Benchmark Pay for Performance

Medi-Cal Program Guidelines

2021 Program Year

Version 2

We value your feedback

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

Go to the feedback form on hpsm.org

Version 2 - Updated September 1, 2021

Version History

Version 2 Revisions – Effective 09/01/2021

1. **Panel Engagement**: HPSM will count COVID-19 immunizations toward the Panel Engagement quality measure and capitation bonuses. Providers must submit to HPSM their CAIR2 COVID-19 vaccinator ID and attest to those assigned members to whom they have administered at least one dose of a COVID-19 vaccine who do not otherwise have an eligible PCP encounter captured on the Active Engagement Report eReport. See instructions on page 15 for full details and deadlines.

2. **CDC-Complete (Comprehensive Diabetes Care – Complete):** The numerator specifications have been clarified. In order to earn credit for this measure, patients must be compliant for the following four components:
    a. Blood Pressure controlled (*see CDC-BP*)
    b. HbA1c test present (*see CDC-A1c*). Note: A1c does not need to be controlled.
    c. Retinal Eye Exam administered (*see CDC-EE*)
    d. Kidney Health Evaluation administered (*see CDC-KED*)

3. **CDF (Depression Screening & Follow-Up):** Code set for numerator compliance expanded to include additional eligible procedure codes to match prior year allowances. Added 96127, G0444, G8510, G8511, 3351F, 3352F, 3353F, 3354F, 1220F, 0545F.

4. **IHA (Initial Health Assessment):** HPSM will now accept manual attestations for outreach attempts. Providers who conduct and document at least three outreach attempts with DOS in the measurement year to activate new members can attest for partial credit when the attestation period opens in April 2022. Providers will also be asked to submit a description of outreach modalities (e.g. scripting for phone/email/text outreach, copy of mailing flyer, etc.).

5. **FLU (Seasonal Influenza Vaccine):** Flu vaccines administered July 1, 2021 through March 31, 2022 will be counted for credit in the 2021 program— this expands the original DOS of August 1 — December 31, 2021. Note that given the estimated three-month claims lag, providers may have to attest to any compliant members missing from the April 2022 eReports.

6. **WCV (Well Child Visits 3-21 years old):** Updated the list of eligible procedure codes to reflect current HEDIS allowances. Added S0302, Z00.00, Z00.01. Retired Z00.5, Z00.8, Z02.1, Z02.2, Z02.3, Z02.4, Z02.71, Z02.82.

7. **W15 (Well Child Visits 0-15 months old)** & **W30 (Well Child Visits (16-30 months)**: Updated measure descriptions to include complete list of eligible procedure codes.

Table of Contents

Version History ... 2

I. Program Overview ... 5

Provider Eligibility ... 5
Program Sub-tracks ... 5
Quality Measure Selection ... 5
Data Reports ... 5
Program Timeline ... 6
Incentive Payment Formula ... 6

II. Adult Track Summary ... 8

Adult Payment Quality Measure Set ... 8
Adult Reporting-Only Quality Measure Set ... 8

III. Family Practice Track Summary ... 10

Family Practice Payment Quality Measure Set ... 10
Family Practice Reporting-Only Quality Measure Set ... 10

IV. Pediatric Track Summary ... 12

Pediatric Payment Quality Measure Set ... 12
Pediatric Reporting-Only Quality Measure Set ... 12

V. Panel Engagement Measure ... 14

Panel Engagement Overview ... 14

Primary care visits that count towards patient engagement: ... 14

COVID-19 Immunization Encounters ... 15

VI. Quality Measure Specifications ... 16

ACE: Trauma Screening ... 16
AMB-ED: Ambulatory Emergency Care ... 17
AMR: Asthma Medication Ratio ... 18
Avoid-ED: Avoidable Emergency Department Visits ... 21
BCS: Mammogram for Breast Cancer Screening ... 22
CBP: Controlling High Blood Pressure ... 23
CCS: Cervical Cancer Screening ... 24
CHL: Chlamydia Screening in Women ... 27
CDC-Complete: Comprehensive Diabetes Care- Complete ... 28
CDC-BP: Diabetes Blood Pressure Control ... 29
CDC-A1c: Diabetes HbA1c Testing ... 30
CDC-EE: Diabetes Retinal Eye Exam ... 31
CDC-Control: Diabetes HbA1c Control ... 35
CDC-KED: Kidney Health Evaluation ... 36
CDF: Depression Screening and Follow-up ... 37

