2024

COVERED CA QUALITY TRANSFORMATION PROGRAM (QTP)

(FOR PCPs)

Program Technical Guide

IEHP Covered

Contact: *QualityPrograms@iehp.org*

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TABLE OF CONTENTS

PROGRAM OVERVIEW

This program guide provides an overview of the 2024 Covered CA (CCA) Quality Transformation Program (QTP) for IEHP Direct Primary Care Physicians (PCPs). The IEHP Covered CA Quality Transformation Program (QTP) for PCPs is designed to support the quality of health care for IEHPs Covered CA Members. The Covered CA Quality Transformation Program (QTP) aligns with the CCA Quality Exhibit IEHP Covered CA IEHP Direct PCPs contract requirements.

If you would like more information about IEHP's Covered CA Quality Transformation Program (QTP) or best practices to help improve quality scores and outcomes, visit our Secure Provider Portal at ***www.iehp.org***, email the Quality Team at ***QualityPrograms@iehp.org*** or call the IEHP Provider Relations Team at (909) 890-2054.

Eligibility

To be eligible for enhanced quality payments in the 2024 Covered CA Quality Transformation Program (QTP), PCPs must meet the following criteria:

- IEHP Direct Covered CA Primary Care Physicians (PCPs) who have a CCA Quality Exhibit IEHP Covered CA IEHP Direct PCP contract are eligible to participate in the Covered CA Quality Transformation Program (QTP).
- Have at least 20 Members in the denominator as of December 2024 for each quality measure to qualify for scoring.
- Have at least three quality measures that meet minimum denominator requirements in order for a CCA Star Rating score to be calculated.

☑ Minimum Data Requirements

Claims Data

Claims data is foundational to performance measurement and is essential in the 2024 Covered CA Quality Transformation Program. Complete, timely and accurate claims data should be submitted through normal reporting channels for all services rendered to IEHP Members. Please use the appropriate codes listed in Appendix 2 to meet measure requirements.

Lab Results

Data from lab results data is also foundational to Program performance measurement. Providers should ensure they submit complete lab results data for services rendered to IEHP Members. Work with IEHP to ensure you are using the appropriate lab vendors for IEHP Members.

Lab results that are performed in the office (e.g., point of care HbA1c testing, urine tests, etc.) should be coded and submitted through your encounter data.

Immunizations

To maximize performance in immunization-based measures, **IEHP requires all Providers to report all immunizations via the California Immunization Registry (CAIR2)**. For more information on how to register for CAIR2, please visit *http://cairweb.org/*. IEHP works closely with CAIR to ensure data sharing to support the Covered CA Quality Transformation program.

☑ Provider Research Inquiries

All Provider research inquiries, related to the data collected to measure program metrics, must be submitted in an excel worksheet. The following information must be included in the research inquiry to support the description of the dispute: Provider Name, Provider NPI, Member Name, Member ID, Measure Name, DOS, Procedure Code/ICD-10 code, and any other information that would be helpful to research the inquiry.

Program Terms and Conditions

- Good Standing: A Provider currently contracted with Plan for the delivery of services, not pursuing any litigation or arbitration or has a pending claim pursuant to the California Government Tort Claim Act (Cal. Gov. Code Sections 810, et seq.) filed against Plan at the time of program application or at the time additional funds may be payable, and has demonstrated the intent, in Plan's sole determination, to continue to work together with Plan on addressing community and Member issues. Additionally, at the direction of the CEO or their designee, Plan may determine that a Provider is not in good standing based on relevant quality, payment, or other business concerns.
- Criteria for calculating Provider Star Rating are subject to change at any time, with or without notice, at IEHP's sole discretion.
- In consideration of IEHP's offering of the IEHP Covered CA Quality Transformation Program (QTP), participants agree to fully and forever release and discharge IEHP from any and all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by IEHP of the IEHP Covered CA Quality Transformation Program (QTP).
- The determination of IEHP regarding performance scoring and Quality Performance Adjustments under the IEHP Covered CA Quality Transformation Program (QTP) is final.
- As a condition of receiving payment under the IEHP Covered CA Quality Transformation Program (QTP), Providers must be active and contracted with IEHP and have active assigned Members at the time of payment.
- Providers will not charge IEHP for medical records for HEDIS, Risk Adjustment, and other health plan operational activities.

