



Fee for Service Pay for Performance Program Guidelines

2019 Program Year

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General Program Guidelines

Program Overview

Health Plan of San Mateo's (HPSM) fee for service Pay for Performance (FFS P4P) program offers performance bonus payments to contracted Medi-Cal and CareAdvantage primary care providers for targeted quality measures to improve outcomes for HPSM members. The program is also designed to share data with HPSM primary care providers on patient care information for assigned HPSM patients. The targeted quality performance measure set focuses on member access and preventive care services.

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

Provider Participation Eligibility

Providers must have an active Medi-Cal and/or CareAdvantage primary care contract with HPSM and must have a specialty type designation as a primary care provider (or OB/GYN provider for specific measures) to receive FFS P4P program payments. The contract must be active as of the date of payment.

Starting January 1, 2019 Medi-Cal primary care providers need to be designated as Track 1 or 2 in the HPSM Primary Care Medi-Cal payment model to receive FFS P4P payments for Medi-Cal members.

Both Medi-Cal and CareAdvantage contracted primary care providers are eligible to receive FFS P4P payments for assigned CareAdvantage members.

Payment Schedule & Reports

Performance bonus payment by measure is contingent on meeting the measure specification criteria. Once the encounter information has been received and eligibility has been determined, payment will be made in the regular weekly Medi-Cal and/or CareAdvantage Remittance Advice (RA). Additional member detail and payment summary reports will be made available to providers through the HPSM eReports portal on a monthly basis. See the FFS P4P report specifications on the HPSM website for additional information on how to interpret the monthly P4P Member Detail report.

Website for eReports login: <https://reports.hpsm.org>

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

Blood Pressure Control (CBP) – Diabetes and Hypertension

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

Payment Rate: up to once per eligible patient per calendar year (either poor control or not in poor control)

- Poor control $\geq 140/90$ mm Hg: \$30
- Not in poor control $< 140/90$ mm Hg: \$70

Measure Definition: Annual blood pressure monitoring

Billing Guidelines: *Must submit combination of one procedure code from systolic measurement, one from diastolic measurement, and a qualifying ICD-10 diagnosis code.

Systolic Procedure Codes

- **3077F**; Systolic (equal or greater than) > 140 mmHg (poor control)
- **3075F**; Systolic 130-139 mmHg (not in poor control)
- **3074F**; Systolic < 130 mmHg (not in poor control)

Diastolic Procedure Codes

- **3078F**; Diastolic < 80 mmHg (not in poor control)
- **3079F**; Diastolic 80-89 mmHg (not in poor control)
- **3080F**; Diastolic (equal or greater than) > 90 mmHg (poor control)

[ICD-10 Diagnosis Codes](#)

Line of business: MC and CA

Body Mass Index (BMI)

Patient Eligibility: All age ranges

Payment Rate: \$25 up to once per eligible patient per calendar year

Measure Definition: Measure BMI for each patient annually and retain in patient's medical record

Billing Guidelines:

- Procedure Code **3008F**; and BMI diagnosis code as applicable by age range (see below)
- Patients 0-2 years old: measure and record the weight-for-length percentile
- Patients 2-20 years old: measure and record BMI percentile
- Patients 21 years and older: measure and record height, weight, and BMI
- For patients 0-18 years old; include nutritional and physical activity counseling diagnosis codes if applicable

ICD-10 Diagnosis Codes

Patients 2-20 years old: BMI percentile

- | | | | |
|-----------------|---------------------|-----------------|----------------------|
| • Z68.51 | < 5th % for age | • Z68.53 | 85% to < 95% for age |
| • Z68.52 | 5% to < 85% for age | • Z68.54 | $\geq 95%$ for age |

Patients 21 years and older: BMI

- **Z68.1** < 20
- **Z68.20** 20.0-20.9
- **Z68.21** 21.0-21.9
- **Z68.22** 22.0-22.9
- **Z68.23** 23.0-23.9
- **Z68.24** 24.0-24.9
- **Z68.25** 25.0-25.9
- **Z68.26** 26.0-26.9
- **Z68.27** 27.0-27.9
- **Z68.28** 28.0-28.9
- **Z68.29** 29.0-29.9
- **Z68.30** 30.0-30.9
- **Z68.31** 31.0-31.9
- **Z68.32** 32.0-32.9
- **Z68.33** 33.0-33.9
- **Z68.34** 34.0-34.9
- **Z68.35** 35.0-35.9
- **Z68.36** 36.0-36.9
- **Z68.37** 37.0-37.9
- **Z68.38** 38.0-38.9
- **Z68.39** 39.0-39.9
- **Z68.41** 40.0-44.9
- **Z68.42** 45.0-49.9
- **Z68.43** 50.0-59.9