CIS-10: Immunizations for Children – Combo 10 39
DEV: Developmental Screening 41
Encounter Threshold 42
FLU: Seasonal Influenza Vaccination 43
FVN: Fluoride Varnish 45
IMA-2: Immunization for Adolescents (IMA) 46
IHA: Initial Health Assessments 47
PCR: Plan All-Cause Readmissions 52
SBIRT: Substance Misuse Screening and Follow Up 53
WCC-BMI: BMI Assessment for Children 54
WCC-N: Nutrition Counseling for Children 55
WCC-PA: Physical Activity Counseling for Children 56
WCV: Well Child & Adolescent Visit (ages 3-21) 57
W15: Well Child Visit (ages 0-15 mo.) 59
W30: Well Child Visit (ages 16-30 mo.) 61

VII. Health Education Resources that Support P4P 62

VIII. Terms & Conditions 62

I. Program Overview

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

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

Provider Eligibility

Providers must have an active Medi-Cal contract with HPSM and must have a specialty type designation as a primary care provider. The contract must be active as of the date of payment. Providers must have 100 HPSM Medi-Cal members assigned to their panel as of January 1st, 2021 to be eligible to participate.

Program Sub-tracks

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

- **Adult**: Assigned members 18 years and older
- **Family Practice**: Assigned members 0 – 999 years
- **Pediatrics**: Assigned members 0 – 18 or 0 – 22 years

Quality Measure Selection

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

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

Data Reports

Performance bonus payment in the Benchmark P4P program is contingent on meeting the specified measure benchmarks for assigned patients who meet the measure criteria. Once the encounter information has been received and eligibility has been determined, providers will get credit towards the annual benchmark. Monthly member detail

benchmark progress reports are available to providers through the HPSM eReports portal. The website for eReports login is: https://reports.hpsm.org.

Program Timeline

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

Period	Dates*	Description
Program Year	01/01/2021 – 12/31/2021	This is the anchor program year for all dates of service (DOS). For measures with a lookback period of multiple years, include 2021 DOS as the first year.
Claims Submission Deadline	03/31/2022	All HPSM claims and qualifying reporting codes must be submitted by this date to quality for payment credit.
Attestation Period	04/02/2022 – 04/30/2022	Providers may manually attest for compliance in cases where the claims submission process has not captured all relevant data. Instructions for attestation will be distributed Spring 2022.
Payment Finalization	05/01/2022 – 06/30/2022	HPSM compiles all performance data submissions and calculates a payment using the formula below. Incentive payments are distributed via lump sum in the form of a check mailed to the primary mailing address on file.

*Subject to change

Incentive Payment Formula

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

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

Term Definitions

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

Composite Quality Score: Average score for all earned quality points based on final performance rate following the program calendar year. For quality points to be attributed to an assigned measure, the participating provider must have at minimum number of eligible patients in the denominator.

$Benchmark P4P PMPM: Specific per member per month rate determined by HPSM no later than April 30 following the program calendar year. Allocations will be determined based on the pool of funds allocated for Benchmark P4P program and number of members covered by the program.

Full Credit Benchmark Bonus: Potential additional bonus amount added if all full credit quality benchmarks are met in the program calendar year.

II. Adult Track Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 18 years of age and older (or a similar age range) report on the Adult quality measure set. These measures are in addition to the Panel Engagement capitation bonus.

Adult Payment Quality Measure Set

Provider performance in the payment measures below relative to the full and partial credit benchmarks earn quality score points used to generate a Composite Quality Score for incentive payments:

Shorthand*	**Payment Measure Name**	**Measure Source**	**Performance Benchmarks *(Quality Score Points)***	
			Full Credit	Partial Credit
AMR	Asthma Medication Ratio	HEDIS	73.36% (2)	68.08% (1)
CDC-Complete	Comprehensive Diabetes Care – Complete	HPSM	40.00% (2)	30.00% (1)
CDC-BP	Diabetes Blood Pressure Control	HEDIS	76.40% (2)	71.05% (1)
CDC-Control	Diabetes HbA1c Control (<8.0%)	HEDIS	60.77% (2)	55.96% (1)
CBP	Controlling High Blood Pressure	HEDIS	72.75% (2)	67.64% (1)
CDF	Depression Screening and Follow-Up	DHCS	75.00% (2)	60.00% (1)
Encounter Threshold	Encounter Threshold	HPSM	1.75 member month/year (3)	1.5 member month/year (1)
FLU	Seasonal Influenza Vaccine	HPSM	68.00% (2)	62.00% (1)
IHA	Initial Health Assessments	DHCS	75.00% (2)	60.00% (1)
SBIRT	Substance Misuse Screening	HPSM	75.00% (2)	60.00% (1)