Financial Overview: Quality Adjustment

Providers are eligible to receive a quality adjustment that will be based on the Provider's quality performance in the measurement year (2024). This quality adjustment may be an increase, or reduction, in the Providers IEHP base fee schedule rate. Refer to your CCA PCP agreement, Quality Exhibit for details.

Performance Measures

Appendix 1 provides a list of the 5 measures in the 2024 Covered CA Quality Transformation Core Program (QTP) and includes thresholds and benchmarks associated with respective Tier Goals.

Measures included in this program use standard Healthcare Effectiveness Data and Information Set (HEDIS®) process and outcomes measures that are based on the specifications published by the National Committee for Quality Assurance (NCQA). Non-HEDIS® measures that are included in the program come from the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Quality Program.

Program Measures:

- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes
- Chlamydia Screening in Women
- Child and Adolescent Well-Care Visits
- Initial Health Appointment

☑ Scoring Methodology

In this first year of the Covered CA Quality Transformation Program, Provider performance will be assessed based on the current measurement year (2024). Quality adjustments in this program will be determined by the Providers performance in the program metrics being assessed. The measurement performance will begin once the IEHP Covered CA Member assignment begins with a Provider. The performance in this program will determine the "Quality Adjustment" rate that may impact the Provider's CCA Exhibit base rate, starting July 2025. The 2024 measurement year will assess performance within the period of January 1 – December 31, 2024.

Note: The Providers CCA Exhibit base rate will reset each measurement year back to the original base rate.

Year-Over-Year Improvement

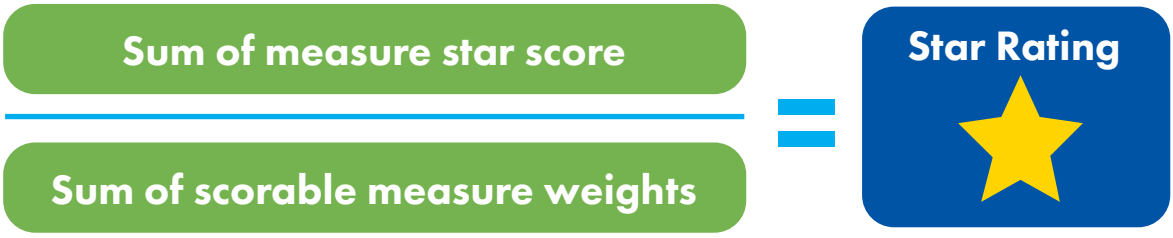
The current measurement year (2024) performance will set the baseline for the following measurement year (2025). This program is designed to focus on value-based care where Provider reimbursement is directly tied to the quality of care provided to IEHP Members. The direction of this program will progress and there will be improvement factors that will take place in the 2025 (and forward) Covered CA Quality Transformation Program (QTP).

Performance Methodology

Calculating the Star Score

Provider performance for each measure will be given a star value (i.e., a measure score). Measure scores are applied based on star threshold cut points that are assigned per measure (see Appendix 1 for star threshold cut points).

The following formula will be used to calculate the overall Star Rating Score:
Star Rating Score = Sum (measure star rating * measure weight) / Sum of measure weights



The Star Rating will follow the rounding rules found in Table 1 below:

TABLE 1. COVERED CA QUALITY TRANSFORMATION PROGRAM (QTP) – STAR RATING	
Initial Star Rating	**Overall Star Rating***
≥ 0.750000 and < 1.250000	1.0 Stars
≥ 1.250000 and < 1.750000	1.5 Stars
≥ 1.750000 and < 2.250000	2.0 Stars
≥ 2.250000 and < 2.750000	2.5 Stars
≥ 2.750000 and < 3.250000	3.0 Stars
≥ 3.250000 and < 3.750000	3.5 Stars
≥ 3.750000 and < 4.250000	4.0 Stars
≥ 4.250000 and < 4.750000	4.5 Stars
≥ 4.750000 and ≤ 5.000000	5.0 Stars

**The results of the overall star rating calculations are rounded down to the nearest whole number.*

Calculating the Quality Adjustment

There will be **one** adjustment calculated for the 2024 performance year:

1) Quality Performance Adjustment

Quality Performance Adjustment

A Quality Performance Adjustment will be calculated for the current measurement year (2024) performance. The Quality Performance Adjustment will determine if there is a rate change made to the Provider's base CCA contractual rate.

The following method will be used to calculate the **Quality Performance Adjustment:**

Step 1: Determine current measurement year (2024) star rating (see Calculating the Star Score methodology).

