2024

GLOBAL QUALITY P4P
(FOR IPAs)

Pay for Performance (P4P) Program Technical Guide

Inland Empire Health Plan

Contact: *QualityPrograms@iehp.org*

Published: June 11, 2025

TABLE OF CONTENTS

TABLE OF CONTENTS (CONTINUED)

PROGRAM OVERVIEW

This program guide provides an overview of the 2024 Global Quality Pay for Performance (GQ P4P) Program for Independent Physician Associations (IPAs). In this ninth year of the program, IEHP has made program enhancements based on feedback from Providers in an effort to continually improve effectiveness. The IEHP GQ P4P Program for IPAs is designed to reward IPAs for high performance and year-over-year improvement in key quality performance measures. This program guide is designed as an easy reference for IPAs and their staff to understand the GQ P4P Program.

This year's GQ P4P Program continues to provide financial rewards to Providers for improving health care quality across multiple domains and measures. The 2024 Global Quality P4P Program includes core measures, process measures and penalty "risk" measures.

IEHP also encourages all IPAs to attend IEHP P4P meetings that are held throughout the year to support your efforts to maximize earnings in this program.

If you would like to get more information about IEHP's GQ P4P Program 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.

What's New?

Nine measures were added

Core Measures

- Adult Pneumococcal Vaccine
- Adult Td/Tdap Vaccine
- Adult Zoster Vaccine
- Timeliness of Prenatal Care
- Postpartum Care
- Lead Screening for Children
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Process Measures

- Health Equity: Provider Diversity Equity Inclusion Survey

Penalty Measure

- Customer Service Grievance

Two measures were revised

- Equity Quality Improvement Activity: Reducing Health Disparities
- Screening for Clinical Depression in Primary Care

Three measures were retired

- Manifest MedEx Connectivity
- Provider Grievance Response Rate
- HbA1c Lab Results Data Completeness

Eligibility and Participation

To be eligible for incentive payments in the 2024 GQ P4P Program, IPAs must meet the following criteria:

- Have at least 5,000 IEHP Medi-Cal Members assigned as of January 2024.
- Have at least 30 Members in the denominator as of December 2024 for each quality measure to qualify.
- Quality Score must be 1.0 or higher in order to qualify for incentive payments.

- Submit a GQ P4P Quality Work Plan to IEHP by April 28, 2024 in order to enroll in the program (see Work Plan details in Appendix 10).
- Meet minimum Encounter Data Gates in order to qualify for incentive payments.
- IPA must designate a Quality Team of two to four staff dedicated to quality improvement work for the IPA. Quality Team framework will require an attestation and submission of staffing plan by 7/1/2024.

☑ Minimum Data Requirements

Lab Results

Data from lab results is also foundational to Program performance scoring. Providers should ensure they submit complete lab results data for services rendered to IEHP Members. IPAs should work with their network Providers to ensure they are using the appropriate lab vendors for IEHP Members, and submitting complete lab results data to IEHP.

Lab results that are performed in the office (e.g., point of care HbA1c testing, urine tests, etc.) should be coded and submitted through Providers' 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 GQ P4P program.

☑ Provider P4P Research Inquiries

All Provider research inquiries, related to the data collected to measure P4P 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.

Supplemental Data

What is Supplemental Data?

When services are not captured in traditional encounter data systems, other Supplemental Data sources may be used to collect information about services rendered to Members to support Quality Reporting.

When Supplemental Data may be needed

- For services that were provided prior to eligibility with IEHP
- When a Provider has "proof-of-service" for a noted gap in care (e.g., cervical cancer screening, immunizations rendered by another provider)
- When a Provider has "proof-of-service" for an eligible-population exclusion (e.g., total hysterectomy, bilateral mastectomy)

How to use Supplemental Data to support Global Quality P4P

Create an electronic log that includes the minimum required data elements. See Appendix 11 for file layout requirements. Below is a list of minimum data elements needed in a supplemental data log.