*Shorthand is used to identify measure in eReports

Adult Reporting-Only Quality Measure Set

HPSM collects performance data on the measures below. Reporting-only measures are not eligible for inclusion in payment calculations but are subject for inclusion as payment measures in future P4P Program years. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Measure Name	Measure Source
ACE	Trauma Screening (Adverse Childhood Experience)	HPSM
AMD-ED	Ambulatory Emergency Department Visits	HEDIS
Avoid-ED	Avoidable Emergency Department Visits	HPSM
BCS	Mammogram for Breast Cancer Screening	HEDIS
CCS	Cervical Cancer Screening	HEDIS
CDC-A1c	Diabetes A1c Testing*	HEDIS
CDC-EE	Diabetes Retinal Eye Exam*	HEDIS
CDC-KED	Diabetes Kidney Health Evaluation*	HEDIS
CHL	Chlamydia Screening in Women (16-24 years old)	HEDIS
PCR	Plan All-Cause Readmissions	HEDIS

*Reporting-only as solo measures, but are included as components in the payment measure CDC-Complete.

III. Family Practice Track Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 999 years of age (no maximum) or a similar age range report on the Family Practice quality measure set. These measures are in addition to the Panel Engagement capitation bonus.

Family Practice Payment Quality Measure Set

Provider performance in the payment measures below relative to the full and partial credit benchmarks earn quality score points used to generate a Composite Quality Score for incentive payments:

Shorthand*	Payment Measure Name	Measure Source	Performance Benchmarks *(Quality Score Points)*	
			Full Credit	Partial Credit
AMR	Asthma Medication Ratio	HEDIS	73.36% (2)	68.08% (1)
CBP	Controlling High Blood Pressure	HEDIS	72.75% (2)	67.64% (1)
CDC-Complete	Comprehensive Diabetes Care – Complete	HPSM	40.00% (2)	30.00% (1)
CDC-Control	Diabetes HbA1c Control (<8.0%)	HEDIS	60.77% (2)	55.96% (1)
CDF	Depression Screening & Follow Up (12 years and older)	HEDIS	75.00% (2)	60.00% (1)
Encounter Threshold	Encounter Threshold	HPSM	1.75 member month/year (3)	1.5 member month/year (1)
FLU	Seasonal Influenza Vaccine	HPSM	68.00% (2)	62.00% (1)
IHA	Initial Health Assessment	DHCS	75.00% (2)	60.00% (1)
W15	Well Child Visit (0-15 months old)	HEDIS	77.08% (2)	72.99% (1)
WCV	Well Child and Adolescent Visit (3 – 21 years old)	HEDIS	70.65% (2)	64.72% (1)

*Shorthand is used to identify measure in eReports

Family Practice Reporting-Only Quality Measure Set

HPSM collects performance data on the measures below. Reporting-only measures are not eligible for inclusion in payment calculations but are subject for inclusion as payment measures in future P4P Program years. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Measure Name	Measure Source
ACE	Trauma Screening (Adverse Childhood Experience)	HPSM
AMB-ED	Ambulatory Emergency Department Visits	HEDIS
Avoid-ED	Avoidable Emergency Department Visits	HPSM
BCS	Mammogram for Breast Cancer Screening	HEDIS
CCS	Cervical Cancer Screening	HEDIS
CDC-A1c	Diabetes HbA1c Testing*	HEDIS
CDC-BP	Diabetes Blood Pressure Control*	HEDIS
CDC-EE	Diabetes Retinal Eye Exam*	HEDIS
CDC-KED	Diabetes Kidney Health Evaluation*	HEDIS
CHL	Chlamydia Screening in Women (16 – 24 year old)	HEDIS
CIS-10	Childhood Immunizations (Combination 10)	HEDIS
DEV	Developmental Screening	HPSM
FVN	Fluoride Varnish	HPSM
IMA-2	Adolescent Immunizations (Combination 2)	HEDIS
PCR	Plan All-Cause Readmissions	HEDIS
SBIRT	Substance Misuse Screening and Follow Up (12 years and older)	HPSM
W30	Well Child Visit (16-30 months)	HEDIS
WCC-BMI	Pediatric BMI Assessment	HEDIS
WCC-N	Nutrition Counseling for Children	HEDIS
WCC-PA	Physical Activity Counseling for Children	HEDIS

*Reporting-only as solo measures, but are included as components in the payment measure CDC-Complete.

IV. Pediatric Track Summary

Medi-Cal primary care providers with an assigned panel of HPSM members 0 - 18 or 0 - 22 years of age report on the Pediatric quality measure set. These measures are in addition to the Panel Engagement capitation bonus.