Step 2: Determine Provider current measurement year (2024) Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview).

Step 3: Determine Quality Performance Adjustment Amount based on current measurement year (2024) Provider Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview).

TABLE 2. PROVIDER COMPOSITE QUALITY SCORE & ASSOCIATED QUALITY PERFORMANCE ADJUSTMENT OVERVIEW	
Provider Composite Quality Score	**Quality Performance Adjustment Amount**
5 Star Rating: Performance at the 90th percentile or higher	20% increase in base rate
4 Star Rating: Performance between the 66th percentile and 89th percentile	10% increase in base rate
3 Star Rating: Performance between the 33rd percentile and the 65th percentile	No change in base rate
2 Star Rating: Performance between the 10th percentile and 32nd percentile	5% reduction in base rate
1 Star Rating: Performance below the 10th percentile	10% reduction in base rate

Step 4: Calculate the Initial PCP Quality Adjustment Amount:

Initial PCP Quality Adjustment Amount = PCP base CCA rate + current measurement year (2024) Quality Performance Adjustment Amount.

Scoring Methodology Example:

Provider Example: Calculating Provider Initial PCP Quality Adjustment Amount

PROVIDER JOHN DOE 2024 QUALITY PERFORMANCE ADJUSTMENT FACTORS	
PCP Base Rate	100%
2024 Star Rating	2 star

Calculating 2024 Initial PCP Quality Adjustment Amount:

The following method will be used to calculate the **Quality Performance Adjustment:**

Step 1: Determine current measurement year (2024) star rating: *Provider finished the current measurement year (2024) with a 2 star rating.*

Step 2: Determine Provider current measurement year (2024) Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview): *Providers Composite Quality Score is at a 2 star rating: between the 10th and 32nd percentile.*

Step 3: Determine Quality Performance Adjustment Amount based on current measurement year (2024) Provider Composite Quality Score (see Table 2: Provider Composite Quality Score & Associated Quality Performance Adjustment Overview): *Providers Composite Quality Score is between the 10th and 32nd percentile and meets a Quality Performance Adjustment amount reduction of 5%.*

TABLE 2. PROVIDER COMPOSITE QUALITY SCORE & ASSOCIATED QUALITY PERFORMANCE ADJUSTMENT OVERVIEW	
Provider Composite Quality Score	**Quality Performance Adjustment Amount**
5 Star Rating: Performance at the 90th percentile or higher	20% increase in base rate
4 Star Rating: Performance between the 66th percentile and 89th percentile	10% increase in base rate
3 Star Rating: Performance between the 33rd percentile and the 65th percentile	No change in base rate
2 Star Rating: Performance between the 10th percentile and 32nd percentile	5% reduction in base rate
1 Star Rating: Performance below the 10th percentile	10% reduction in base rate

Step 4: Calculate the Initial PCP Quality Adjustment Amount:

Initial PCP Quality Adjustment Amount = PCP Base CCA rate + current measurement year (2024) Quality Performance Adjustment Amount.