Patients 0-18 years old nutrition and physical activity diagnosis codes

- **Z71.3** Nutrition Counseling
- **Z71.89** Physical Activity Counseling

Line of business: MC and CA

Care for Older Adults (4 components)

Patient Eligibility: 66 years and older as of Dec. 31 of the measurement year

Line of business: MC & CA – applies to all four components of care for older adults

1. Measure: Pain Assessment

Billing Guidelines: Procedure codes

1125F Pain severity quantified; pain present (COA) (ONC)

1126F Pain severity quantified; no pain present (COA) (ONC)

Payment Rate: \$10

Frequency: Either of the two codes up to once per calendar year (only one payment for one code, if another code is submitted in the same calendar year another bonus payment will not be made)

2. Measure: Advance care planning

Billing Guidelines: Procedure codes

1123F Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)

1124F Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)

1157F Advance care plan or similar legal document present in the medical record (COA)

1158F Advance care planning discussion documented in the medical record (COA)

Payment Rate: \$45; Any one of the four codes up to once per calendar year (only one payment for one code, if another code is submitted in the same calendar year it will not qualify for another bonus payment)

3. Measure: Medication review

Billing Guidelines: Procedure code **1160F**

Rate: \$10 up to once per member per calendar year

Measure definition: A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.

4. Measure: Functional status assessment

Billing Guidelines: Procedure code **1170F**

Payment Rate: \$10 up to once per member per calendar year.

Cervical Cancer Screening

Primary care providers can submit for this quality performance measure if they have documented and reviewed that the patient had a cervical cancer screening during the current calendar year, regardless of whether they performed the screening themselves. The date of service submitted on the claim for the cervical cancer screening FFS P4P measure should be the date of service the screening result was documented and reviewed by the PCP.

Patient Eligibility: Women age 21-64 years old who have not had a complete hysterectomy.

Payment Rate: \$30 up to once per eligible patient per calendar year.

Measure Definition: Cervical cytology/pap smear screening

Billing Guidelines: Procedure Code **3015F**

Date of Service: Bill with the date of service the screening is reviewed and documented in the patient's chart.

Line of business: MC and CA

Colorectal Cancer Screening

Patient Eligibility: Members 50-75 years old

Payment Rate: \$30 up to once per eligible patient per calendar year.

Billing Guidelines: Procedure Code **3017F****Line of business:** MC and CA**Measure Definition:** Appropriate screening for colorectal cancer and documentation.

One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two years prior to the measurement year

Documentation requirements: Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the “medical history” section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

Depression Screening & Follow-up

Patient Eligibility: Patients 12 years old and up**Payment Rate:** \$30 up to once per eligible patient per calendar year.

Measure Definition: Annual depression screening using a standard depression screening tool (including HPSM Behavioral Health Screening tool available at: www.hpsm.org/p4p, which includes PHQ-2 standard screening questions).

- Screening must be documented in patient’s medical record
- If screening is positive, follow-up plan must be documented

Billing Guidelines: Procedure Codes

- **G8510** for negative screens (PHQ-2 score less than 3)
- **G8431** for positive screens and documented follow-up plan

*Submit HPSM P4P procedure codes in addition to covered benefit procedure codes for annual screenings. See HPSM Provider Announcements; www.hpsm.org/provider-news or email PCPreports@hpsm.org for a copy of the P4P and covered benefit billing guidelines if the HPSM Behavioral Health Screening tool is used.

Line of business: MC & CA

Diabetes Eye Exam

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

Payment Rate: \$30 up to once per eligible patient per calendar year

Measure Definition: Annual diabetic retinal eye exam

Billing Guidelines: *Must submit combination of one procedure code and ICD-10 diabetes diagnosis code.

The [Diabetes diagnosis code list](#) is available on hpsm.org. Primary care provider should **refer for the exam to an eye care specialist** and submit the P4P code once the result has been **sent back to the primary care provider and** recorded in the patient's medical record. Submit for date of service when the test was ordered.

Procedure Codes

- **3072F**; Low risk for retinopathy (no evidence of retinopathy in the prior year as indicated by prior dilated eye exam)
- **2026F**; Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
- **2024F**; 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
- **2022F**; Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

[ICD-10 Diabetes Diagnosis Codes](#)

Line of business: MC and CA

Diabetes HbA1c

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

Payment Rate:** up to ***twice per eligible patient per calendar year

- Poor control $\geq 9.0\%$: \$15
- Not in poor control $< 9.0\%$: \$50

Measure Definition: Diabetic HbA1c blood glucose testing

Billing Guidelines: *Must submit combination of one procedure code and ICD-10 diabetes diagnosis code.