- Member ID
- Date of Service
- Provider Identification
- Provider Specialty
- Diagnosis Code(s) – if applicable
- Procedure Code(s)
- Lab Results – if applicable

Requirements for using Supplemental Data in Global Quality P4P Reporting

- The IPA must have clearly defined policies and procedures (in writing) that describe how Supplemental Data is collected, validated and used for P4P reporting
- Policies/procedures must be shared with IEHP and must be in place to validate quality / accuracy of Supplemental Data
- The IPA must collect "proof-of-service" documentation to confirm all services that are reported in the Supplemental Data log
- The IPA must receive approval from IEHP's Quality Team to use Supplemental Data in Global Quality Reporting (deadline for approval is October 31, 2024)
- The IPA must complete IPA data validation activities prior to submitting Supplemental Data to IEHP no later than November 30, 2024
- The IPA must submit an audit-ready Supplement Data log to IEHP via SFTP no later than December 20, 2024.
- The IPA must complete a P4P Roadmap no later than December 1, 2024
- Final data refreshes for pre-validated supplemental data (for remaining dates of service in December 2024) are due by January 31, 2025

Data Validation Requirements for Supplemental Data in Global Quality P4P Reporting

- To be counted in the final IPA Global Quality P4P rates, the Supplemental Data file must pass IEHP's independent HEDIS® audit process
- The IPA must present "proof-of-service" documents within required timeframes when requested by IEHP's auditors
- An auditor review will compare "proof-of-service" documents to submitted data
- Supplemental Data records must pass 100 percent validation to be included in the final P4P reporting

☑ 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.
- Participation in IEHP's GQ P4P Program, as well as acceptance of incentive payments, does not in any way modify or supersede any terms or conditions of any agreement between IEHP and Providers or IPAs, whether that agreement is entered into prior to or subsequent to the date of this communication.
- There is no guarantee of future funding for, or payment under, any IEHP Provider incentive program. The IEHP GQ P4P Program and/or its terms and conditions may be modified or terminated at any time, with or without notice, at IEHP's sole discretion.
- Criteria for calculating incentive payments 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 GQ P4P Program, 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 GQ P4P Program.
- The determination of IEHP regarding performance scoring and payments under the IEHP GQ P4P Program is final.
- As a condition of receiving payment under the IEHP GQ P4P Program, Providers and IPAs 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

Providers are eligible to receive financial rewards for performance excellence and for performance improvement. Financial rewards are based on a tiered system, providing increasing financial rewards as IPAs reach each level of higher performance. The 2024 GQ P4P Program incentive pool is $50 million for the IPA Program. Incentive dollars for the 2024 performance period will be distributed via a monthly Per Member Per Month (PMPM) Quality Payment beginning in July 2025 and continuing through June 2026. Based on IPA performance, payment methodologies may be adjusted to ensure that the 2024 program year costs do not exceed this $50 million pool for the IPA Program.

IPA Encounter Data Gates

IPA encounter data submissions must meet minimum adequacy requirements in order to receive GQ P4P Program incentive dollars. IPA encounter data performance is based on all professional encounters submitted by the IPA for services rendered during the measurement year (e.g., 2024 dates of service). IPA encounter data volume will be compared to established encounter data benchmarks for Seniors and Persons with Disabilities (SPD) and Non-SPD Members. IPA performance will be calculated against each IPA's proportion of SPD and Non-SPD Members.

Encounter data benchmarks have been established and correspond to an Encounter Data Gate, reflecting higher encounter data volumes. As IPAs reach higher levels of encounter data performance, they become eligible for a larger percentage of the total possible GQ P4P incentive. Encounter rates are expressed as the number of encounters per Member per year (PMPY). An encounter is defined as a unique visit per Member per Provider per day. The table below describes the Encounter Data Gates, performance levels, and their impact on IPA GQ P4P Program incentive payments.

PERCENT OF POSSIBLE INCENTIVE PAYMENT	ENCOUNTER DATA GATE	NON-SPD PMPY	SPD PMPY
50%	Gate 1	3.0	9.0
75%	Gate 2	4.0	11.0
100%	Gate 3	5.0	13.0

Encounter data must be submitted to IEHP in a timely way and must adhere to the reporting timeframes delineated in IEHP's Provider Policy and Procedure Manual - Policy MC_21A.