Initial PCP Quality Adjustment Amount = 100 % - 5% = 95% CCA rate

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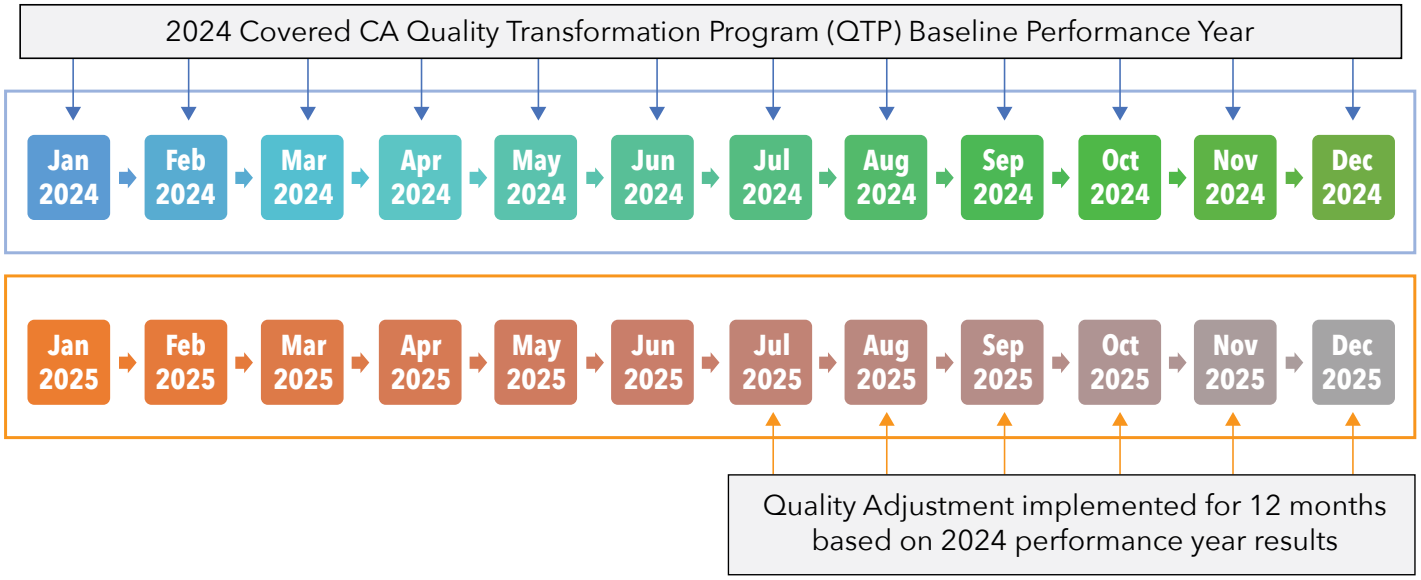
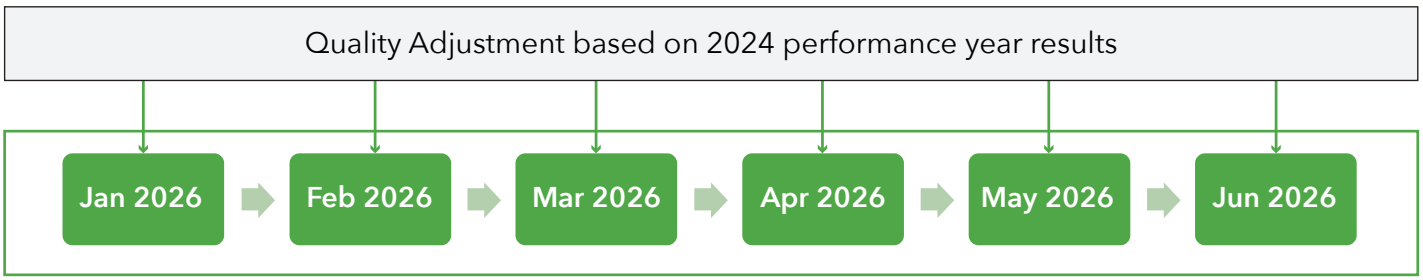
The Initial PCP Quality Adjustment Amount of 95% will be the adjusted rate that will be applied as the Providers CCA contractual rate from July of the following year (2025) through June of the next year (2026).

Covered CA Quality Transformation Program Timeline:





Getting Help

Please direct questions and/or comments related to this program to the IEHP Provider Relations Team at (909) 890-2054 or IEHP's Quality Department at ***QualityPrograms@iehp.org***.

APPENDIX 1: *2024 PCP Covered CA Quality Transformation Program (QTP) Measures*

2024 COVERED CA QUALITY TRANSFORMATION PROGRAM (QTP) MEASURE LIST:								
Domain	**Measure Name**	**Population**	**1 Star Rating**	**2 Star Rating**	**3 Star Rating**	**4 Star Rating**	**5 Star Rating**	**Measure Weight**
Clinical Quality	Controlling High Blood Pressure▪	Adult	<58%	58%	64%	71%	77%	3.0
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes♦	Adult	<65%	65%	74%	80%	83%	3.0
Clinical Quality	Chlamydia Screening in Women▪	Women	<34%	34%	42%	51%	63%	1.0
Clinical Quality	Child and Adolescent Well-Care Visits▪	Child	<34%	34%	44%	56%	69%	1.0
Clinical Quality	Initial Health Appointment^	All	<37%	37%	55%	72%	85%	1.0

▪ *Star Rating set as published in the 2024 (MY 2023) NCQA Exchange Quality Compass*

♦ *Star Rating set as published in the MY 2023 CMS Benchmarks*

^ *Star Rating set at the MY 2023 Medi-Cal Network Performance*

The goals in Appendix 1 may be adjusted once measurement year (2024) national benchmarks are available. The goals are based on a combination of national and network performance and may be adjusted higher or lower based on network trends.

