



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

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2025 Measurement Year - Final Release

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



You may be looking for [Care Gap Pay-for-Performance Incentive Program Guidelines](#), administered through Stellar Health.

# Summary of Changes to 2025 **Medi-Cal** Benchmark Pay-for-Performance (“Benchmark P4P”)

Measures with ‘NCQA HEDIS’ listed as the ‘Metric Source’ align with the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Measurement Year 2024 (MY2024) Technical Specifications for Health Plans. The associated code lists provided herein may detail only a subset of the qualifying codes for metric inclusion and exclusion.

## **Adult Track Incentive-eligible Quality Metric Set**

### **Changed**

1. Depression Screening and Follow-up (12 years and older) (CDF) renamed **Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**.
2. Hemoglobin A1c Control for Patients with Diabetes (>9.0%) (HBD-2) renamed **Glycemic Status Assessment for Patients with Diabetes (GSD-2)** to align with NCQA HEDIS.

## **Adult Track Reporting-only Quality Metric Set**

### **Changed**

1. Hemoglobin A1c Control for Patients with Diabetes (<8.0%) (HBD-1) renamed **Glycemic Status Assessment for Patients with Diabetes (GSD-1)** to align with NCQA HEDIS.

### **Removed**

1. **Emergency Department Visits for Ambulatory Care Sensitive Condition (AMB-ED)** removed. NCQA retired the related ‘Ambulatory Care’ measure.
2. **Comprehensive Diabetes Management (CDM)** removed; component rates are being measured individually.

## **Family Practice Incentive-eligible Quality Metric Set**

### **Changed**

1. Depression Screening and Follow-up (12 years and older) (CDF) renamed **Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)**.

## **Family Practice Reporting-only Quality Metric Set**

### **Removed**

1. **Emergency Department Visits for Ambulatory Care Sensitive Condition (AMB-ED)** removed. NCQA retired the related ‘Ambulatory Care’ measure.
3. **Comprehensive Diabetes Management (CDM)** removed; component rates are being measured individually.

### **Pediatric Incentive-eligible Quality Metric Set**

Metrics within the Pediatric Incentive-eligible Quality Metric Set remain the same as MY2024.

### **Pediatric Reporting-only Quality Metric Set**

Metrics within the Pediatric Reporting-only Metric Set remain the same as MY2024.

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## I. Overview

Health Plan of San Mateo's (HPSM) Benchmark Pay-for-Performance Incentive ("Benchmark P4P" or "incentive") shares data with in-network Medi-Cal providers regarding assigned HPSM patients and offers incentives for achieving targeted quality metrics to improve population health outcomes. The quality performance metric sets focus on member access and preventive care services.

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

### Provider Eligibility

Primary care providers participate at the clinic-level. All primary care clinics are automatically opted in for incentive eligibility if they meet all the following criteria:

1. Clinic must have an active Medi-Cal primary care contract with HPSM for the entire duration between January 1, 2025 and June 30, 2026;
2. Clinic and/or associated medical group must have a minimum of 100 HPSM Medi-Cal members assigned to their panel for the entire duration of the 2025 calendar year (i.e., January 1, 2025 through December 31, 2025);
3. Clinic and/or associated medical group is not currently opted into the Care Gap Pay-for-Performance Incentive ("Care Gap P4P"), administered by Stellar Health.

### Program Tracks

Medi-Cal providers will be assigned one of three Benchmark P4P sub-tracks based on the approximate age range of members assigned to their clinic and/or associated medical group:

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

### Quality Metric Selection

Quality metrics are selected for inclusion in Benchmark P4P based on several factors, including:

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

## Benchmarks and Improvement Targets

### Standard Benchmarks

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

- National performance benchmarks
- Prior year network performance
- Critical mass thresholds for population health management

Benchmarks may be adjusted in the event no clinic meets the full credit benchmark. Decisions to adjust benchmarks are made during the incentive bonus calculation process after conclusion of the data submission period and at the sole discretion of HPSM.

### Improvement Targets

Clinics can receive partial credit for any quality metric in which their performance improves by an established margin compared to the prior Benchmark P4P Measurement Year (MY). A minimum 10% improvement “on the negative” is required to earn partial credit, when partial credit benchmark is not otherwise reached.

- Example A: If MY2024 rate = 10%, then MY2025 partial credit would be awarded for  $\geq 19\%$  (10% improvement on 90% non-compliance)
- Example B: If MY2024 rate = 90%, then MY2025 partial credit would be awarded for  $\geq 91\%$  (10% improvement on 10% non-compliance)

## Data Reports and Additional Coding Resources

Performance bonus in Benchmark P4P is contingent on meeting specified metric benchmarks for assigned patients who meet the metric criteria. Once encounter information has been received and eligibility has been determined by HPSM, providers get credit toward the annual metric benchmark. Monthly progress reports are available to providers through the HPSM eReports portal. These progress reports summarize the clinic’s progress to each metric benchmark and provide member-level details to support action to close relevant care gaps. Reports for the 2025 Program Year are published **at the beginning of each month between September 2025 and April 2026**. The website for eReports login is: <https://reports.hpsm.org>. Additional resources, including an eReports User Guide and select code lists are available at: <https://www.hpsm.org/provider/incentive-payments>.

## Timeline

Period	Dates (subject to change)	Description
<b>Measurement Year</b>	01/01/2025 – 12/31/2025	This is the anchor year for all dates of service (DOS). For metrics with a lookback period of multiple years, count 2025 as year 1.
<b>Monthly eReports Available</b>	05/01/2025 – 04/30/2026	Monthly metric performance and associated member-level reports available via HPSM eReports portal. All providers may access; contact <a href="mailto:PSInquiries@hpsm.org">PSInquiries@hpsm.org</a> for new account set up. As applicable, eReports' metric numerator and denominator inclusion/exclusion criteria align with NCQA HEDIS MY2024 Technical Specifications for Health Plans.
<b>Supplemental Data Submission Deadline</b>	03/31/2026*	All supplemental data (e.g., EMR extracts, lab submissions) must be submitted by this date to ensure inclusion for incentive calculation.
<b>Claims Submission Deadline</b>	03/31/2026	All HPSM claims and qualifying codes must be submitted by this date to ensure inclusion for incentive calculation.
<b>Attestation Period</b>	04/01/2026 – 04/30/2026	Providers may manually attest for compliance for select metrics where the claims submission process is known to not capture all relevant data. Instructions for attestation are distributed each Spring and available on the <a href="#">HPSM Provider Incentives</a> webpage.
<b>Bonus Payment Finalization</b>	06/01/2026 – 07/31/2026	HPSM compiles all performance data and calculates bonus payment as explained in the 'Incentive Bonus Calculation Formula' section. Bonus is distributed as a single electronic payment or check mailed to the financial address on file.

\*March 31 is the cut-off date for HPSM to receive established and validated files from providers. December 31 of the measurement year is the cut-off date for files being received by HSPM for the first time.

## Incentive Bonus Calculation Formula

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

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

### Formula Term Definitions

*Eligible Member Months:* Total of all member months for Medi-Cal members assigned to the clinic or associated medical group for at least 9 months during the calendar year.

- Nine (9) months of assignment do not need to be continuous.
- 1 member month = 1 member assigned for every 1 month (i.e. 12 member months = 1 member assigned for 12 months or 12 members assigned for 1 month each).
- Members receiving hospice or palliative care services are excluded from eligible member months.

*Composite Quality Score:* Average (i.e., mean) score for all earned quality points based on final performance rates following the data submission period. **For MY2025, earning full credit nets two (2) quality score points while partial credit nets one (1) point for all metrics.** For quality points to be attributed to an assigned metric, the participating provider must have at least fifteen (15) eligible patients in the denominator. If less than fifteen 15 eligible patients are in the denominator, the provider is considered ineligible for that metric and it is excluded from their composite quality score calculation.

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

*Full Credit Benchmark Bonus:* Potential 25% additional bonus amount added if the clinic or associated medical group meets all full credit benchmarks for its assigned track's quality metric set in the measurement year.

HPSM sets an earnings ceiling which is calculated utilizing the maximum potential composite quality score and network-standard capitation rates, plus the 25% additional Full Credit Benchmark Bonus.