CORE MEASURES

Performance Measures

Appendix 1 provides a list of the 44 measures in the 2024 GQ P4P Core Program and includes the thresholds and benchmarks associated with respective tier goals. These measures are categorized into four domains: *Access; Clinical Quality; Behavioral Health Integration; Patient Experience*.

Most measures included in the *Clinical Quality Domain* primarily 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 and the Pharmacy Quality Alliance (PQA).

Clinical Quality Domain Measures:

- Asthma Medication Ratio
- Breast Cancer Screening
- Cervical Cancer Screening
- Child and Adolescent Well-Care Visits
- Childhood Immunization – Combo 10
- Chlamydia Screening in Women
- Timeliness of Prenatal Care
- Postpartum Care
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetes Care – Blood Pressure Control <140/90
- Glycemic Status Assessment for Patients with Diabetes (GSD)
- Diabetes Care – Kidney Health Evaluation
- Developmental Screening
- Lead Screening for Children
- Adult Influenza Vaccine
- Adult Pneumococcal Vaccine
- Adult Td/Tdap Vaccine
- Adult Zoster Vaccine
- Immunizations for Adolescents – Combo 2
- Initial Health Appointment
- Post Discharge Follow-Up
- Statin Therapy Received in Patients with Cardiovascular Disease and Diabetes
- Use of Imaging Studies for Low Back Pain

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
    - Counseling for Physical Activity
    - Counseling for Nutrition
    - BMI Percentile
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the First 30 Months of Life

IEHP's HEDIS® measurement year 2024 data set and Managed Care Accountability Set (MCAS) will be used to evaluate Providers' year-end performance. These measure sets undergoes an independent audit review prior to rate finalization.

The Initial Health Appointment (IHA) measure follows IEHP's IHA internal compliance monitoring methodology and is not a HEDIS® measure.

The Post Discharge Follow-Up measure is an IEHP-defined measure developed to support transitions of care needs of IEHP Members.

Access Domain:

- After Hours Availability - On-Call Physician Access
- After Hours Availability - Life-Threatening Emergency Calls
- Appointment Availability - Urgent
- Appointment Availability - Routine
- Potentially Avoidable Emergency Department (ED) Visits

The *Access* measures are based on the Department of Managed Health Care (DMHC) and NCQA requirements for monitoring access to care across the network. See Appendix 2 for measure details.

Behavioral Health Integration Domain Measures:

Measures in this domain come from various measure stewards including: the National Quality Forum (NQF), HEDIS, and the Department of Health Care Services (DHCS).

- Antidepressant Medication Management
- Screening for Clinical Depression in Primary Care
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Substance Use Assessment in Primary Care for Adolescents
- Substance Use Assessment in Primary Care
- Social Determinants of Health Screening
- Social Determinants of Health Identification Rate

Patient Experience Domain Measures:

Patient Experience Domain measures include Member Satisfaction Survey questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that is published by the Agency for Healthcare Research and Quality (AHRQ). IEHP conducts a Member Satisfaction Survey that is a modified CAHPS survey and is the sole data source used for this measure domain. The IEHP Member Satisfaction Survey is conducted between June and December of each year. Surveys received from the 2024 Member Satisfaction Survey will be used to calculate the Patient Experience Domain measures. Below are the three areas included in the Patient Experience Domain for the 2024 program.

- Access to Care Needed Right Away
- Coordination of Care
- Access to Routine Care

Scoring Methodology

Payments within the core program will be awarded to IPAs based on individual performance in reaching established Quality Goals (e.g., Tier Goals for each measure).

In the *Clinical Quality Domain,* HEDIS® measure results are based on each measure's total eligible population assigned to the IPA. The eligible population is defined as the set of Members that meet the denominator criteria specified in each measure. Members in the eligible population are attributed to the assigned PCP on the anchor date of each measure, as defined within each measure. Members contribute to a IPA's measure denominator if continuous enrollment criteria are met at the health plan level. For each measure, the measure score reflects the proportion of the eligible population that complies with the numerator criteria. For measures that are based on the HEDIS methodology, IEHP will adhere to the most current HEDIS technical specifications (Volume 2) for determining both numerators and denominators.