CORE MEASURES

APPENDIX 2: *Measures Overview*

☑ Population: Adult

Controlling High Blood Pressure (CBP)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age, with a diagnosis of hypertension (HTN), and whose blood pressure (BP) was controlled (<140/90 mm Hg) during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Age 18-85 years of age as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP of up to 45 days during the measurement year (2024).
    3. Members who had at least two different visits with a hypertension diagnosis on or between January 1 of the year prior to the measurement year (2023) and June 30 of the measurement year (2024). Visit can be in any outpatient setting.

Denominator: All Members 18-85 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a BP reading taken during the measurement year (2024), in any of the following settings: office visits, e-visits, telephone visits or online assessments. The most recent BP of the measurement year (2024) will be used to determine compliance for this measure. **Provider must bill one diastolic code, one systolic code and one visit type code.**

NOTE: The BP reading must be taken on or after the date of the second hypertension diagnosis.

CODES TO IDENTIFY BLOOD PRESSURE SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Blood Pressure Screening	CPT- CAT-II	3079F	Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3078F	Most recent diastolic blood pressure less than 80 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT- CAT-II	3074F	Most recent systolic blood pressure less than 130 mm Hg (DM), (HTN, CKD, CAD)
Blood Pressure Screening	CPT- CAT-II	3075F	Most recent systolic blood pressure 130-139 mm Hg (DM) (HTN, CKD, CAD)

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
Office Visit	CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99241	Office consultation for a new or established patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99242	Office consultation for a new or established patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99243	Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99244	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99245	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99341	Home visit for the evaluation and management of a new patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99342	Home visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99343	Home visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99344	Home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99345	Home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem-focused interval history; A problem-focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem-focused interval history; An expanded problem-focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99350	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99385	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; 18-39 years.
Office Visit	CPT	99386	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; 40-64 years.
Office Visit	CPT	99387	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; 65 years and older.
Office Visit	CPT	99395	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; 18-39 years.
Office Visit	CPT	99396	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; 40-64 years.
Office Visit	CPT	99397	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; 65 years and older.
Office Visit	CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
Office Visit	CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
Office Visit	CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
Office Visit	CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
Office Visit	CPT	99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.
Office Visit	CPT	99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.
Office Visit	CPT	99429	Unlisted preventive medicine service.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99455	Work-related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
Office Visit	CPT	99456	Work-related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Office Visit	HCPCS	G0071	Payment for communication technology-based services for five minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or five minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.
Office Visit	HCPCS	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
Office Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Office Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	HCPCS	T1015	Clinic Visit/encounter, All-inclusive

CODES TO IDENTIFY E-VISITS:			
Service	**Code Type**	**Code**	**Code Description**
E-Visit	CPT	98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.
E-Visit	CPT	98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.
E-Visit	CPT	98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.
E-Visit	CPT	99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.
E-Visit	CPT	99422	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.
E-Visit	CPT	99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.
E-Visit	HCPCS	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
E-Visit	HCPCS	G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

CODES TO IDENTIFY TELEPHONE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Telephone Visit	CPT	98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
Telephone Visit	CPT	99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	CPT	98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
Online Assessment	CPT	98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	CPT	99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
Online Assessment	CPT	99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
Online Assessment	HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Glycemic Status Assessment for Patients with Diabetes (GSD)

Summary of Changes to the Covered CA Quality Transformation Program Guide:

- Update to the Measure Title
- Update to the Measure Description
- Update to the eligible population
- Update to the exclusions

Methodology: HEDIS®

Measure Description: The percentage of Members 18-75 years of age and have a diagnosis of diabetes (type 1 and type 2) who had the following:

- Glycemic Status (<8.0%) – This includes diabetics whose most recent Glycemic Status (hemoglobin A1c or glucose management indicator [GMI]) during the measurement year (2024) has a value <8.0%.
    - The Member is not numerator compliant if the result for the most recent Glycemic Status Assessment is ≥8.0% or is missing a result, or if an Glycemic Status Assessment was not done during the measurement year (2024).
- The eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years old as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP in the measurement year (2024) with no more than one gap of up to 45 days during the measurement year (2024).
    3. Members who meet any of the following criteria during the measurement year (2024) or the year prior to the measurement year (2023). Count services that occur over both years:
        - Members who had at least two diagnoses of diabetes on different days of service during the measurement year (2024) or the year prior to the measurement year (2023).
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (2024) or the year prior to the measurement year (2023) and have at least one diagnosis of diabetes during the measurement year (2024) or the year prior to the measurement year (2023).