## II. Adult Track Quality Metric Summary

Medi-Cal primary care clinics with an assigned panel of HPSM members 18 years of age and older (or a similar age range) report on the Adult Track quality metric set.

**Exclusions:** Members receiving hospice at any time during the measurement period are excluded from all metrics.

### Adult Track Incentive-eligible Quality Metric Set

Clinics earn quality score points for each Incentive-eligible Metric in which their performance meets or exceeds the full or partial credit benchmark. For all MY2025 Incentive-eligible Metrics, full credit nets two (2) quality score points and partial credit nets one (1) point. See ‘Incentive Payment Bonus Calculation Formula’ section for details. Performance benchmarks released each Summer following the conclusion of prior year data collection.

Shorthand	Incentive-eligible Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit <sup>i</sup>
BCS-E	<a href="#">Breast Cancer Screening</a>	NCQA HEDIS	63%	60%
BPD	<a href="#">Blood Pressure Control for Patients with Diabetes</a>	NCQA HEDIS	66%	54%
CBP	<a href="#">Controlling High Blood Pressure</a>	NCQA HEDIS	69%	62%
CCS-E	<a href="#">Cervical Cancer Screening</a>	NCQA HEDIS	61%	57%
DSF-E	<a href="#">Depression Screening and Follow-Up for Adolescents</a>	HPSM	48%	31%
EED	<a href="#">Eye Exam for Patients with Diabetes</a>	NCQA HEDIS	59%	56%
FLU	<a href="#">Seasonal Influenza Vaccine</a>	HPSM	68%	57%
GSD-2*	<a href="#">Glycemic Status Assessment for Patients with Diabetes: &gt;9.0%</a>	NCQA HEDIS	25%	33%
IHA	<a href="#">Initial Health Appointment</a>	HPSM	63%	50%
SBIRT	<a href="#">Substance Misuse Screening</a>	HPSM	47%	30%

\*Inverted metric; lower rate indicates better performance.

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

## Adult Reporting-only Quality Metric Set

HPSM collects and monitors performance data on “reporting-only” metrics. Reporting-only metrics are not included in incentive calculations but are subject for inclusion as incentive-eligible metrics in future P4P measurement years. While provider performance is not measured against benchmarks, HPSM shares back prior year network performance data to encourage performance improvement.

Shorthand	Reporting-Only Metric Name	Metric Source
ACE	<a href="#">Trauma Screening (Adverse Childhood Experiences)</a>	HPSM
Avoid-ED*	<a href="#">Avoidable Emergency Department Visits</a>	HPSM
CHA	<a href="#">Cognitive Health Assessment</a>	HPSM
CHL	<a href="#">Chlamydia Screening in Women (16-24 years old)</a>	HEDIS
GSD-1	<a href="#">Glycemic Status Assessment for Patients with Diabetes: &lt;8.0%</a>	HEDIS
KED	<a href="#">Kidney Health Evaluation for Patients with Diabetes</a>	HEDIS
PCR*	<a href="#">Plan All-Cause Readmissions</a>	HEDIS
SDoH	<a href="#">Z-Coding for Social Determinants of Health</a>	HPSM
TBC	<a href="#">Tobacco Use Screening and Cessation Intervention (12 years and older)</a>	HPSM

\*Inverted metric; lower rate indicates better performance.

### III. Family Practice Track Quality Metric Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 999 years of age (no maximum) or a similar age range report on the Family Practice quality metric set.

**Exclusions:** Members receiving hospice at any time during the measurement period are excluded from all metrics.

#### Family Practice Incentive-eligible Quality Metric Set

Clinics earn quality score points for each Incentive-eligible Metric in which their performance meets or exceeds the full or partial credit benchmark. For all MY2025 Incentive-eligible Metrics, full credit nets two (2) quality score points and partial credit nets one (1) point. See ‘Incentive Payment Bonus Calculation Formula’ section for details. Performance benchmarks released each Summer following the conclusion of prior year data collection.

Shorthand	Incentive-eligible Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit <sup>ii</sup>
<b>BCS-E</b>	<a href="#">Breast Cancer Screening</a>	NCQA HEDIS	63%	60%
<b>CBP</b>	<a href="#">Controlling High Blood Pressure</a>	NCQA HEDIS	69%	62%
<b>CCS-E</b>	<a href="#">Cervical Cancer Screening</a>	NCQA HEDIS	61%	58%
<b>DSF-E</b>	<a href="#">Depression Screening &amp; Follow Up (12 years and older)</a>	HPSM	61%	48%
<b>EED</b>	<a href="#">Eye Exam for Patients with Diabetes</a>	NCQA HEDIS	61%	58%
<b>FLU</b>	<a href="#">Seasonal Influenza Vaccine</a>	HPSM	68%	57%
<b>GSD-2*</b>	<a href="#">Glycemic Status Assessment for Patients with Diabetes: &gt;9.0%</a>	NCQA HEDIS	28%	33%
<b>IHA</b>	<a href="#">Initial Health Appointment</a>	NCQA HEDIS	73%	64%
<b>W30-6</b>	<a href="#">Well Child Visit (0-15 months old)</a>	NCQA HEDIS	70%	65%
<b>WCV</b>	<a href="#">Well Child and Adolescent Visit (3 – 21 years old)</a>	NCQA HEDIS	65%	58%

\*Inverted metric; lower rate indicates better performance.

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

## Family Practice Reporting-only Quality Metric Set

HPSM collects and monitors performance data on “reporting-only” metrics. Reporting-only metrics are not included in incentive calculations but are subject for inclusion as incentive-eligible metrics in future P4P measurement years. While provider performance is not measured against benchmarks, HPSM shares back prior year network performance data to encourage performance improvement.

Shorthand	Reporting-Only Metric Name	Metric Source
<b>ACE</b>	<a href="#">Trauma Screening (Adverse Childhood Experiences)</a>	HPSM
<b>Avoid-ED*</b>	<a href="#">Avoidable Emergency Department Visits</a>	HPSM
<b>BPD</b>	<a href="#">Blood Pressure Control for Patients with Diabetes</a>	NCQA HEDIS
<b>CHA</b>	<a href="#">Cognitive Health Assessment</a>	HPSM
<b>CHL</b>	<a href="#">Chlamydia Screening in Women (16 – 24 years old)</a>	NCQA HEDIS
<b>CIS-10</b>	<a href="#">Childhood Immunizations (Combination 10)</a>	NCQA HEDIS
<b>DEV</b>	<a href="#">Developmental Screening</a>	HPSM
<b>FVN</b>	<a href="#">Fluoride Varnish</a>	HPSM
<b>GSD-1</b>	<a href="#">Glycemic Status Assessment for Patients with Diabetes: &lt;8.0%</a>	NCQA HEDIS
<b>IMA-2</b>	<a href="#">Immunizations for Adolescent (Combination 2)</a>	NCQA HEDIS
<b>KED</b>	<a href="#">Kidney Health Evaluation for Patients with Diabetes</a>	NCQA HEDIS
<b>PCR*</b>	<a href="#">Plan All-Cause Readmissions</a>	NCQA HEDIS
<b>SBIRT</b>	<a href="#">Substance Misuse Screening and Follow Up (12 years and older)</a>	HPSM
<b>SDoH</b>	<a href="#">Z-Coding for Social Determinants of Health</a>	HPSM
<b>TBC</b>	<a href="#">Tobacco Use Screening and Cessation Intervention (12 years and older)</a>	HPSM

Shorthand	Reporting-Only Metric Name	Metric Source
<b>W30-2</b>	<a href="#">Well Child Visit (15-30 months)</a>	NCQA HEDIS
<b>WCC-BMI</b>	<a href="#">Pediatric BMI Assessment</a>	NCQA HEDIS
<b>WCC-N</b>	<a href="#">Nutrition Counseling for Children</a>	NCQA HEDIS
<b>WCC-PA</b>	<a href="#">Physical Activity Counseling for Children</a>	NCQA HEDIS

*\*Inverted metric; lower rate indicates better performance.*

## IV. Pediatric Track Quality Metric Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 18 years of age (or similar ranges) report on the Pediatric quality metric set.