In the Clinical Quality Domain, non-HEDIS measures include the Initial Health Appointment and the Post Discharge Follow-Up measure. Each measure was designed by IEHP using validated coding and technical specifications. The Initial Health Appointment Measure is based on DHCS requirements and includes new health plan Members who are assigned to the IPA during the measurement year and who remain enrolled with IEHP and the IPA through the end of the 120 day post-enrollment period. The Post Discharge Follow-Up measure is described in detail in Appendix 2.

In the *Access Domain*, PCP telephone handling for appointments and after hours access is assessed via Plan-conducted phone surveys. IEHP follows the DMHC Timely Access Standards Provider Appointment Availability Study methodology to assess PCP adherence to Appointment Availability Standards. IEHP follows the NCQA standards of assessing PCP adherence to After Hours access to care and call handling protocols.

In the *Patient Experience Domain*, monthly Member Satisfaction Survey measures are based on Members who meet eligibility criteria to receive a mailed survey between June and December of the measurement year. Members eligible to receive a Member Satisfaction Survey must have been continuously enrolled with IEHP for at least six months in the measurement year (2024) and must have had an office visit in the prior six months, based on encounter data submitted to IEHP. Members who meet the survey eligibility criteria are randomly sampled to receive a survey. Survey measure results are attributed to the Member's assigned IPA based on the most recent encounter that qualified the Member for the survey. A Member is eligible to receive only one survey per calendar year.

Payment Methodology

IPA performance for each quality measure will be given a point value (i.e., a Quality Score). Points are assigned based on the Tier Goal achieved (i.e., Tier 1 = one point, Tier 2 = two points, Tier 3 = three points) for each measure.

IPAs who have at least three quality measures that meet the minimum denominator size (n = 30) will be considered for payment calculations. An overall weighted average of all eligible Quality Scores will determine the overall GQ Performance Score. Individual measure weights will be assigned as follows:

- Process measures (such as screenings) are given a weight of 1
- Patient experience measures are given a weight of 1.5
- Outcome and intermediate outcome measures (e.g., HbA1c or blood pressure control and childhood immunizations) are given a weight of 3

Please reference Appendix 1 for a list of individual measure weights for the 2024 GQP4P measure set.

The following formula will be used to calculate the overall **GQ Performance Score**:

GQ Performance Score (i.e. overall weighted average) = Sum (measure tier * measure weight) / Sum of measure weights

GQ P4P Program payments will be awarded according to the following formula:

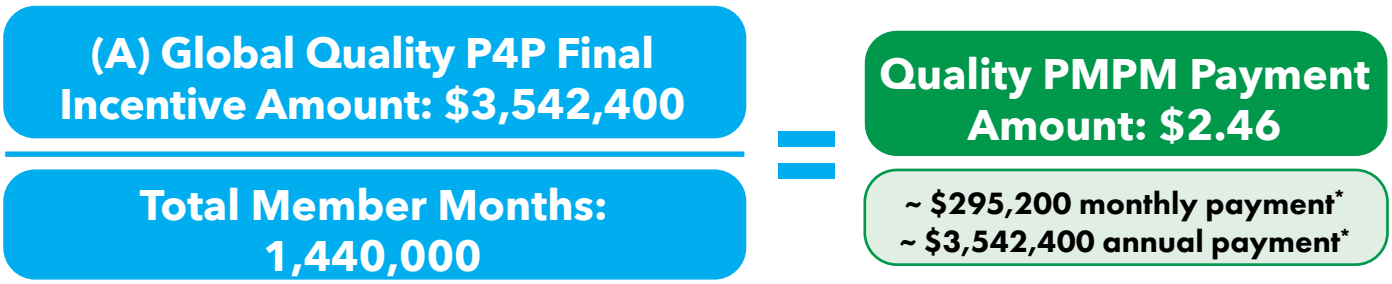
([Global Quality Performance Score] x [# Medi-Cal Average Membership] x [GQ P4P Multiplier] / [Total Medi-Cal Member Months]) + Process Measures - Penalty Measures = GQ P4P PMPM Bonus

The GQ P4P payment multiplier is subject to change based on Network performance and budget limits. The GQ P4P payment multiplier value displayed in the Interim Reports may not be the final value used in determining final Quality PMPM payment amounts.