CODES TO IDENTIFY GLYCEMIC STATUS TESTS:			
Service	**Code Type**	**Code**	**Code Description**
Glycemic Status Result	CPT-CAT-II	3046F	Most Recent Hemoglobin A1c Level Greater Than 9.0% (DM)
Glycemic Status Result	CPT-CAT-II	3051F	Most Recent Hemoglobin A1c (HbA1c) Level Greater Than Or Equal To 7.0% And Less Than 8.0%
Glycemic Status Result	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%
Glycemic Status Result	CPT-CAT-II	3044F	Most Recent Hemoglobin A1c (HbA1c) Level Less Than 7.0% (DM)

- Members who met any of the following criteria are excluded:
    1. Members in hospice.
    2. Members receiving palliative care.
    3. Members who expired at any time during the measurement year (2024).
    4. Members 66 years of age and older as of December 31 of measurement year (2024) with both frailty and advanced illness.

Denominator: Members 18-75 years of age who meet all the criteria for eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had the most recent glycemic status test result of <8 during the measurement year (2024).

☑ Population: Women

Chlamydia Screening in Women (CHL)

Methodology: HEDIS®

Measure Description: The percentage of women 16-24 years of age who identified as sexually active and had at least one test for chlamydia during the measurement year (2024).

- The eligible population in the measure meets all of the following criteria:
  1. Women 16-24 years as of December 31 of the measurement year (2024).
  2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in enrollment of up to 45 days.
  3. There are two methods to identify sexually active women: claim/encounter data or pharmacy data.

CODES TO IDENTIFY SEXUALLY ACTIVE WOMEN:			
Service	**Code Type**	**Code**	**Code Description**
Sexually Active	CPT	86631	Antibody Chlamydia
Sexually Active	CPT	86632	Antibody Chlamydia Igm
Sexually Active	CPT	87810	Infectious Agent Detection By Immunoassay With Direct Optical Observation Chlamydia Trachomatis
Sexually Active	CPT	87270	Infectious Agent Antigen Detection By Immunofluorescent Technique Chlamydia Trachomatis
Sexually Active	CPT	87320	Infectious Agent Antigen Detection By Enzyme Immunoassay Technique Qualitative Or Semiquantitative Multiple Step Method Chlamydia
Sexually Active	CPT	87492	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Quantification
Sexually Active	CPT	87110	Culture Chlamydia Any Source
Sexually Active	CPT	87490	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Direct Probe Technique
Sexually Active	CPT	87491	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Amplified Probe Technique
Sexually Active	CPT	87492	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Quantification

CONTRACEPTIVE MEDICATIONS	
Description	**Prescription**
Contraceptives	Desogestrel-ethinyl estradiol Dienogest-estradiol (multiphasic) Drospirenone-ethinyl estradiol Drospirenone-ethinyl estradiol-levomefolate (biphasic) Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin Ethinyl estradiol-norethindrone Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Norethindrone
Diaphragm	Diaphragm
Spermicide	Nonxynol 9

CODES TO IDENTIFY CHLAMYDIA SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Chlamydia Screening	CPT	87110	Culture Chlamydia Any Source
Chlamydia Screening	CPT	87270	Infectious Agent Antigen Detection By Immunofluorescent Technique Chlamydia Trachomatis
Chlamydia Screening	CPT	87320	Infectious Agent Antigen Detection By Enzyme Immunoassay Technique Qualitative Or Semiquantitative Multiple Step Method Chlamydia
Chlamydia Screening	CPT	87490	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Direct Probe Technique
Chlamydia Screening	CPT	87491	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Amplified Probe Technique
Chlamydia Screening	CPT	87492	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Chlamydia Trachomatis Quantification
Chlamydia Screening	CPT	87810	Infectious Agent Detection By Immunoassay With Direct Optical Observation Chlamydia Trachomatis
Chlamydia Screening	CPT	0353U	Infectious Agent Detection By Nucleic Acid (dna), Chlamydia Trachomatis And Neisseria Gonorrhoeae, Multiplex Amplified Probe Technique, Urine, Vaginal, Pharyngeal, Or Rectal, Each Pathogen Reported As Detected Or Not Detected

Denominator: Women 16-24 years of age who meet the criteria for eligible population.