**Exclusions:** Members receiving hospice at any time during the measurement period are excluded from all metrics.

### Pediatric Incentive-eligible Quality Metric Set

Clinics earn quality score points for each Incentive-eligible Metric in which their performance meets or exceeds the full or partial credit benchmark. For all MY2025 Incentive Metrics, earning full credit nets two (2) quality score points and partial credit nets one (1) point. See ‘Incentive Payment Bonus Calculation Formula’ section for details. Performance benchmarks released each Summer following the conclusion of prior year data collection.

Shorthand	Incentive-eligible Metric Name	Metric Source	Performance Benchmarks	
			Full Credit	Partial Credit <sup>iii</sup>
<b>CIS-10</b>	<a href="#">Childhood Immunizations (Combination 10)</a>	NCQA HEDIS	64%	52%
<b>DSF-E</b>	<a href="#">Depression Screening and Follow Up (12 years and older)</a>	HPSM	81%	75%
<b>FLU</b>	<a href="#">Seasonal Influenza Vaccine</a>	HPSM	70%	60%
<b>IMA-2</b>	<a href="#">Immunizations for Adolescent (Combination 2)</a>	NCQA HEDIS	68%	57%
<b>SBIRT</b>	<a href="#">Substance Misuse Screening</a>	NCQA HEDIS	65%	53%
<b>TBC</b>	<a href="#">Tobacco Use Screening and Cessation Intervention (12 years and older)</a>	HPSM	52%	36%
<b>W30-6</b>	<a href="#">Well Child Visit (0-15 months old)</a>	NCQA HEDIS	70%	65%
<b>WCC-N</b>	<a href="#">Weight Assessment &amp; Nutrition Counseling for Children</a>	NCQA HEDIS	83%	80%
<b>WCC-PA</b>	<a href="#">Physical Activity Counseling for Children</a>	NCQA HEDIS	81%	77%
<b>WCV</b>	<a href="#">Well Child and Adolescent Visit (3-21 years old)</a>	NCQA HEDIS	65%	58%

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

## Pediatric Reporting-only Quality Metric Set

HPSM collects and monitors performance data on “reporting-only” metrics. Reporting-only metrics are not included in incentive calculations but are subject for inclusion as incentive-eligible metrics in future P4P measurement years. While provider performance is not measured against benchmarks, HPSM shares back prior year network performance data to encourage performance improvement.

Shorthand	Reporting-Only Metric Name	Metric Source
<b>ACE</b>	<a href="#">Trauma Screening (Adverse Childhood Experiences)</a>	HPSM
<b>Avoid-ED*</b>	<a href="#">Avoidable Emergency Department Visit</a>	HPSM
<b>CHL</b>	<a href="#">Chlamydia Screening in Women (16-24 years old)</a>	HEDIS
<b>DEV</b>	<a href="#">Developmental Screening</a>	HPSM
<b>FVN</b>	<a href="#">Fluoride Varnish</a>	HPSM
<b>IHA</b>	<a href="#">Initial Health Appointment</a>	HPSM
<b>SDoH</b>	<a href="#">Z-Coding for Social Determinants of Health</a>	HPSM
<b>W30-2</b>	<a href="#">Well Child Visit (15-30 months old)</a>	HEDIS
<b>WCC-BMI</b>	<a href="#">Pediatric BMI Assessment</a>	HEDIS

*\*Inverted metric; lower rate indicates better performance.*

## V. Quality Metric Specifications

### ACE: Adverse Childhood Experiences Trauma Screening

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

**Source:** California Department of Health Care Services (DHCS), under Proposition 56 directed payments.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Background:** Eligible providers continue to receive directed payments of \$29 per screening via Proposition 56 funds. To participate, providers must complete and attest to a free two-hour training on the science of ACEs and toxic stress. Providers may also earn Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits through this training.

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

**Definition:** Percentage of assigned HPSM Medi-Cal members under age 21 screened for ACEs using the *Pediatric ACEs and Related Life-events Screener (PEARLS)* tool during the measurement period.

**Denominator:** Assigned HPSM Medi-Cal members under age 21.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes during the measurement period:

- Trauma Screening Healthcare Common Procedure Coding System (HCPCS) Codes:

Code	Definition	Code System
<b>G9919</b>	Trauma Screening: Positive screen with patient score of 4 or greater	HCPCS
<b>G9920</b>	Trauma Screening: Negative screen with patient score of 0 to 3	HCPCS

## Avoid-ED: Avoidable Emergency Department Visits

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

**Source:** HPSM internal metric.

**Type:** Percentage.

**Aim:** Lower percentage indicates quality performance.

**Definition:** The percentage of avoidable emergency department (ED) visits among assigned HPSM Medi-Cal members 1 year of age and older.

**Denominator:** Assigned HPSM Medi-Cal members 1 year of age and older with an ED visit during the measurement period.

**Numerator:** Members meeting denominator inclusion criteria whose primary diagnosis for the ED visit HPSM qualifies as an 'avoidable ED visit'.

Refer to <https://www.hpsm.org/provider/value-based-payment> for the complete list of qualifying *Avoidable ED Visit Codes*.

## BCS-E: Breast Cancer Screening

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 50–74 years of age recommended for routine breast cancer screening who had a mammogram to screen for breast cancer.

**Denominator:** Assigned HPSM Medi-Cal members 50-74 years of age recommended for routine breast cancer screening.

Additional Additional exclusions:

- Members who had a bilateral mastectomy or both right and left unilateral mastectomies prior to the end of the measurement period.
- Members who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria prior to the end of the measurement period.
- Members excluded from mammography for documented medical reasons.

### Mammography Exclusion Code

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

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

## Mammography Procedure Codes

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

## BPD: Blood Pressure Control for Patients with Diabetes

Adult	Family Practice	Pediatrics
Incentive-eligible	Reporting-only	Not Included

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18–75 years of age with diabetes (types 1 and 2) whose most recent blood pressure (BP) reading was adequately controlled (<140/90 mm Hg).

**Denominator:** Member 18-75 years old with diabetes (types 1 or 2) as identified by either:

- Claim/encounter data documenting at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data documenting the member was dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year.

**Numerator:** Members meeting denominator inclusion criteria for whom the most recent BP taken during the measurement period is <140/90 mm Hg, as documented through administrative data or medical record review. Must include both systolic and diastolic blood pressure results as documented through administrative data.

### Diabetes Blood Pressure Procedure Codes

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

## CBP: Controlling High Blood Pressure

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement period.

**Denominator:** Assigned HPSM Medi-Cal members 18-85 years old who had at least two visits (outpatient, telephone, e-visit, or virtual) on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

### Additional Exclusions:

- Members with a diagnosis that indicates end-stage renal disease (ESRD) on or prior to December 31 of the measurement year.
- Members with a procedure that indicates ESRD: dialysis, nephrectomy, or kidney transplant on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy any time during the measurement year.
- Members who had a nonacute inpatient admission during the measurement year.

**Numerator:** Members meeting denominator inclusion criteria for whom the most recent BP reading taken in an outpatient setting during the measurement year is <140/90 mm Hg. The representative BP reading must be taken on or after the date of the second diagnosis of hypertension.

- The member is not compliant if the BP is  $\geq 140/90$  mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
- If there are multiple BPs on the same date of service, the lowest systolic and lowest diastolic BP are used.

### Hypertension Diagnosis Code

Code	Definition	Code System
I10	Essential (primary) hypertension	ICD10CM

## Blood Pressure Reading Codes

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

## CCS-E: Cervical Cancer Screening

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 21–64 years of age recommended and screened for cervical cancer screening who were screened for cervical cancer.

**Denominator:** Assigned HPSM Medi-Cal members 21–64 years of age who were recommended for routine cervical cancer screening.