Pediatric Payment Quality Measure Set

Provider performance in the payment measures below relative to the full and partial credit benchmarks earn quality score points used to generate a Composite Quality Score for incentive payments:

Shorthand*	Payment Measure Name	Measure Source	Performance Benchmarks *(Quality Score Points)*	
			Full Credit	Partial Credit
AMR	Asthma Medication Ratio	HEDIS	73.36% (2)	68.08% (1)
CDF	Depression Screening and Follow Up (12 years and older)	DHCS	75.00% (2)	60.00% (1)
CIS-10	Childhood Immunizations (Combination 10)	HEDIS	52.07% (2)	44.77% (1)
DEV	Developmental Screening	HPSM	70.00% (2)	55.00% (1)
Encounter Threshold	Encounter Threshold	HPSM	1.75 member month/year (3)	1.5 member month/year (1)
FLU	Seasonal Influenza Vaccine	HPSM	68.00% (2)	62.00% (1)
IHA	Initial Health Assessment	DHCS	75.00% (2)	60.00% (1)
W15	Well Child Visit (0-15 months old)	HEDIS	77.08% (2)	72.99% (1)
WCV	Well Child and Adolescent Visit (3-21 years old)	HEDIS	70.65% (2)	64.72% (1)

*Shorthand is used to identify measure in eReports

Pediatric Reporting-Only Quality Measure Set

HPSM collects performance data on the measures below. Reporting-only measures are not eligible for inclusion in payment calculations but are subject for inclusion as payment measures in future P4P Program years. While provider performance is not measured against payment benchmarks, HPSM shares back prior year network performance data in an effort to continuously improve performance.

Shorthand	Reporting-Only Measure Name	Measure Source
ACE	Trauma Screening (Adverse Childhood Experience)	HPSM
Avoid-ED	Avoidable Emergency Department Visit	HPSM
CHL	Chlamydia Screening in Women (16-24 years old)	HEDIS
FVN	Fluoride Varnish	HPSM
IMA-2	Adolescent Immunizations (Combination 2)	HEDIS
SBIRT	Substance Misuse Screening and Follow Up (12 years and older)	HPSM
W30	Well Child Visit (16-30 months old)	HEDIS
WCC-BMI	Pediatric BMI Assessment	HEDIS
WCC-N	Nutrition Counseling for Children	HEDIS
WCC-PA	Physical Activity Counseling for Children	HEDIS

V. Panel Engagement Measure

Panel Engagement Overview

Access to primary care is a key driver for managing the health of our shared patient population and we want to recognize the work our providers do to engage assigned HPSM patients at their clinics/offices. Capitated providers will be eligible to earn an additional 30% of capitation each month by meeting the engagement benchmark each quarter. The engagement benchmark is defined as follows:

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

Patient engagement will be measured primarily through HPSM claims data.

Primary care visits that count towards patient engagement:

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

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

COVID-19 Immunization Encounters

Beginning with the Q4 2021 capitation payment cycle, HPSM credits COVID-19 immunizations performed by the assigned PCP clinic toward the panel engagement rate and capitation bonuses. The Department of Health Care Services (DHCS) has carved out COVID-19 vaccines from Medi-Cal managed care health plans. In order to properly match and crosswalk member immunizations to PCP vaccinators at this time, providers who wish to have COVID-19 immunizations counted for the panel engagement measure must complete the following steps:

1. Provider must be registered as a COVID-19 vaccinator. For information on how to become a vaccinator, please visit https://www.hpsm.org/provider-covid-resources/vaccine-resources.
2. Provider must notify HPSM of their COVID-19 vaccinator ID registered with CAIR. IDs typically follow the format "CA###B###" with some combination of 6-12 numbers therein.
3. Provider must review their Active Engagement eReport published the month before quarterly capitation updates and attest to those assigned members to whom they have administered at least one dose of a COVID-19 vaccine who do not otherwise have an eligible PCP encounter captured on the report. Providers should add a column to the report that lists the date of service for the latest COVID-19 vaccine dose they administered to a member.
4. Provider must submit Vaccinator ID and modified Active Engagement Report with attestation column via secure email to PSInquiries@hpsm.org by the 21st day of the month before quarterly capitation updates. For example, for capitation payments dated October through December 2021, providers should insert attestations into the Active Engagement Report published to eReports at the beginning of September 2021 and submit to HPSM by September 21, 2021. See table below for complete timeline. Providers who do not receive an email confirmation of receipt within 24 hours of submission should follow up with HPSM.