- Anchor Date: December 31, 2024

Numerator: Women in the denominator who were tested at least once for chlamydia during the measurement year (2024).

☑ Population: Child

Child and Adolescent Well-Care Visits (WCV)

Methodology: HEDIS®

Measure Description: The percentage of Members ages 3-21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Ages 3-21 as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP throughout the measurement year (2024). No more than one gap in enrollment of up to 45 days during the measurement year (2024).

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	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 through 4 years)
Well-Care Visit	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 through 11 years)
Well-Care Visit	CPT	99384	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; adolescent (age 12 through 17 years)
Well-Care Visit	CPT	99385	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; 18-39 years
Well-Care Visit	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 through 4 years)

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	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 through 11 years)
Well-Care Visit	CPT	99394	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; adolescent (age 12 through 17 years)
Well-Care Visit	CPT	99395	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; 18-39 years
Well-Care Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
Well-Care Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
Well-Care Visit	HCPCS	S0302	Completed early periodic screening diagnosis and treatment (EPSDT) service (list in addition to code for appropriate evaluation and management service)
Well-Care Visit	HCPCS	S0610	Annual gynecological examination, new patient
Well-Care Visit	HCPCS	S0612	Annual gynecological examination, established patient
Well-Care Visit	HCPCS	S0613	Annual gynecological examination; clinical breast examination without pelvic evaluation
Well-Care Visit	ICD-10	Z00.00	Encounter for general adult medical examination without abnormal findings
Well-Care Visit	ICD-10	Z00.01	Encounter for general adult medical examination with abnormal findings
Well-Care Visit	ICD-10	Z00.121	Encounter for routine child health examination with abnormal findings
Well-Care Visit	ICD-10	Z00.129	Encounter for routine child health examination without abnormal findings
Well-Care Visit	ICD-10	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Well-Care Visit	ICD-10	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Well-Care Visit	ICD-10	Z00.2	Encounter for examination for period of rapid growth in childhood
Well-Care Visit	ICD-10	Z00.3	Encounter for examination for adolescent development state
Well-Care Visit	ICD-10	Z02.5	Encounter for examination for participation in sport
Well-Care Visit	ICD-10	Z76. 1	Encounter for health supervision and care of foundling
Well-Care Visit	ICD-10	Z76. 2	Encounter for health supervision and care of other healthy infant and child

Denominator: The eligible population.

- Anchor Date December 31, 2024

Numerator: Members in the denominator who had one or more well-care visits with a PCP or an OB/GYN during the measurement year (2024).

☑ Population: All

Initial Health Appointment (IHA)

Methodology: IEHP-Defined Quality Measure

Measure Description: The IHA is a comprehensive assessment that is completed during the Member's initial encounter with a PCP, appropriate medical specialist, or Non-Physician Medical Provider, and it must be documented in the Member's medical record. The IHA enables the Member's PCP to assess and manage the acute, chronic and preventive health needs of the Member.

IEHP provides PCPs with a monthly detailed Member roster on the secure IEHP Provider Portal for all newly enrolled IEHP Members who are due for an IHA at 120 days of enrollment.

- The eligible population is newly assigned Members with an IEHP effective enrollment date of January 1, 2024 through December 31, 2024. The IHA must be provided within 120 days of enrollment (e.g., Member enrolled in December 2024 must be seen by April 2025 and PCP must submit encounter by May 2025).
- IHA visits completed during the 11 months prior to enrollment with IEHP count towards numerator compliance.

An IHA must include all of the following:

- A history of the Member's physical and mental health
- An identification of risks
- An assessment of need for preventive screens or services
- Health education
- The diagnosis and plan for treatment of any diseases

CODES TO IDENTIFY IHA VISITS:		
Code	**Code Type**	**Description**
96160	CPT	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
96161	CPT	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
99202	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

CODES TO IDENTIFY IHA VISITS:		
Code	**Code Type**	**Description**
99203	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	CPT	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	CPT	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	CPT	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99241	CPT	Office consultation for a new or established patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	CPT	Office consultation for a new or established patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY IHA VISITS:		
Code	**Code Type**	**Description**
99243	CPT	Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	CPT	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	CPT	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
99354	CPT	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215]).
99355	CPT	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service).
99381	CPT	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; infant (age younger than 1 year).
99382	CPT	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 through 4 years).
99383	CPT	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 through 11 years).