Additional exclusions:

- 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, 2022 may be excluded (see “[Cervical Cancer Exclusion Codes](#)”)

### Cervical Cancer Screening Exclusion Codes

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

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

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation of cervical cancer screening within the measurement period per one of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years (36 calendar months).
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years (72 calendar months).
- Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

### Cervical Cancer Screening Procedure Codes

Code	Definition	Code System
<b>88141</b>	Cervical Cytology	CPT
<b>88142</b>	Cervical Cytology	CPT
<b>88143</b>	Cervical Cytology	CPT
<b>88147</b>	Cervical Cytology	CPT
<b>88148</b>	Cervical Cytology	CPT
<b>88150</b>	Cervical Cytology	CPT
<b>88152</b>	Cervical Cytology	CPT
<b>88153</b>	Cervical Cytology	CPT
<b>88154</b>	Cervical Cytology	CPT
<b>88164</b>	Cervical Cytology	CPT
<b>88165</b>	Cervical Cytology	CPT
<b>88166</b>	Cervical Cytology	CPT
<b>88167</b>	Cervical Cytology	CPT
<b>88174</b>	Cervical Cytology	CPT
<b>88175</b>	Cervical Cytology	CPT
<b>G0123</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision (G0123)	HCPCS
<b>G0124</b>	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician (G0124)	HCPCS

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

## HPV Testing Codes

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

## CHA: Cognitive Health Assessment

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

**Source:** HPSM internal metric, in compliance with the California Department of Health Care Services (DHCS) [All Plan Letter \(APL\) 22-025](#).

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 65 and older who received an eligible cognitive health assessment in the measurement year.

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

**Denominator:** Assigned HPSM Medi-Cal members 65 years of age and older.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation confirming an eligible cognitive health assessment was completed within the measurement period. Eligible Cognitive assessment tools used to determine if a full dementia evaluation is needed include, but are not limited to:

- Patient assessment tools
  - General Practitioner assessment of Cognition (GPCOG)
  - Mini-Cog
- Informant tools (family members and close friends)
  - Eight-item Informant Interview to Differentiate Aging and Dementia
  - GPCOG
  - Short Informant Questionnaire on Cognitive Decline in the Elderly

## Cognitive Health Assessment Procedure Codes

Code	Definition	Code System
<b>96116</b>	Neuropsychological testing	CPT
<b>96136</b>	Neuropsychological testing	CPT
<b>96138</b>	Neuropsychological testing	CPT
<b>96146</b>	Neuropsychological testing	CPT
<b>99483</b>	Neuropsychological testing	CPT
<b>71492-3</b>	Total Score, Saint Louis University Mental Status examination (SLUMS)	LOINC
<b>71947-6</b>	Saint Louis University Mental Status examination (SLUMS)	LOINC
<b>72088-8</b>	Clinical Dementia Rating (CDR)	LOINC
<b>72106-8</b>	Total Score, Mini-Mental State Examination (MMSE)	LOINC
<b>72107-6</b>	Mini-Mental State Examination (MMSE)	LOINC
<b>72133-2</b>	Montreal Cognitive Assessment [MoCA]	LOINC
<b>72172-0</b>	Total Score, Montreal Cognitive Assessment [MoCA]	LOINC
<b>72233-0</b>	Total Score, Mini-cog	LOINC
<b>72234-8</b>	Mini-cog	LOINC

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

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

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.

**Denominator:** Assigned HPSM Medi-Cal members 16–24 years of age identified as sexually active and recommended for routine chlamydia screening.

Additional Additional exclusions:

- Members for whom the assigned sex at birth was male.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

### Chlamydia Testing Codes

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

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

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

**Source:** Combination 10 of the [NCQA HEDIS](#) metric CIS-E.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 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.

**Denominator:** Assigned HPSM Medi-Cal members who turn 2 years of age during the measurement period.

Additional Additional exclusions:

- Members who had a contraindication to an included vaccine on or before their second birthday.
- Members who had an organ or bone marrow transplant on or before their second birthday.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received documentation of sufficient compliance for each of the following criteria on or before the child’s second birthday:

- Diphtheria, tetanus and acellular pertussis (DTaP)
  - At least four DTaP vaccinations, with different dates of service on or after 42 days after birth.
  - Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine.
  - Encephalitis due to the diphtheria, tetanus or pertussis vaccine.
- Polio (IPV)
  - At least three IPV vaccinations with different dates of service on or after 42 days after birth.
  - Anaphylaxis due to the IPV vaccine.
- Measles, mumps and rubella (MMR)
  - At least one MMR vaccination on or between the child’s first and second birthdays.
  - All of the following any time on or before the child’s second birthday:
    - History of measles illness.
    - History of mumps illness.
    - History of rubella illness.

- Anaphylaxis due to the MMR vaccine.
- Haemophilus influenza type B (HiB)
  - At least three HiB vaccinations with different dates of service on or after 42 days after birth.
  - Anaphylaxis due to the HiB vaccine.
- Hepatitis B (HepB)
  - At least three hepatitis B vaccinations with different dates of service.
    - One of the three vaccinations may be a newborn hepatitis B vaccination (ICD-10-PCS code 3E0234Z) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
  - History of hepatitis B illness.
  - Anaphylaxis due to the hepatitis B vaccine.
- Chicken pox (VZV)
  - At least one VZV vaccination with a date of service on or between the child's first and second birthdays.
  - History of varicella zoster (e.g., chicken pox) illness on or before the child's second birthday.
  - Anaphylaxis due to the VZV vaccine.
- Pneumococcal conjugate (PCV)
  - At least four pneumococcal conjugate vaccinations with different dates of service on or after 42 days after birth.
  - Anaphylaxis due to the pneumococcal vaccine.
- Hepatitis A (HepA)
  - At least one hepatitis A vaccination with a date of service on or between the child's first and second birthdays.
  - History of hepatitis A illness.
  - Anaphylaxis due to the hepatitis A vaccine.
- Rotavirus (RV)
  - At least two doses of the two-dose rotavirus vaccine on different dates of service on or after 42 days after birth.
  - At least three doses of the three-dose rotavirus vaccine on different dates of service on or after 42 days after birth.

- At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine all on different dates of service on or after 42 days after birth.
- Anaphylaxis due to the rotavirus vaccine.
- Influenza (flu)
  - At least two influenza vaccinations with different dates of service on or after 180 days after birth.
    - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) administered on the child’s second birthday meets criteria for one of the two required vaccinations.
  - Anaphylaxis due to the influenza vaccine.

### CIS Procedure Codes

Code	Definition	Code System
90700	DTaP Vaccine Procedure	CPT
90721	DTaP Vaccine Procedure	CPT
90723	DTaP Vaccine Procedure	CPT
90633		CPT
90644	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90645	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90646	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90647	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90648	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90698	Haemophilus Influenzae Type B (HiB) Vaccine Procedure/DTaP Vaccine Procedure	CPT
90721	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
90748	Haemophilus Influenzae Type B (HiB) Vaccine Procedure	CPT
B15.0	Hepatitis A with hepatic coma	ICD10CM
B15.9	Hepatitis A without hepatic coma	ICD10CM
B16.0	Acute hepatitis B with delta-agent with hepatic coma	ICD10CM
B16.1	Acute hepatitis B with delta-agent without hepatic coma	ICD10CM
B16.2	Acute hepatitis B without delta-agent with hepatic coma	ICD10CM

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

## DEV: Developmental Screening

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

**Source:** DHCS, under Proposition 56 directed payments in compliance with [APL 23-016](#)

**Type:** Percentage

**Aim:** Higher percentage indicates quality performance.

**Background:** Providers continue to receive directed payments via Proposition 56 funds. Providers receive \$59.90 for each eligible developmental screening performed and reported using the Current Procedural Terminology (CPT) code 96110, without the KX modifier used to document screening for Autism Spectrum Disorder (ASD). **Note:** FQHCs are excluded from Prop 56 directed payments. For more information, please refer to the DHCS guidance at:

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

**Definition:** Percentage of assigned HPSM Medi-Cal members 30 months of age receiving developmental screening using standardized developmental screening tools during the periodic pediatric health visits that occur at 9 months, 18 months and 30 months.

**Denominator:** Assigned HPSM Medi-Cal members 30 months of age.

Additional Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days during the measurement year.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received the CPT code 96110, without the KX modifier used to document screening for ASD, indicating developmental screenings, with scoring and documentation per a standardized instrument, were conducted during periodic health visits at 9 months, 18 months and 30 months per the following criteria:

- ‘9-month’ developmental screening conducted on or before the first birthday.
- ‘18-month’ developmental screening conducted after the first birthday and before or on the second birthday.
- ‘30-month’ developmental screening after the second birthday and on or before the 30-month birthday.
- Providers must use a validated and age-appropriate standardized screening tool that meets the criteria set forth by the American Academy of Pediatrics (AAP) and the Centers for Medicare and Medicaid Services (CMS). The following tools currently meet the aforementioned criteria and are approved by DHCS:
  - Ages and Stages Questionnaire (ASQ) - 4 months to age 5
  - Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
  - Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months

- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Providers must document and retain all of the following in the member's medical record:
  - Tool that was used
  - Completed screen was reviewed
  - Results of the screen
  - Interpretation of results
  - Discussion with the member and/or family
  - Any appropriate actions taken. This documentation
- CPT code 96110, without the KX modifier used to document screening for Autism Spectrum Disorder.
- Additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX.