Diabetes diagnosis code list can be found on the HPSM website. Primary care provider should order the test and submit the P4P code once the result has been recorded in the patient's medical record. Submit for date of service when the test was ordered.

Procedure Codes

- **3044F**; HbA1c level $< 7.0\%$
- **3045F**; HbA1c level $7.0-9.0\%$
- **3046F**; HbA1c level $> 9.0\%$ (poor control)

[ICD-10 Diabetes Diagnosis Code](#)

Line of business: MC and CA

Diabetes Medical Attention for Nephropathy (including screening)

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

Payment Rate: \$30 up to once per eligible patient per calendar year

Measure Definition: Annual nephropathy screening or medical attention for diabetic nephropathy

Billing Guidelines: *Must submit combination of one procedure code and ICD-10 diabetes diagnosis code. The [Diabetes diagnosis code list](#) can be found on hpsm.org. Primary care provider should order the test and submit the P4P code once the result has been recorded in the patient's medical record. Submit for date of service when the test was ordered.

Procedure Codes

- **4010F;** Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken
- **3066F;** Documentation of treatment for nephropathy (e.g., patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)
- **3062F;** Positive MACROalbuminuria test result documented and reviewed
- **3061F;** Negative microalbuminuria test result documented and reviewed
- **3060F;** Positive MICROalbuminuria test result documented and reviewed

ICD-10 Diabetes Diagnosis Codes

Line of business: MC and CA

Mammogram for Breast Cancer Screening

Primary care providers can submit for this quality performance measure if they have documented and reviewed that the patient had a mammogram during the current calendar year, regardless of whether they performed the mammogram themselves. The date of service submitted on the claim for the Mammogram FFS P4P measure should be the date of service the screening result was documented and reviewed by the PCP.

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

Payment Rate: \$10 up to once per eligible patient per calendar year

Measure Definition: Mammogram for breast cancer screening; Primary care provider should order the test and submit the P4P code once the result has been recorded in the patient's medical record. Submit for date of service when the test was ordered.

Billing Guidelines: [Procedure Code 3014F](#)

Date of Service: Bill with the date of service the screening is reviewed and documented in the patient's chart

Line of business: MC and CA

Postpartum Exam (OB/GYN)

Patient Eligibility: Women who gave birth in the last 21 to 56 days

Payment Rate: \$50 up to once per patient per pregnancy

Measure Definition: Postpartum exam performed within 21 to 56 days after delivery

Billing Guidelines: Procedure code **0503F**

Line of Business: MC

Prenatal Visit (OB/GYN)

Patient Eligibility: Women in their first trimester of pregnancy

Payment Rate: \$100 up to once per patient per pregnancy

Measure Definition: Prenatal visit with OB/GYN within first trimester of pregnancy

Billing Guidelines: Procedure code **0500F**

Line of Business: MC

Substance Misuse Screening (including alcohol)

Screening, Brief Intervention, Referral & Treatment (SBIRT Screening)

Patient Eligibility: Patients 12 years old and up

Payment Rate: \$25 up to once per eligible patient per calendar year

Measure Definition: Annual substance misuse screening using a standard screening tool (including HPSM Behavioral Health Screening tool available on: www.hpsm.org/p4p, which includes AUDIT-C standard screening questions).

Screening results must be documented in patient's medical record.

If screening is positive, follow-up plan must be documented and a brief intervention can be done in the primary care setting, which can be billed through patient's covered benefits (codes depend on type of insurance – see covered benefit billing guidelines; www.hpsm.org/provider-news).

Billing Guidelines: Procedure Code **3016F**

*Submit HPSM P4P procedure codes in addition to covered benefit procedure codes for annual screenings. See HPSM Provider Announcement referenced above or email PCPreports@hpsm.org for a copy of the P4P and covered benefit billing guidelines if the HPSM Behavioral Health Screening tool is used.

Line of business: MC and CA

Free Health Education Materials that Support P4P

We realize that, with more focus on obesity and weight management, diabetes and other health conditions, our members may turn to you and to HPSM for assistance on how to address these problems. To prepare for this need, HPSM has some generic health education materials in each of these areas. Many of these resources are available in English, Spanish, Chinese and Tagalog. If our members are interested in additional health education materials, have them call our Health Education line at **650-616-2165**. Some hospitals offer free educational classes on diabetes and other topics that are either available to the general community or require a physician referral. Check to see if your clinic offers these. We strongly encourage you to refer our members to these classes if they are free. If you need any other health education resources that you or your office staff think would be helpful for our members, please let us know. We appreciate working in partnership with you in caring for our members.

Terms & Conditions

Participation in HPSM's P4P program, as well as acceptance of performance bonus payments, does not in any way modify or supersede any terms or conditions of any agreement between HPSM and participating providers.