IPA PMPM Quality Payment Methodology

From July 2025 – June 2026, IPAs will receive a monthly Quality PMPM (per member per month) payment based on their 2024 GQ P4P performance using the following formula:

IPA payment example: *IPA with monthly average of 120,000 Members (1,440,000 Member Months), 2.0 GQ Quality Score and Encounter Data Gate 3 met*



**Assuming stable membership volume and there is no additional incentive for process measures, and no PCP penalty to be deducted from the Quality PMPM bonus.*

Note: Members with and Other Health Coverage will be removed from the measure denominators before the final payment calculation.

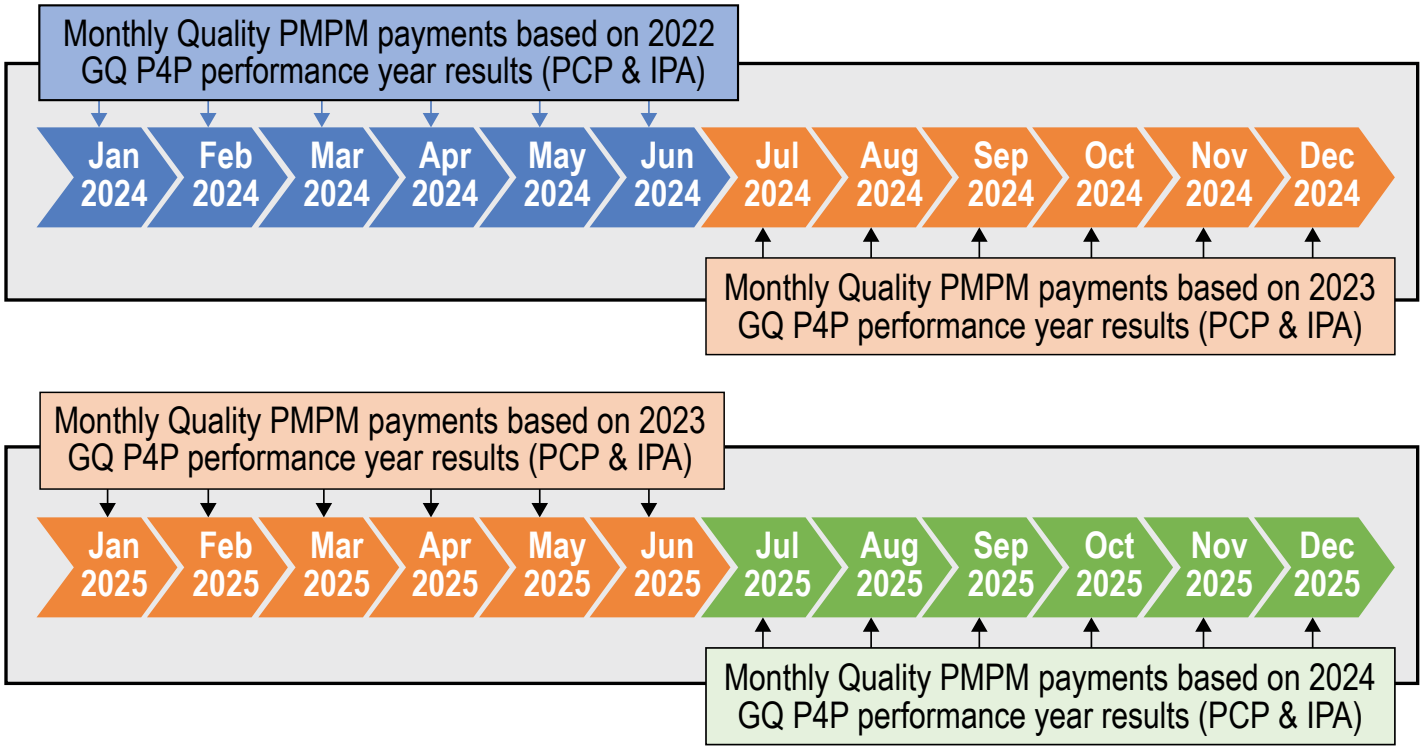
Reporting Timeline

Below is a table describing the flow of encounter data to IEHP in support of the GQ P4P Program reporting.