Capitation Payment Cycle	Date of Active Engagement Report [1]	Attestation(s) Due Date
Q4 2021 (October – December 2021)	September 1, 2021	September 21, 2021
Q1 2022 (January – March 2022)	December 1, 2021	December 21, 2021
Q2 2022 (April – June 2022)	March 1, 2022	March 21, 2022

[1] Dates are approximate. eReports typically release on the first weekday of every calendar month

VI. Quality Measure Specifications

ACE: Trauma Screening

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

Patient Eligibility: Members under age 21

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

Trauma Screening Procedure Codes

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

Additionally, providers who complete and attest to a free two-hour training on the science of ACEs and toxic stress are eligible for additional incentive dollars ($35.97 for each eligible screening) and CME/MOC credits awarded by DHCS. For more information, please visit https://acesaware.org or email PSInquiries@hpsm.org.

AMB-ED: Ambulatory Emergency Care

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

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

Exclusions:

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

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

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

AMR: Asthma Medication Ratio

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

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

Exclusions: See "Criteria for identifying patients with persistent asthma" below.

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

Asthma Controller Medications

Generic Ingredient	Medication Name(s)	Description
beclomethasone	Qvar inhaler, Qvar Redihaler	*glucocorticoids, inhaled*
benralizumab	Fasenra syringe, Fasenra pen	*interleukin-5 (IL-5) receptor alpha antagonist, MAB*
budesonide	Pulmicort Flexhaler	*glucocorticoids, inhaled*
budesonide/formoterol	Budesonide-Formoterol inhaler, Symbicort inhaler	*beta-adrenergic and glucocorticoid combo, inhaled*
ciclesonide	Alvesco inhaler	*glucocorticoids, inhaled*
dupilumab	Dupixent (syringe, pen)	*monoclonal antibody -interleukin-4 antagonist*
dyphylline-guaifenesin	Dyphylline/Guaifenesin oral solutions/tablets	
flunisolide	Aerospan inhaler	*glucocorticoids, inhaled*
fluticasone	Arnuity Ellipta inhaler	*glucocorticoids, inhaled*
fluticasone/vilanterol	Breo Ellipta inhaler	*beta-adrenergic and glucocorticoid combo, inhaled*
fluticasone	Armonair Respiclick , Flovent (Diskus and HFA inhaler)	*glucocorticoids, inhaled*
fluticasone/salmeterol	Advair (Diskus and HFA inhaler), Airduo Respiclick , Fluticasone-Salmeterol inhaler, Wixela Inhub	*beta-adrenergic and glucocorticoid combo, inhaled*
mepolizumab	Nucala (vial, auto-injector, syringe)	*monoclonal antibody - interleukin-5 antagonists*
mometasone	Asmanex Inhaler, Asmanex Twisthaler	*glucocorticoids, inhaled*
mometasone/formoterol	Dulera inhaler	*beta-adrenergic and glucocorticoid combo, inhaled*
montelukast	Montelukast Sodium (tablet, granule, and chew)	*leukotriene receptor antagonists*

	Singulair (tablet, granule, and chew)	
omalizumab	Xolair (vial and syringe)	*monoclonal antibodies to immunoglobulin E (IGE)*
reslizumab	Cinqair vial	*monoclonal antibody - interleukin-5 antagonists*
theophylline	Elixophyllin Elixir, Theo-24 ER capsule, Theochron ER tablet, Theophylline (solution and ER tablets)	*xanthines*
zafirlukast	Accolate tablet, Zafirlukast tablet	*leukotriene receptor antagonists*
zileuton	Zileuton ER tablet, Zyflo filmtab, Zyflo CR tablet	*5-lipoxygenase inhibitors*

Asthma Reliever Medications

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

Asthma Diagnosis Codes

Code	Definition	Code System
J45.20	Mild intermittent asthma, uncomplicated	ICD10CM
J45.21	Mild intermittent asthma with (acute) exacerbation	ICD10CM
J45.22	Mild intermittent asthma with status asthmaticus	ICD10CM
J45.30	Mild persistent asthma, uncomplicated	ICD10CM
J45.31	Mild persistent asthma with (acute) exacerbation	ICD10CM
J45.32	Mild persistent asthma with status asthmaticus	ICD10CM
J45.40	Moderate persistent asthma, uncomplicated	ICD10CM
J45.41	Moderate persistent asthma with (acute) exacerbation	ICD10CM
J45.42	Moderate persistent asthma with status asthmaticus	ICD10CM
J45.50	Severe persistent asthma, uncomplicated	ICD10CM

J45.41	Severe persistent asthma with (acute) exacerbation	ICD10CM
J45.52	Severe persistent asthma with status asthmaticus	ICD10CM
J45.901	Unspecified asthma with (acute) exacerbation	ICD10CM
J45.902	Unspecified asthma with status asthmaticus	ICD10CM
J45.909	Unspecified asthma, uncomplicated	ICD10CM
J45.990	Exercise induced bronchospasm	ICD10CM
J45.991	Cough variant asthma	ICD10CM
J45.998	Other asthma	ICD10CM

Criteria for identifying patients with persistent asthma

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

- At least one ED visit, with a principal diagnosis of asthma.
- At least one acute inpatient encounter, with a principal diagnosis of asthma.
- At least one acute inpatient discharge, with a principal diagnosis of asthma.
- At least four outpatient visits, observation visits, telephone visits, or online assessments, on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events for any controller medication (Asthma Controller Medications List) or reliever medication. Visit type need not be the same for the four visits. For a complete list of outpatient visit codes, please refer to https://www.hpsm.org/provider/value-based-payment.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor.