### Developmental Screening Procedure Codes

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

## DSF-E: Depression Screening and Follow-Up for Adolescents and Adults

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Incentive-eligible

**Source:** HPSM internal metric, modified from the [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 12 years of age and older with an outpatient visit who were screened for clinical depression and, if screened positive, received follow-up care.

**Denominator:** Assigned HPSM Medi-Cal members 12 years old and up (patients who will turn 13 years of age as of December 31<sup>st</sup> of the measurement year) who had an outpatient visit during the measurement period.

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

Additional exclusions:

- Members who have a documented active diagnosis of depression or bipolar disorder.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient document of a completed screening for clinical depression and, if screened positive, follow-up care.

- Screening tool may be a standardized instrument or the HPSM Behavioral Health Screening tool available at: [hpsm.org/provider-forms](https://www.hpsm.org/provider-forms), which includes PHQ-2 standard screening questions.
- Screening must be documented in patient’s medical record.
- If screening is positive, follow-up plan must be documented on the same date as a positive screen.

## Depression Screening Procedure Codes

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

## EED: Eye Exam for Patients with Diabetes

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18–75 years of age with a diagnosis of diabetes (types 1 and 2) with sufficient documentation of screening or monitoring for diabetic retinal disease as identified by administrative data.

**Denominator:** Assigned HPSM Medi-Cal members 18 -75 years of age with a diagnosis of diabetes (types 1 or 2) as identified by claim/encounter data and/or pharmacy data. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

- Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

### Additional exclusions:

- Bilateral absence of eyes any time during the member’s history through December 31 of the measurement year.
- Bilateral eye enucleation any time during the member’s history through December 31 of the measurement year:
  - Unilateral eye enucleation with a bilateral modifier (CPT Modifier code 50).
  - Two unilateral eye enucleations with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
  - Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service.
  - A unilateral eye enucleation and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart.
  - A unilateral eye enucleation and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart.

*NOTE: Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*

**Numerator:** Members meeting denominator inclusion criteria for whom there is sufficient documentation of screening or monitoring for diabetic retinal disease via administrative data.

- This includes people with diabetes who had one of the following:
  - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
  - A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Any of the following meet criteria:
  - Retinal eye exam billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
  - Retinal eye exam billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications.
  - Eye exam with evidence of retinopathy billed by any provider type during the measurement year.
  - Eye exam without evidence of retinopathy billed by any provider type during the year prior to the measurement year.
  - Retinal imaging with interpretation and reporting by a qualified reading center billed by any provider type during the measurement year.
  - Automated Autonomous eye exam (CPT code 92229) billed by any provider type during the measurement year.
  - Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F) billed by any provider type during the measurement year.
  - Any combination that indicates findings from a retinal exam for diabetic retinopathy performed in both the left and right eye by any provider, or a combination that indicates one eye is enucleated and the other was examined.

## 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
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

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>92002</b>	Diabetic Retinal Screening	CPT
<b>92004</b>	Diabetic Retinal Screening	CPT
<b>92012</b>	Diabetic Retinal Screening	CPT
<b>92014</b>	Diabetic Retinal Screening	CPT
<b>92018</b>	Diabetic Retinal Screening	CPT
<b>92019</b>	Diabetic Retinal Screening	CPT
<b>92134</b>	Diabetic Retinal Screening	CPT
<b>92225</b>	Diabetic Retinal Screening	CPT
<b>92226</b>	Diabetic Retinal Screening	CPT
<b>92227</b>	Diabetic Retinal Screening	CPT
<b>92228</b>	Diabetic Retinal Screening	CPT
<b>92230</b>	Diabetic Retinal Screening	CPT
<b>92235</b>	Diabetic Retinal Screening	CPT
<b>92240</b>	Diabetic Retinal Screening	CPT
<b>92250</b>	Diabetic Retinal Screening	CPT
<b>92260</b>	Diabetic Retinal Screening	CPT
<b>99203</b>	Diabetic Retinal Screening	CPT
<b>99204</b>	Diabetic Retinal Screening	CPT
<b>99205</b>	Diabetic Retinal Screening	CPT
<b>99213</b>	Diabetic Retinal Screening	CPT
<b>99214</b>	Diabetic Retinal Screening	CPT
<b>99215</b>	Diabetic Retinal Screening	CPT
<b>99242</b>	Diabetic Retinal Screening	CPT
<b>99243</b>	Diabetic Retinal Screening	CPT
<b>99244</b>	Diabetic Retinal Screening	CPT
<b>99245</b>	Diabetic Retinal Screening	CPT

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>S0620</b>	Diabetic Retinal Screening	HCPCS
<b>S0621</b>	Diabetic Retinal Screening	HCPCS
<b>S3000</b>	Diabetic Retinal Screening	HCPCS
<b>3072F</b>	Diabetic Retinal Screening Negative	CPT II
<b>2022F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>2023F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>2024F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>2025F</b>	Diabetic Retinal Screening With Eye Care Professional	CPTII
<b>2026F</b>	Diabetic Retinal Screening With Eye Care Professional	CPTII
<b>2033F</b>	Diabetic Retinal Screening With Eye Care Professional	CPT II
<b>65091</b>	Unilateral Eye Enucleation	CPT
<b>65093</b>	Unilateral Eye Enucleation	CPT
<b>65101</b>	Unilateral Eye Enucleation	CPT
<b>65103</b>	Unilateral Eye Enucleation	CPT
<b>65105</b>	Unilateral Eye Enucleation	CPT
<b>65110</b>	Unilateral Eye Enucleation	CPT
<b>65112</b>	Unilateral Eye Enucleation	CPT
<b>65114</b>	Unilateral Eye Enucleation	CPT
<b>08B10ZX</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B10ZZ</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B13ZX</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B13ZZ</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B1XZX</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B1XZZ</b>	Unilateral Eye Enucleation Left	ICD10PCS
<b>08B00ZX</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B00ZZ</b>	Unilateral Eye Enucleation Right	ICD10PCS

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>08B03ZX</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B03ZZ</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B0XZX</b>	Unilateral Eye Enucleation Right	ICD10PCS
<b>08B0XZZ</b>	Unilateral Eye Enucleation Right	ICD10PCS

## FLU: Seasonal Influenza Vaccination

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Incentive-eligible

**Source:** HPSM internal metric.

**Type:** Percentage

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 6 months and older receiving a seasonal flu vaccination July 1, 2025 through March 31, 2026.

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

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

Additional exclusions:

- Diagnosis of pregnancy during the measurement period.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation a flu vaccine was administered between July of the measurement year through March of the following calendar year *OR* evidence of flu vaccine from California Immunization Registry (CAIR) administered July of the measurement year through March of the following calendar year.

### Flu Vaccine Procedure Codes

Code	Definition	Code System
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	CPT
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	CPT
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	CPT
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	CPT
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	CPT
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	CPT

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>90662</b>	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	CPT
<b>90672</b>	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	CPT
<b>90673</b>	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
<b>90674</b>	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
<b>90682</b>	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
<b>90685</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
<b>90686</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
<b>90687</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	CPT
<b>90688</b>	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	CPT
<b>90689</b>	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use	CPT
<b>90694</b>	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use	CPT
<b>90756</b>	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use	CPT
<b>Q2034</b>	Influenza virus vaccine, split virus, for intramuscular use (agriflu)	HCPCS
<b>Q2035</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (afluria)	HCPCS
<b>Q2036</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (flulaval)	HCPCS
<b>Q2037</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluvirin)	HCPCS
<b>Q2038</b>	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (fluzone)	HCPCS
<b>Q2039</b>	Influenza virus vaccine, not otherwise specified	HCPCS
<b>G0008</b>	Administration of influenza virus vaccine	HCPCS

## FVN: Fluoride Varnish

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

**Source:** HPSM internal metric.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** Percentage of assigned HPSM Medi-Cal members ages 0-5 who received fluoride varnish at least two times during the measurement period.