P4P ENCOUNTER DATA REPORTING TIMELINE:					
Month of Service	**Provider Encounters Due to IPA**	**IPA Encounters Due to IEHP**	**P4P Data Freeze**	**Dates of Service Assessed**	**Rosters Updated**
January 2024	2/1/2024	2/15/2024	2/15/2024	January 2024	3/10/2024
January 2024	2/1/2024	3/1/2024	3/1/2024	January 2024	3/25/2024
January 2024	2/1/2024	3/15/2024	3/15/2024	January 2024	4/10/2024
January 2024	2/1/2024	4/1/2024	4/1/2024	January 2024	4/25/2024
January 2024	2/1/2024	4/15/2024	4/15/2024	January 2024	5/10/2024
January 2024	2/1/2024	5/1/2024	5/1/2024	January 2024	5/25/2024
January 2024	2/15/2024	5/15/2024	5/15/2024	January 2024	6/10/2024
February 2024	3/1/2024	6/1/2024	6/1/2024	January - February 2024	6/25/2024
February 2024	3/15/2024	6/15/2024	6/15/2024	January - February 2024	7/10/2024
March 2024	4/1/2024	7/1/2025	7/1/2025	January - March 2024	7/25/2024
March 2024	4/15/2024	7/15/2024	7/15/2024	January - March 2024	8/10/2024
April 2024	5/1/2024	8/1/2024	8/1/2024	January - April 2024	8/25/2024
April 2024	5/15/2024	8/15/2024	8/15/2024	January - April 2024	9/10/2024
May 2024	6/1/2024	9/1/2024	9/1/2024	January - May 2024	9/25/2024
May 2024	6/15/2024	9/15/2024	9/15/2024	January - May 2024	10/10/2024
June 2024	7/1/2024	10/1/2024	10/1/2024	January - June 2024	10/25/2024
June 2024	7/15/2024	10/15/2024	10/15/2024	January - June 2024	11/10/2024
July 2024	8/1/2024	11/1/2024	11/1/2024	January - July 2024	11/25/2024
July 2024	8/15/2024	11/15/2024	11/15/2024	January - July 2024	12/10/2024
August 2024	9/1/2024	12/1/2024	12/1/2024	January - August 2024	12/25/2024
August 2024	9/15/2024	12/15/2024	12/15/2024	January - August 2024	1/10/2025
September 2024	10/1/2024	1/1/2025	1/1/2025	January - September 2024	1/25/2025
September 2024	10/15/2024	1/15/2025	1/15/2025	January - September 2024	2/10/2025
October 2024	11/1/2024	2/1/2025	2/1/2025	January - October 2024	2/25/2025
October 2024	11/15/2024	2/15/2025	2/15/2025	January - October 2024	3/10/2025
November 2024	12/1/2024	3/1/2025	3/1/2025	January - November 2024	3/25/2025
November 2024	12/15/2024	3/15/2025	3/15/2025	January - November 2024	4/10/2025
December 2024	1/1/2025	4/1/2025	4/1/2025	January - December 2024	4/25/2025
December 2024	1/15/2025	4/15/2025	4/15/2025	January - December 2024	5/10/2025
December 2024	2/1/2025	5/1/2025	5/1/2025	January - December 2024	5/25/2025

This timeline depicts the latest reporting dates based on IEHP's policies and procedures. However, Providers and IPAs are encouraged to report their encounter data as soon as possible to IEHP. All encounters received by IEHP are considered when calculating updated reports and rosters including those encounters that are reported earlier than the encounter data due date.