There is no guarantee of future funding or payment under any HPSM P4P performance bonus program. HPSM's P4P program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at HPSM's sole discretion.

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

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

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

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

Summary of 2019 Program Year Updates

Reminder – assigned CareAdvantage members are eligible for FFS P4P payments for all contracted PCPs regardless of Medi-Cal P4P track selection.

- CA FFS P4P payments are now available to CA-contracted primary care providers.
- Payments for CA members are paid through the regular CA Remittance Advice (RA).
- Payment summaries are posted monthly to the HPSM eReports portal.
- Please see the line of business applicable to each measure in these guidelines.

Retired measures:

- Women’s health exam measure. Now replaced by separate cervical cancer and breast cancer screening measures
- PCP OB referral measure
- Initial Health Assessments (available through the Benchmark P4P program)
- Adolescent well-visits (available through the Benchmark P4P program)
- Child well-visits (available through the Benchmark P4P program)

New measures:

- Colorectal cancer screening
- Controlling high blood pressure
- Care for older adults (4 components)
 1. Pain Assessment
 2. Advanced Care Planning
 3. Medication Review
 4. Functional Status Assessment

Current measure updates:

- See revised guidelines for prenatal and post-partum measures. There are updated procedure codes and these measures will now be paid directly through claims and the regular Medi-Cal RA.
- Updated BMI procedure code
- Updated substance misuse screening procedure code and payment rate
- Updated diagnosis code lists – please see specified list for each measure

Procedure Code Updates

Measure	2018	Jan. 1 - Dec. 31, 2019	Line of business 2019
BMI	99411 AND modifier WT	3008F	MC and CA
Women's Health Exam	G0101	Retired	N/A
Postpartum Visit	59430 AND modifier PP	0503F	MC
Prenatal Visit	0500F and modifier K1	0500F; NO MODIFIER	MC
Diabetes - eye exam	2022F; 2024F; 2026F; 3072F	No change from 2018	MC and CA
Diabetes - HbA1c good control	3044F; 3045F	No change from 2018	MC and CA
Diabetes - HbA1c poor control	3046F	No change from 2018	MC and CA
Diabetes - Positive microalbuminuria	3060F	No change from 2018	MC and CA
Diabetes - Negative microalbuminuria	3061F	No change from 2018	MC and CA
Diabetes - Positive microalbuminuria test result documented and reviewed	3062F	No change from 2018	MC and CA
Diabetes - ACE inhibitor or ARB prescribed or currently being taken	4010F	No change from 2018	MC and CA
Diabetes - Treatment for Nephropathy (dialysis, ESRD, CRF, ARF or renal Insufficiency)	3066F	No change from 2018	MC and CA
CBP - Systolic <130 mmHg	3074F	No change from 2018	MC and CA
CBP - Systolic 130-139 mmHg	3075F	No change from 2018	MC and CA
CBP - Systolic (equal or greater than) ≥140 mmHg	3077F	No change from 2018	MC and CA
CBP - Diastolic <80 mmHg	3078F	No change from 2018	MC and CA
CBP - Diastolic 80-89 mmHg	3079F	No change from 2018	MC and CA
CBP - Diastolic (equal or greater than) ≥90 mmHg	3080F	No change from 2018	MC and CA

Measure	2018	Jan. 1 - Dec. 31, 2019	Line of business 2019
Adolescent well-visit	99384 or 99385 or 99394 or 99395 AND claim message 8126	Retired	N/A
Initial Health Assessments	99381, 99382, 99383, 99386 or 99387 AND claim message 8126	Retired	N/A
Well-child visit (3-6 years old)	99392 or 99393 AND claim message 8126	Retired	N/A
Depression Screening	G8510, G8431	G8510, G8431	MC and CA
SBIRT	3725F	3016F	MC and CA
Cervical Cancer Screening	3015F	3015F	MC and CA
Mammogram	3014F	3014F	MC and CA
Colorectal Cancer Screening	N/A	3017F	MC and CA
Care for Older Adults 4 components:		See below	
1. Pain Assessment	N/A	1125F; 1126F	MC and CA
2. Advance Care Planning	N/A	1123F; 1124F; 1157F; 1158F	MC and CA
3. Medication Review	N/A	1160F	MC and CA
4. Functional Status Assessment	N/A	1170F	MC and CA

Legend

Green text	New addition
Green Highlight	Updated this year
Retired	Retired as of Jan. 1, 2019
N/A	Not Applicable
MC	Medi-Cal direct; No primary other health coverage or Medicare FFS
CA	CareAdvantage

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Colorectal cancer screening - Notes for informatics reporting:

Exclude members from eligibility (list as N/A) if they meet the 2019 HEDIS tech specs exclusion criteria