**Denominator:** Assigned HPSM Medi-Cal members 0-5 years of age.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period:

### Fluoride Varnish Procedure Codes

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

## GSD-1: Glycemic Status Assessment for Patients with Diabetes: <8.0%

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

**Source:** Rate 1 of the [NCQA HEDIS](#) metric GSD.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18–75 years of age with a diagnosis of diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was <8.0% during the measurement year as identified by automated laboratory data or administrative data.

**Denominator:** Assigned HPSM Medi-Cal members 18 -75 years old with a diagnosis of diabetes (types 1 or 2) as identified by claim/encounter data and/or pharmacy data. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

- Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

**Numerator:** Members meeting denominator inclusion criteria for whom the most recent glycemic status assessment (HbA1c or GMI) received by HPSM during the measurement year was <8.0%.

- The member is not numerator compliant if the result of the most recent glycemic status assessment is  $\geq 8.0\%$  or is missing a result, or if a glycemic status assessment was not done during the measurement year.
- If there are multiple glycemic status assessments on the same date of service, the lower result will be used.

## Diabetes Glycemic Status Procedure Codes

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

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

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

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

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

## GSD-2: Glycemic Status Assessment for Patients with Diabetes: >9.0%

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Not Included

**Source:** Rate 2 of the [NCQA HEDIS](#) metric GSD.

**Type:** Percentage.

**Aim:** Lower percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18–75 years of age with a diagnosis of diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% during the measurement year as identified by automated laboratory data or administrative data.

**Denominator:** Assigned HPSM Medi-Cal members 18 -75 years old with a diagnosis of diabetes (types 1 or 2) as identified by claim/encounter data and/or pharmacy data. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

- Claim/encounter data: Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- Pharmacy data: Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

**Numerator:** Members meeting denominator inclusion criteria for whom the most recent glycemic status assessment (HbA1c or GMI) received by HPSM during the measurement year was >9.0%.

- The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year.
- The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is  $\leq 9.0\%$ .
- If there are multiple glycemic status assessments on the same date of service, the lower result will be used.

## Diabetes Glycemic Status Procedure Codes

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

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

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

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

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

## IHA: Initial Health Appointment

Adult	Family Practice	Pediatrics
Incentive-eligible	Incentive-eligible	Reporting-Only

**Source:** HPSM internal metric.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** Percent of newly enrolled and assigned HPSM Medi-Cal members who had an Initial Health Appointment (IHA) 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.

**Denominator:** Newly enrolled assigned HPSM Medi-Cal members (within 120 days of Health Plan enrollment AND 90 days of assignment to primary care panel).

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the IHA Procedure Codes within the measurement period, per the requirements below:

A complete IHA must:

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

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

## IHA Procedure Codes

Code	Definition	Code System
99201	Office/Outpt E&M New Minor 10	CPT
99202	Office/Outpt E&M New Low-Mod	CPT
99203	Office/Outpt E&M New Mod Seve	CPT
99204	Office/Outpt E&M New Mod-Hi 4	CPT
99205	Office/Outpt E&M New Mod-Hi 6	CPT
99211	Office/Outpt E&M Estab 5 Min	CPT
99212	Office/Outpt E&M Estab Minor	CPT
99213	Office/Outpt E&M Estab Low-Mo	CPT
99214	Office/Outpt E&M Estab Mod-Hi	CPT
99215	Office/Outpt E&M Estab Mod-Hi	CPT
99241	Office Cons New/Estab Minor 1	CPT
99242	Office Cons New/Est Lo Sever	CPT
99243	Office Cons New/Estab Mod 40	CPT
99244	Office Cons New/Estab Mod-Hi	CPT
99245	Office Cons New/Estab Mod-Hi	CPT
99304	Nursing Facility Care Init	CPT
99305	Nursing Facility Care Init	CPT
99306	Nursing Facility Care Init	CPT
99307	Nursing Fac Care Subseq	CPT
99308	Nursing Fac Care Subseq	CPT
99309	Nursing Fac Care Subseq	CPT
99310	Nursing Fac Care Subseq	CPT
99315	Nurs Facil D/C Da Mgmt; 30 M	CPT
99316	Nurs Facil D/C Da Mgmt; > 30	CPT
99318	Annual Nursing Fac Assessmnt	CPT

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
99324	Domicil/R-Home Visit New Pat	CPT
99325	Domicil/R-Home Visit New Pat	CPT
99326	Domicil/R-Home Visit New Pat	CPT
99327	Domicil/R-Home Visit New Pat	CPT
99328	Domicil/R-Home Visit New Pat	CPT
99334	Domicil/R-Home Visit Est Pat	CPT
99335	Domicil/R-Home Visit Est Pat	CPT
99336	Domicil/R-Home Visit Est Pat	CPT
99337	Domicil/R-Home Visit Est Pat	CPT
99341	Home Visit E&M New Pt Lo Sev	CPT
99342	Home Visit E&M New Pt Mod Se	CPT
99343	Home Visit E&M New Pt Mod-Hi	CPT
99344	Home Visit E&M New Pt Hi Sev	CPT
99345	Home Visit E&M New Pt Unstbl	CPT
99347	Home Visit E&M Estab Minor-1	CPT
99348	Home Visit E&M Estab Low-Mod	CPT
99349	Home Visit E&M Estab Mod-Hi	CPT
99350	Home Visit E&M Estab Mod-Hi	CPT
99354	Prolong Md Serv Outpt W/Pt;	CPT
99355	Prolong Md Serv Outpt W/Pt;	CPT
99381	Init Preven Meds E&M New Pt;	CPT
99382	Init Preven Meds E&M New Pt;	CPT
99383	Init Preven Meds E&M New Pt;	CPT
99384	Init Preven Meds E&M New Pt;	CPT
99385	Init Preven Meds E&M New Pt;	CPT
99386	Init Preven Meds E&M New Pt;	CPT

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>99387</b>	Init Preven Meds E&M New Pt;	CPT
<b>99391</b>	Preven Meds E&M Estab Pt; In	CPT
<b>99392</b>	Preven Meds E&M Estab Pt; 1-	CPT
<b>99393</b>	Preven Meds E&M Estab Pt; 5-	CPT
<b>99394</b>	Preven Meds E&M Estab Pt; 12	CPT
<b>99395</b>	Preven Meds E&M Estab Pt; 18	CPT
<b>99396</b>	Preven Meds E&M Estab Pt; 40	CPT
<b>99397</b>	Preven Meds E&M Estab Pt; 65	CPT
<b>99401</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99402</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99403</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99404</b>	Preven Med Counsl (Sep Pro);	CPT
<b>99411</b>	Preven Med Counsl Grp (Sep P	CPT
<b>99412</b>	Preven Med Counsl Grp (Sep P	CPT
<b>99420</b>	Admin/Intrpt Health Risk Ass	CPT
<b>99429</b>	Unlisted Preven Meds Serv	CPT
<b>99444</b>	Online E/M By Phys	CPT
<b>99446</b>	Interprof Phone/Online 5-10	CPT
<b>99447</b>	Interprof Phone/Online 11-2	CPT
<b>99448</b>	Interprof Phone/Online 21-3	CPT
<b>99449</b>	Interprof Phone/Online 31/>	CPT
<b>99450</b>	Basic Life &/Or Disability E	CPT
<b>99455</b>	Work Relat/Disabl Exam-Treat	CPT
<b>99456</b>	Work Relat/Disabl Exam-Not T	CPT
<b>G0402</b>	Initial Preventive Exam	HCPCS
<b>G0438</b>	Ppps Initial Visit	HCPCS

Code	Definition	Code System
<b>G0439</b>	Ppps Subseq Visit	HCPCS
<b>G0463</b>	Hospital Outpt Clinic Visit	HCPCS
<b>T1015</b>	Clinic Service	HCPCS