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

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

Avoid-ED: Avoidable Emergency Department Visits

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

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

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

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

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

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

BCS: Mammogram for Breast Cancer Screening

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

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

Exclusions:

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

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

Mammography Procedure Codes

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

Mammography Exclusion Code

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

CBP: Controlling High Blood Pressure

Adult	Family Practice	Pediatrics
Payment	Payment	Reporting-Only

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

Exclusions:

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

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

Hypertension Diagnosis Code

Code	Definition	Code System
I10	Essential (primary) hypertension	ICD10CM

Blood Pressure Reading Codes

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

CCS: Cervical Cancer Screening

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

Patient Eligibility: Women 21-64 years old.

Exclusions:

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

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

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

Cervical Cancer Screening Procedure Codes

Code	Definition	Code System
88141	Cervical Cytology	CPT
88142	Cervical Cytology	CPT
88143	Cervical Cytology	CPT
88147	Cervical Cytology	CPT
88148	Cervical Cytology	CPT
88150	Cervical Cytology	CPT
88152	Cervical Cytology	CPT
88153	Cervical Cytology	CPT
88154	Cervical Cytology	CPT
88164	Cervical Cytology	CPT
88165	Cervical Cytology	CPT
88166	Cervical Cytology	CPT

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

HPV Testing Codes

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

Cervical Cancer Screening Exclusion Codes

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

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

CHL: Chlamydia Screening in Women

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

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

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

Chlamydia Testing Codes

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

CDC-Complete: Comprehensive Diabetes Care- Complete

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

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

Exclusions:

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

Measure Definition: Percent of assigned diabetic patients who had an HbA1c test and result submitted to HPSM (CDC-A1c), blood pressure controlled (CDC-BP), retinal eye exam administered (CDC-EE), and kidney health evaluation performed (CDC-KED) in the relevant lookback period for each sub-measure.

CDC-BP: Diabetes Blood Pressure Control

Adult	Family Practice	Pediatrics
Payment	Reporting-Only	Not Included

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

Exclusions:

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

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

Diabetes Blood Pressure Procedure Codes

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

CDC-A1c: Diabetes HbA1c Testing

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

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

Exclusions:

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

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

Diabetes HbA1c Testing Codes

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

CDC-EE: Diabetes Retinal Eye Exam

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

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

Exclusions:

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

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

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

Diabetic Retinal Eye Exam Procedure Codes

Code	Definition	Code System
67028	Diabetic Retinal Screening	CPT
67030	Diabetic Retinal Screening	CPT
67031	Diabetic Retinal Screening	CPT
67036	Diabetic Retinal Screening	CPT
67039	Diabetic Retinal Screening	CPT
67040	Diabetic Retinal Screening	CPT
67041	Diabetic Retinal Screening	CPT
67042	Diabetic Retinal Screening	CPT
67043	Diabetic Retinal Screening	CPT
67101	Diabetic Retinal Screening	CPT
67105	Diabetic Retinal Screening	CPT
67107	Diabetic Retinal Screening	CPT

67108	Diabetic Retinal Screening	CPT
67110	Diabetic Retinal Screening	CPT
67113	Diabetic Retinal Screening	CPT
67121	Diabetic Retinal Screening	CPT
67141	Diabetic Retinal Screening	CPT
67145	Diabetic Retinal Screening	CPT
67208	Diabetic Retinal Screening	CPT
67210	Diabetic Retinal Screening	CPT
67218	Diabetic Retinal Screening	CPT
67220	Diabetic Retinal Screening	CPT
67221	Diabetic Retinal Screening	CPT
67227	Diabetic Retinal Screening	CPT
67228	Diabetic Retinal Screening	CPT
92002	Diabetic Retinal Screening	CPT
92004	Diabetic Retinal Screening	CPT
92012	Diabetic Retinal Screening	CPT
92014	Diabetic Retinal Screening	CPT
92018	Diabetic Retinal Screening	CPT
92019	Diabetic Retinal Screening	CPT
92134	Diabetic Retinal Screening	CPT
92225	Diabetic Retinal Screening	CPT
92226	Diabetic Retinal Screening	CPT
92227	Diabetic Retinal Screening	CPT
92228	Diabetic Retinal Screening	CPT
92230	Diabetic Retinal Screening	CPT
92235	Diabetic Retinal Screening	CPT
92240	Diabetic Retinal Screening	CPT
92250	Diabetic Retinal Screening	CPT