CODES TO IDENTIFY IHA VISITS:		
Code	**Code Type**	**Description**
99384	CPT	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; adolescent (age 12 through 17 years).
99385	CPT	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; 18-39 years.
99386	CPT	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; 40-64 years.
99387	CPT	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; 65 years and older.
99391	CPT	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; infant (age younger than 1 year).
99392	CPT	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 through 4 years).
99393	CPT	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 through 11 years).
99394	CPT	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; adolescent (age 12 through 17 years).
99395	CPT	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; 18-39 years.
99396	CPT	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; 40-64 years.

CODES TO IDENTIFY IHA VISITS:		
Code	**Code Type**	**Description**
99397	CPT	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; 65 years and older.
99401	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
99402	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
99403	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
99404	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
99411	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.
99412	CPT	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.
99429	CPT	Unlisted Preven Meds Serv.
99444	CPT	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network.
99446	CPT	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review.
99447	CPT	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review.
99448	CPT	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review.
99449	CPT	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review.
99450	CPT	Basic life and/or disability examination that includes: Measurement of height, weight, and blood pressure; Completion of a medical history following a life insurance pro forma; Collection of blood sample and/or urinalysis complying with "chain of custody" protocols; and Completion of necessary documentation/certificates.

CODES TO IDENTIFY IHA VISITS:		
Code	**Code Type**	**Description**
99455	CPT	Work-related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99456	CPT	Work-related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
G0402	HCPCS	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
G0438	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
G0439	HCPCS	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.
G0463	HCPCS	Hospital outpatient clinic visit for assessment and management of a patient.
T1015	HCPCS	Clinic visit/encounter, all-inclusive.
Z00.00	ICD10CM	Encounter for general adult medical examination without abnormal findings.
Z00.01	ICD10CM	Encounter for general adult medical examination with abnormal findings.
Z00.121	ICD10CM	Encounter for routine child health examination with abnormal findings.
Z00.129	ICD10CM	Encounter for routine child health examination without abnormal findings.
Z02.5	ICD10CM	Encounter for examination for participation in sport.

QUALITY IMPROVEMENT ACTIVITIES

Quality Improvement Activities

For the 2024 performance year, there will be two quality improvement activities providers will be required to complete as stated in the PCP Covered CA Quality Exhibit:

1) CCA Provider Directory
2) CCA Regional Quality Model Participation

CCA Provider Directory

Methodology: Department of Managed Health Care (DMHC)

Measure Description: Providers are required to submit IEHP Provider Directory demographics twice in the measurement year (2024), timely, during the Summer Provider Directory Verification process.

Provider elements required:

- **Race/Ethnicity** – This is the Provider's race and/or ethnicity. If a Provider is mixed race and identifies with more than one ethnicity, all should be listed on the verification form.
- **Language** Spoken by Staff and Provider – Languages spoken by the Providers, clinical staff, and/or administrative staff.

How the Provider will report or submit info: As part of IEHPs Provider Directory Verification process, Provider offices are asked to report/confirm their Provider demographics. Provider demographics are to be reported to IEHP via the fax number or email address based on Provider preference as part of the Provider Directory Verification process.

Submission Deadline: During the Summer Provider Directory Verification process, Provider offices will have four (4) weeks to sign and attest to the verification form and return it to IEHP. Only responses during this window will be considered compliant for the 2024 Covered CA Quality Transformation Program (QTP).

CCA Regional Quality Model Participation

Methodology: IEHP – Defined Quality Improvement Activity

Measure Description: Inland Empire Health Plan (IEHP) has made quality improvement an essential focus to ensure IEHP Providers and Members reach optimal care and vibrant health. To assist in quality improvement efforts, IEHP has designed the IEHP Regional Quality Model (RQM) that has been created to engage in IEHP Members', Providers' and Community Partner's Quality challenges and needs by applying custom solutions. RQM is a quality improvement system that provides insights, solutions, and services through a regional framework. RQM aligns strategies, tactics, resources, data, metrics and people/teams to meet the unique needs of the communities, Providers and Members.

Goal: Providers, if selected, will be expected to participate in the RQM activities that include (but are not limited to):

- Take part in Quality Specialist Representative Support
- Work with IEHP Quality Engagement Specialists
- Be involved in Quality Coder coding and billing best practice recommendations

NOTES

IEHP Covered

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