## IHA Diagnosis Codes

Code	Definition	Code System
<b>Z00.00</b>	Encounter for general adult medical examination without abnormal findings	ICD10CM
<b>Z00.01</b>	Encounter for general adult medical examination with abnormal findings	ICD10CM
<b>Z00.121</b>	Encounter for routine child health examination with abnormal findings	ICD10CM
<b>Z00.129</b>	Encounter for routine child health examination without abnormal findings	ICD10CM
<b>Z00.5</b>	Encounter for examination of potential donor of organ and tissue	ICD10CM
<b>Z00.8</b>	Encounter for other general examination	ICD10CM
<b>Z02.0</b>	Encounter for examination for admission to educational institution	ICD10CM
<b>Z02.1</b>	Encounter for pre-employment examination	ICD10CM
<b>Z02.2</b>	Encounter for examination for admission to residential institution	ICD10CM
<b>Z02.3</b>	Encounter for examination for recruitment to armed forces	ICD10CM
<b>Z02.4</b>	Encounter for examination for driving license	ICD10CM
<b>Z02.5</b>	Encounter for examination for participation in sport	ICD10CM
<b>Z02.6</b>	Encounter for examination for insurance purposes	ICD10CM
<b>Z02.71</b>	Encounter for disability determination	ICD10CM
<b>Z02.79</b>	Encounter for issue of other medical certificate	ICD10CM
<b>Z02.81</b>	Encounter for paternity testing	ICD10CM
<b>Z02.82</b>	Encounter for adoption services	ICD10CM
<b>Z02.83</b>	Encounter for blood-alcohol and blood-drug test	ICD10CM
<b>Z02.89</b>	Encounter for other administrative examinations	ICD10CM

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>Z02.9</b>	Encounter for administrative examinations, unspecified	ICD10CM

## IMA-2: Immunization for Adolescents

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

**Source:** Combination 2 rate of the [NCQA HEDIS](#) metric IMA-E.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

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

**Denominator:** Assigned HPSM Medi-Cal members who turn 13 years of age during the measurement year.

Additional exclusions:

- Members not enrolled in Medi-Cal on their 13<sup>th</sup> birthday.
- Members not enrolled in Medi-Cal throughout the 365 days prior to their 13th birthday.
- Members with more than one gap in Medi-Cal enrollment of up to 45 days during the 365 days prior to the member's 13th birthday.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation of compliance with all three indicators:

- Meningococcal Serogroups A, C, W, Y:
  - At least one meningococcal vaccine (serogroups A, C, W, Y or A, C, W, Y, B) with a date of service on or between the member's 10th and 13th birthdays.
  - Anaphylaxis due to the meningococcal vaccine any time on or before the member's 13th birthday.
- Tetanus, diphtheria toxoids and acellular pertussis (Tdap):
  - At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine with a date of service on or between the member's 10th and 13th birthdays.
  - Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
  - Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday.
- Human papillomavirus (HPV):

- At least two HPV vaccines on or between the member’s 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
- At least three HPV vaccines with different dates of service on or between the member’s 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine any time on or before the member’s 13th birthday.

### IMA Procedure Codes

Code	Definition	Code System
<b>90649</b>	HPV Vaccine Administered	CPT
<b>90650</b>	HPV Vaccine Administered	CPT
<b>90651</b>	HPV Vaccine Administered	CPT
<b>90734</b>	Meningococcal Vaccine Administered	CPT
<b>90715</b>	Tdap Vaccine Administered	CPT

## KED: Kidney Health Evaluation for Patients with Diabetes

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

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

**Denominator:** Assigned HPSM Medi-Cal members 18-85 years of age with a diagnosis of diabetes (type 1 or type 2).

Additional Additional exclusions:

- Members with a diagnosis of ESRD any time during the member’s history on or prior to December 31 of the measurement year.
- Members who had dialysis any time during the member’s history on or prior to December 31 of the measurement year.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient documentation that both an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one estimated glomerular filtration rate (eGFR)
- At least one urine albumin-creatinine ratio (uACR) identified by either of the following:
  - Both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart.
    - For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
- A uACR lab test result

## eGFR and uACR Procedure Codes

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

## PCR: Plan All-Cause Readmissions

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

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Lower percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 18 years of age and older with an acute inpatient or observation stays during the measurement year followed by an unplanned acute readmission for any diagnosis within 30 days.

**Denominator:** Assigned HPSM Medi-Cal members 18 years of age and older with an acute inpatient or observation stay discharges on or between January 1 and December 1 of the measurement year.

- Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart are considered distinct stays.
- Includes acute discharges from any type of facility (including behavioral healthcare facilities).
- For discharges with one or more direct transfers, the last discharge date is used.

Additional exclusions:

- Nonacute inpatient stays
- Hospital stays where the admission date is the same as the discharge date.
- Hospital stays meeting the following criteria:
  - Member died during the stay.
  - Members with a principal diagnosis of pregnancy on the discharge claim.
  - A principal diagnosis of a condition originating in the perinatal period on the discharge claim.

**Numerator:** Members meeting denominator inclusion criteria for whom the acute inpatient or observation stay was followed by an unplanned acute readmission for any diagnosis within 30 days.

- Readmissions include acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year.

Additional numerator exclusions:

- Acute hospitalizations with any of the following criteria on the discharge claim:
- A principal diagnosis of pregnancy

- A principal diagnosis for a condition originating in the perinatal period
- A planned hospital stay 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.

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

Adult	Family Practice	Pediatrics
Incentive-eligible	Reporting-Only	Incentive-eligible

**Source:** HPSM internal metric.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 12 years of age and older who had an outpatient visit and received a substance misuse screening in the current calendar year.

**Denominator:** Assigned HPSM Medi-Cal members 12 years of age and older.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

## SBIRT Procedure Codes

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

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

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

**Source:** HPSM internal metric, in compliance with [All Plan Letter 21-009](#).

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

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

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

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

**Denominator:** All assigned HPSM Medi-Cal members.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received one of the following procedure codes within the measurement period.

### SDoH Eligible Z-Codes

Z-Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)

<b>Z-Code</b>	<b>Description</b>
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Z73.6	Limitation of activities due to disability
Z74.0	Reduced mobility
Z74.01	Bed confinement status
Z74.09	Other Reduced Mobility
Z99.0	Dependence on aspirator
Z99.1	Dependence on respirator
Z99.2	Dependence on renal dialysis

<b>Z-Code</b>	<b>Description</b>
Z99.3	Dependence on wheelchair
Z99.8	Dependence on other enabling machines and devices

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

Adult	Family Practice	Pediatrics
Reporting-Only	Reporting-Only	Incentive-eligible

**Source:** HPSM internal metric.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** Percentage of assigned HPSM Medi-Cal members 12 years of age and older who were screened for tobacco use using a validated screening tool (e.g., CRAFFT, S2BI, etc.) at least once during the measurement year AND who received tobacco cessation intervention if identified as a tobacco user.

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

**Denominator:** All assigned HPSM Medi-Cal members 12 years and older with at least one preventive encounter OR two outpatient encounters during the measurement year.

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

### Tobacco Screening Procedure Codes

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

## WCC-BMI: Weight Assessment for Children/Adolescents

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

**Source:** Rate 1 of the [NCQA HEDIS](#) metric WCC.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal 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.

**Denominator:** Assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year.

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

Additional exclusions:

- Diagnosis of pregnancy during the measurement year.

**Numerator:** Members meeting denominator inclusion criteria with evidence of BMI percentile documentation during the measurement year as identified by administrative data or medical record review. The percentile ranking is based on the CDC’s BMI-for-age growth charts, which indicates the relative position of the patient’s BMI number among others of the same gender and age. Because BMI norms for youth vary with age and gender, this metric evaluates whether BMI percentile is assessed rather than an absolute BMI value.

- Documentation must include height, weight and BMI percentile during the measurement year.
  - The height, weight and BMI percentile must be from the same data source.
- Either of the following meets criteria for BMI percentile:
  - BMI percentile documented as a value (e.g., 85th percentile).
  - BMI percentile plotted on an age-growth chart.
- Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.
- Member-collected biometric values (height, weight, BMI percentile) that meet the requirements.
- Documentation of >99% or <1% meets criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Additional numerator exclusions:

- Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance.

### BMI Percentile Diagnosis Codes

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

## WCC-N: Weight Assessment and Counseling for Nutrition for Children/Adolescents

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

**Source:** Rate 2 of the [NCQA HEDIS](#) metric WCC.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of nutrition counseling based on their BMI percentile.

**Denominator:** Assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year.

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

Additional Additional exclusions:

- Diagnosis of pregnancy during the measurement year.