92260	Diabetic Retinal Screening	CPT
99203	Diabetic Retinal Screening	CPT
99204	Diabetic Retinal Screening	CPT
99205	Diabetic Retinal Screening	CPT
99213	Diabetic Retinal Screening	CPT
99214	Diabetic Retinal Screening	CPT
99215	Diabetic Retinal Screening	CPT
99242	Diabetic Retinal Screening	CPT
99243	Diabetic Retinal Screening	CPT
99244	Diabetic Retinal Screening	CPT
99245	Diabetic Retinal Screening	CPT
S0620	Diabetic Retinal Screening	HCPCS
S0621	Diabetic Retinal Screening	HCPCS
S3000	Diabetic Retinal Screening	HCPCS
3072F	Diabetic Retinal Screening Negative	CPT II
2022F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2023F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2024F	Diabetic Retinal Screening With Eye Care Professional	CPT II
2025F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2026F	Diabetic Retinal Screening With Eye Care Professional	CPTII
2033F	Diabetic Retinal Screening With Eye Care Professional	CPT II
65091	Unilateral Eye Enucleation	CPT
65093	Unilateral Eye Enucleation	CPT
65101	Unilateral Eye Enucleation	CPT
65103	Unilateral Eye Enucleation	CPT
65105	Unilateral Eye Enucleation	CPT
65110	Unilateral Eye Enucleation	CPT
65112	Unilateral Eye Enucleation	CPT

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

CDC-Control: Diabetes HbA1c Control

Adult	Family Practice	Pediatrics
Payment	Payment	Not Included

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

Exclusions:

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

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

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

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

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

Diabetes HbA1c Procedure Codes

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

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

CDC-KED: Kidney Health Evaluation

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

Patient Eligibility: Members 18-85 years of age with diabetes

Exclusions:

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

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

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

eGFR and uACR Procedure Codes

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

CDF: Depression Screening and Follow-up

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

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

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

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

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

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

Depression Screening Procedure Codes

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

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

CIS-10: Immunizations for Children – Combo 10

Adult	Family Practice	Pediatrics
Not included	Reporting-Only	Payment

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

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

Measure Definition: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

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

DEV: Developmental Screening

Adult	Family Practice	Pediatrics
Not included	Reporting-Only	Payment

Patient Eligibility: Children 30 months of age.

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

Developmental Screening Procedure Code

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

Encounter Threshold

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

Patient Eligibility: All members.

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

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

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

FLU: Seasonal Influenza Vaccination

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

Patient Eligibility: All members 6 months and older.

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

Measure Definition: The percentage of members 6 months and older receiving a seasonal flu vaccination July 1, 2021 through March 31, 2022.

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

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

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

Flu Vaccine Procedure Codes

Code	Definition	Code System
90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use	CPT
90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use	CPT
90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use	CPT
90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	CPT
90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use	CPT
90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	CPT
90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use	CPT
90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	CPT
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	CPT
90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	CPT
90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	CPT
90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	CPT

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

FVN: Fluoride Varnish

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

Patient Eligibility: Members ages 0-5.

Measure Definition: Percentage of members ages 0-5 who have received fluoride varnish at least two (2) times during the measurement period.

Fluoride Varnish Procedure Codes

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

IMA-2: Immunization for Adolescents (IMA)

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

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

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

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

IMA Procedure Codes

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

IHA: Initial Health Assessments

Adult	Family Practice	Pediatrics
Payment	Payment	Payment

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

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

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

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
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
99387	Init Preven Meds E&M New Pt;	CPT
99391	Preven Meds E&M Estab Pt; In	CPT
99392	Preven Meds E&M Estab Pt; 1-	CPT
99393	Preven Meds E&M Estab Pt; 5-	CPT
99394	Preven Meds E&M Estab Pt; 12	CPT
99395	Preven Meds E&M Estab Pt; 18	CPT
99396	Preven Meds E&M Estab Pt; 40	CPT
99397	Preven Meds E&M Estab Pt; 65	CPT
99401	Preven Med Counsl (Sep Pro);	CPT
99402	Preven Med Counsl (Sep Pro);	CPT
99403	Preven Med Counsl (Sep Pro);	CPT
99404	Preven Med Counsl (Sep Pro);	CPT
99411	Preven Med Counsl Grp (Sep P	CPT
99412	Preven Med Counsl Grp (Sep P	CPT
99420	Admin/Intrpt Health Risk Ass	CPT

