitment to armed forces
Z02.4	ICD10CM	Encounter for examination for driving license
Z02.5	ICD10CM	Encounter for examination for participation in sport

Code	System	Definition
Z02.6	ICD10CM	Encounter for examination for insurance purposes
Z02.71	ICD10CM	Encounter for disability determination
Z02.79	ICD10CM	Encounter for issue of other medical certificate
Z02.81	ICD10CM	Encounter for paternity testing
Z02.82	ICD10CM	Encounter for adoption services
Z02.83	ICD10CM	Encounter for blood-alcohol and blood-drug test
Z02.89	ICD10CM	Encounter for other administrative examinations
Z02.9	ICD10CM	Encounter for administrative examinations, unspecified

22. Mammogram for Breast Cancer Screening (BCS)

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

Exclude members 66 years of age and older by the end of the Measurement Period, with frailty **and** advanced illness

Full Credit: 69.2%

Partial Credit: 64%

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

Procedure Codes

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

Mammography Exclusion Codes

Code	Definition	Code System
3014F	**Modifier 1P** Screening mammography not performed for medical reasons	CPT II

23. Plan All-Cause Readmissions (PCR)

Patient Eligibility: Members 18 and older

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

Full Credit: 20.6%

Partial Credit: 17.3%

Measure 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

24. Substance Misuse (SBIRT)

Patient Eligibility: Patients 12 years old and up

Full Credit: 75%

Partial Credit: 60%

Measure Definition: The percentage of patients 12 years old and up who had an outpatient visit and received a substance misuse screening in the current calendar year.

Procedure Codes

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

25. Trauma Screening

Patient Eligibility: Patients under age 21

Full Credit: 75%

Partial Credit: 60%

Measure Definition: Percentage of members under age 21 screened for ACEs using the PEARLS tool during the measurement year.

Trauma Screening Procedure Codes

Code	Definition	Code System
G9919	Trauma Screening	HCPCS
G9920	Trauma Screening	HCPCS

26. Well-child Visit (ages 0-15 mo.) (W15)

Patient Eligibility: Patients who turned 15 months old during the measurement year

Full Credit: 73.2%

Partial Credit: 69.8%

Measure 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
- Complete the SHA Tool and Instruction Guide found here: hpsm.org/providers-forms

Do not count visits billed with a telehealth modifier or telehealth POS code.

*See procedure code list for Well-child Visits (ages 3-6)

27. Well-child Visit (ages 3-6) (W34)

Patient Eligibility: Patients age 3-6 years old during the calendar year.

Full Credit: 83.9%

Partial Credit: 78.5%

Measure Definition: The percentage of members 3–6 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 3-6 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/providers-forms
- Do not count visits billed with a telehealth modifier or telehealth POS code

Procedure Codes

Code	Definition	Code System
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
99381		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

Code	Definition	Code System
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
99394		CPT
99395		CPT
99461		CPT
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit (G0438)	HCPCS
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit (G0439)	HCPCS
Z00.110	[Z00.110] Health examination for newborn under 8 days old	ICD10CM
Z00.111	[Z00.111] Health examination for newborn 8 to 28 days old	ICD10CM
Z00.121	[Z00.121] Encounter for routine child health examination with abnormal findings	ICD10CM
Z00.129	[Z00.129] Encounter for routine child health examination without abnormal findings	ICD10CM
Z00.5	[Z00.5] Encounter for examination of potential donor of organ and tissue	ICD10CM
Z00.8	[Z00.8] Encounter for other general examination	ICD10CM
Z02.0	[Z02.0] Encounter for examination for admission to educational institution	ICD10CM
Z02.1	[Z02.1] Encounter for pre-employment examination	ICD10CM
Z02.2	[Z02.2] Encounter for examination for admission to residential institution	ICD10CM
Z02.3	[Z02.3] Encounter for examination for recruitment to armed forces	ICD10CM
Z02.4	[Z02.4] Encounter for examination for driving license	ICD10CM
Z02.5	[Z02.5] Encounter for examination for participation in sport	ICD10CM
Z02.6	[Z02.6] Encounter for examination for insurance purposes	ICD10CM
Z02.71	[Z02.71] Encounter for disability determination	ICD10CM
Z02.82	[Z02.82] Encounter for adoption services	ICD10CM
Z76.1	[Z76.1] Encounter for health supervision and care of foundling	ICD10CM

Code	Definition	Code System
Z76.2	[Z76.2] Encounter for health supervision and care of other healthy infant and child	ICD10CM

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. We appreciate working in partnership with you in caring for our members.

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.