**Numerator:** Members meeting denominator inclusion criteria with documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

- Documentation must include a note indicating the date and at least one of the following:
  - Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
  - Checklist indicating nutrition was addressed.
  - Counseling or referral for nutrition education.
  - Member received educational materials on nutrition during a face-to-face visit.
  - Anticipatory guidance for nutrition.
  - Weight or obesity counseling.

## Nutrition Counseling Procedure Codes

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

## WCC-PA: Weight Assessment and Counseling for Physical Activity for Children/Adolescents

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

**Source:** Rate 3 of the [NCQA HEDIS](#) metric WCC.

**Type:** Percentage

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of physical activity counseling based on their BMI percentile.

**Denominator:** Assigned HPSM Medi-Cal members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN during the measurement year.

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

Additional Additional exclusions:

- Diagnosis of pregnancy during the measurement year.

**Numerator:** Members meeting denominator inclusion criteria with documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

- Documentation must include a note indicating the date and at least one of the following:
  - Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
  - Checklist indicating physical activity was addressed.
  - Counseling or referral for physical activity.
  - Member received educational materials on physical activity during a face-to-face visit.
  - Anticipatory guidance specific to the child’s physical activity.
  - Weight or obesity counseling.

## Physical Activity Counseling Procedure Codes

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

## WCV: Child and Adolescent Well-Care Visits (3-21 years of age)

Adult	Family Practice	Pediatrics
Not Included	Incentive-eligible	Incentive-eligible

**Source:** [NCQA HEDIS](#) metric of the same name.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

**Denominator:** Assigned HPSM Medi-Cal members 3–21 years of age during the measurement year.

Additional Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient evidence of one or more well-care visits during the measurement year.

- The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.
- Annual well child visit for patients 3-21 years old must include:
  - A health, physical developmental, and mental developmental history
  - Complete physical exam
  - Anticipatory guidance and health education
  - Complete the Staying Healthy Assessment (SHA) Questionnaires and Instructions found here: <https://www.hpsm.org/provider/resources/forms>

Additional numerator Additional exclusions:

- Telehealth visits
- Annual well child visit for patients 3-21 years old must include:
  - A health, physical developmental, and mental developmental history
  - Complete physical exam
  - Anticipatory guidance and health education

Complete the SHA Tool and Instruction Guide found here: [hpsm.org/provider-forms](https://www.hpsm.org/provider-forms)

## WCV Well Child & Adolescent Visit Procedure Codes

Code	Definition	Code System
<b>99381</b>		CPT
<b>99382</b>	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
<b>99383</b>	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
<b>99384</b>		CPT
<b>99385</b>		CPT
<b>99391</b>		CPT
<b>99392</b>	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
<b>99393</b>	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5-11 years)	CPT
<b>99394</b>		CPT
<b>99395</b>		CPT
<b>99461</b>		CPT
<b>G0438</b>	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	HCPCS
<b>G0439</b>	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	HCPCS
<b>S0302</b>	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service) (S0302)	HCPCS
<b>Z00.00</b>	Encounter for general adult medical examination without abnormal findings	ICD10CM
<b>Z00.01</b>	Encounter for general adult medical examination with abnormal findings	ICD10CM
<b>Z00.110</b>	Health examination for newborn under 8 days old	ICD10CM
<b>Z00.111</b>	Health examination for newborn 8 to 28 days old	ICD10CM
<b>Z00.121</b>	Encounter for routine child health examination with abnormal findings	ICD10CM

<b>Code</b>	<b>Definition</b>	<b>Code System</b>
<b>Z00.129</b>	Encounter for routine child health examination without abnormal findings	ICD10CM
<b>Z00.2</b>	Encounter for examination for period of rapid growth in childhood	ICD10CM
<b>Z00.3</b>	Encounter for examination for adolescent development state	ICD10CM
<b>Z02.0</b>	Encounter for examination for admission to educational institution	ICD10CM
<b>Z02.5</b>	Encounter for examination for participation in sport	ICD10CM
<b>Z02.6</b>	Encounter for examination for insurance purposes	ICD10CM
<b>Z76.1</b>	Encounter for health supervision and care of foundling	ICD10CM
<b>Z76.2</b>	Encounter for health supervision and care of other healthy infant and child	ICD10CM

## W30-6: Well-Child Visits in the First 15 Months

Adult	Family Practice	Pediatrics
Not Included	Incentive-eligible	Incentive-eligible

**Source:** Rate 1 of the [NCQA HEDIS](#) metric W30.

**Type:** Percentage.

**Aim:** Higher percentage indicates quality performance.

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

**Denominator:** Assigned HPSM Medi-Cal members who turned 15 months old during the measurement year.

Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient evidence of six or more well-child visits with a PCP during their first 15 months of life.

- The well-care visit must occur with a primary care provider (PCP), but the practitioner does not have to be the practitioner assigned to the member.
- 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

Additional numerator Additional exclusions:

- Telehealth visits

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

### W15 & W30 Well Child Visit Procedure Codes

Code	Definition	Code System
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<b>99381</b>		CPT
<b>99382</b>		CPT
<b>99383</b>		CPT
<b>99384</b>		CPT
<b>99385</b>		CPT
<b>99391</b>		CPT
<b>99392</b>		CPT
<b>99393</b>		CPT
<b>99394</b>		CPT
<b>99395</b>		CPT
<b>99461</b>		CPT
<b>G0438</b>	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	HCPCS
<b>G0439</b>	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	HCPCS
<b>S0302</b>	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service	HCPCS
<b>Z00.00</b>	Encounter for general adult medical examination without abnormal findings	ICD10CM
<b>Z00.01</b>	Encounter for general adult medical examination with abnormal findings	ICD10CM
<b>Z00.110</b>	Health examination for newborn under 8 days old	ICD10CM
<b>Z00.111</b>	Health examination for newborn 8 to 28 days old	ICD10CM
<b>Z00.121</b>	Encounter for routine child health examination with abnormal findings	ICD10CM
<b>Z00.129</b>	Encounter for routine child health examination without abnormal findings	ICD10CM
<b>Z00.2</b>	Encounter for examination for period of rapid growth in childhood	ICD10CM
<b>Z00.3</b>	Encounter for examination for adolescent development state	ICD10CM
<b>Z02.5</b>	Encounter for examination for participation in sport	ICD10CM
<b>Z76.1</b>	Encounter for health supervision and care of foundling	ICD10CM
<b>Z76.2</b>	Encounter for health supervision and care of other healthy infant and child	ICD10CM

## W30-2: Well-Child Visits for Age 15 Months–30 Months

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

**Source:** Rate 2 of the [NCQA HEDIS](#) metric W30.

**Type:** Percentage

**Aim:** Higher percentage indicates quality performance.

**Definition:** The percentage of assigned HPSM Medi-Cal members who turned 30 months old during the measurement year and had two or more well-child visits with a primary care provider (PCP) between the child's 15-month birthday plus one day and 30-month birthday.

**Denominator:** Assigned HPSM Medi-Cal members who turned 30 months old during the measurement year.

Additional Additional exclusions:

- Members with more than one gap in enrollment of up to 45 days.

**Numerator:** Members meeting denominator inclusion criteria for whom HPSM received sufficient evidence of two or more well-child visits with a PCP between the child's 15-month birthday plus one day and 30-month birthday.

- The well-care visit must occur with a primary care provider (PCP), but the practitioner does not have to be the practitioner assigned to the member.
- Annual well child visit for patients 15-30 months old must include:
  - A health, physical developmental, and mental developmental history
  - Complete physical exam
  - Anticipatory guidance and health education

Additional numerator Additional exclusions:

- Telehealth visits

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

## VI. Health Education Resources

Some patients may benefit from additional support or information regarding health education or lifestyle changes 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 online Health Education Guide offers a wide variety of 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 may call HPSM's Health Education line at **650-616-2165**.

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

## VII. Terms & Conditions

Participation in HPSM's Benchmark P4P, as well as acceptance of performance bonus payments, does not in any way modify or supersede terms or conditions of any agreement between HPSM and participating providers. There is no guarantee of future funding or incentive under any HPSM P4P performance bonus program. HPSM Benchmark P4P 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 incentive, 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 Benchmark P4P.

Any monies paid under Benchmark P4P 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 incentives.

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