99429	Unlisted Preven Meds Serv	CPT
99444	Online E/M By Phys	CPT
99446	Interprof Phone/Online 5-10	CPT
99447	Interprof Phone/Online 11-2	CPT
99448	Interprof Phone/Online 21-3	CPT
99449	Interprof Phone/Online 31/>	CPT
99450	Basic Life &/Or Disability E	CPT
99455	Work Relat/Disabl Exam-Treat	CPT
99456	Work Relat/Disabl Exam-Not T	CPT
G0402	Initial Preventive Exam	HCPCS
G0438	Ppps Initial Visit	HCPCS
G0439	Ppps Subseq Visit	HCPCS
G0463	Hospital Outpt Clinic Visit	HCPCS
T1015	Clinic Service	HCPCS

IHA Diagnosis Codes

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

Z02.4	Encounter for examination for driving license	ICD10CM
Z02.5	Encounter for examination for participation in sport	ICD10CM
Z02.6	Encounter for examination for insurance purposes	ICD10CM
Z02.71	Encounter for disability determination	ICD10CM
Z02.79	Encounter for issue of other medical certificate	ICD10CM
Z02.81	Encounter for paternity testing	ICD10CM
Z02.82	Encounter for adoption services	ICD10CM
Z02.83	Encounter for blood-alcohol and blood-drug test	ICD10CM
Z02.89	Encounter for other administrative examinations	ICD10CM
Z02.9	Encounter for administrative examinations, unspecified	ICD10CM

PCR: Plan All-Cause Readmissions

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

Patient Eligibility: Members 18 and older

Exclusions:

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

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

SBIRT: Substance Misuse Screening and Follow Up

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

Patient Eligibility: Members 12 years and older

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

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

SBIRT Procedure Codes

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

WCC-BMI: BMI Assessment for Children

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

Patient Eligibility: Members 3-17 years old.

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

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

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

BMI Percentile Diagnosis Codes

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

WCC-N: Nutrition Counseling for Children

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

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

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

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

Nutrition Counseling Procedure Codes

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

WCC-PA: Physical Activity Counseling for Children

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

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

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

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

Physical Activity Counseling Procedure Codes

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

WCV: Well Child & Adolescent Visit (ages 3-21)

Adult	Family Practice	Pediatrics
Not Included	Payment	Payment

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

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

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

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

WCV Well Child & Adolescent Visit Procedure Codes

Code	Definition	Code System
99381		CPT
99382	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient: early childhood (age 1-4 years)	CPT
99383	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures, new patient: late childhood (age 5-11 years)	CPT
99384		CPT
99385		CPT
99391		CPT
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1-4 years)	CPT
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5-11 years)	CPT
99394		CPT

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

W15: Well Child Visit (ages 0-15 mo.)

Adult	Family Practice	Pediatrics
Not Included	Payment	Payment

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

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

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

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

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

W15 & W30 Well Child Visit Procedure Codes

Code	Definition	Code System
99381		CPT
99382		CPT
99383		CPT
99384		CPT
99385		CPT
99391		CPT
99392		CPT
99393		CPT
99394		CPT
99395		CPT
99461		CPT
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	HCPCS
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	HCPCS

S0302	Completed early periodic screening diagnosis and treatment (epsdt) service (list in addition to code for appropriate evaluation and management service	HCPCS
Z00.00	Encounter for general adult medical examination without abnormal findings	ICD10CM
Z00.01	Encounter for general adult medical examination with abnormal findings	ICD10CM
Z00.110	Health examination for newborn under 8 days old	ICD10CM
Z00.111	Health examination for newborn 8 to 28 days old	ICD10CM
Z00.121	Encounter for routine child health examination with abnormal findings	ICD10CM
Z00.129	Encounter for routine child health examination without abnormal findings	ICD10CM
Z00.2	Encounter for examination for period of rapid growth in childhood	ICD10CM
Z00.3	Encounter for examination for adolescent development state	ICD10CM
Z02.5	Encounter for examination for participation in sport	ICD10CM
Z76.1	Encounter for health supervision and care of foundling	ICD10CM
Z76.2	Encounter for health supervision and care of other healthy infant and child	ICD10CM

W30: Well Child Visit (ages 16-30 mo.)

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

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

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

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

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

*See procedure code list for W15 and W30 above

VII. Health Education Resources that Support P4P

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

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

VIII. Terms & Conditions

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

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

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

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

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