Quality Incentive Payout Timeline: Provider Communication Timeline



Getting Help

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

APPENDIX 1: *2024 IPA Global Quality P4P Program Measures*

2024 GQ P4P PROGRAM MEASURE LIST:							
Domain	**Measure Name**	**Population**	**Tier 1**	**Tier 2**	**Tier 3 [1]**	**Tier 4 [2]**	**Measure Weight**
Clinical Quality	Asthma Medication Ratio	Adult	Improvement demonstrated by meeting the following 2 conditions: 10% reduction in non-compliance **AND Improvement of at least 2% points**	**If baseline is below 50th percentile:** 20% reduction in non-compliance **AND** must meet the 50th percentile **If baseline is at or above 50th percentile: Improvement of at least 2% points**	72%	77%	3.0
Clinical Quality	Colorectal Cancer Screening	Adult			44%	49%	1.0
Clinical Quality	Controlling Blood Pressure	Adult			69%	73%	3.0
Clinical Quality	Diabetes Care- Blood Pressure Control <140/90	Adult			74%	77%	3.0
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes (GSD)	Adult			61%	64%	3.0
Clinical Quality	Diabetes Care- Kidney Health Evaluation	Adult			45%	50%	1.0
Clinical Quality	Adult Influenza Vaccine	Adult			20%	26%	1.0
Clinical Quality	Adult Pneumococcal Vaccine	Adult			58%	68%	1.0
Clinical Quality	Adult Td/Tdap Vaccine	Adult			50%	58%	1.0
Clinical Quality	Adult Zoster Vaccine	Adult			16%	21%	1.0
Clinical Quality	Post Discharge Follow-Up	Adult			70%	80%	1.0
Clinical Quality	Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes[3]	Adult			76%	79%	1.0
Behavioral Health Integration	Substance Use in Primary Care Adolescents	Child			15%	25%	1.0
Behavioral Health Integration	Antidepressant Medication Management	Adult and Adolescent			59%	69%	1.0
Behavioral Health Integration	Depression Screening and Follow-Up for Adolescents and Adults[4]	Adult and Adolescent	Monitoring Only				NA
Clinical Quality	Use of Imaging Studies for Low Back Pain[4]	Adult and Adolescent	Monitoring Only				NA
Behavioral Health Integration	Social Determinants of Health Screening[4]	Adult and Adolescent	Monitoring Only				NA
Behavioral Health Integration	Social Determinants of Health Identification Rate	Adult and Adolescent	10%	15%	20%	25%	1.0
Behavioral Health Integration	Screening for Clinical Depression in Primary Care	Adult and Adolescent	Improvement demonstrated by meeting the following 2 conditions: 10% reduction in non-compliance **AND Improvement of at least 2% points**	**If baseline is below 50th percentile:** 20% reduction in non-compliance **AND** must meet the 50th percentile **If baseline is at or above 50th percentile: Improvement of at least 2% points**	56%	72%	1.0
Behavioral Health Integration	Substance Use Assessment in Primary Care	Adult			17%	32%	1.0
Clinical Quality	Breast Cancer Screening	Women			60%	63%	1.0
Clinical Quality	Cervical Cancer Screening	Women			62%	67%	1.0
Clinical Quality	Chlamydia Screening in Women	Women			64%	69%	1.0
Clinical Quality	Timeliness of Prenatal Care	Women			89%	92%	1.0
Clinical Quality	Postpartum Care	Women			83%	87%	1.0
Clinical Quality	Child and Adolescent Well-Care Visits	Child			58%	65%	1.0
Clinical Quality	Childhood Immunizations - Combo 10[†]	Child			35%	42%	3.0
Clinical Quality	Developmental Screening	Child			39%	46%	1.0

2024 GQ P4P PROGRAM MEASURE LIST:							
Domain	**Measure Name**	**Population**	**Tier 1**	**Tier 2**	**Tier 3 [1]**	**Tier 4 [2]**	**Measure Weight**
Clinical Quality	Immunizations for Adolescents - Combo 2	Child	Improvement demonstrated by meeting the following 2 conditions: 10% reduction in non-compliance **AND Improvement of at least 2% points**	**If baseline is below 50th percentile:** 20% reduction in non-compliance **AND** must meet the 50th percentile **If baseline is at or above 50th percentile: Improvement of at least 2% points**	42%	49%	3.0
Clinical Quality	Lead Screening for Children	Child			71%	80%	1.0
Clinical Quality	Well-Child Visits First 15 Months of Life	Child			65%	70%	1.0
Clinical Quality	Well-Child Visits First 30 Months of Life	Child			73%	80%	1.0
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Counseling for Physical Activity	Child			77%	82%	1.0
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Counseling for Nutrition	Child			79%	84%	1.0
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - BMI Percentile	Child			88%	91%	1.0
Clinical Quality	Initial Health Appointment	All			65%	75%	1.0
Access	After Hours Availability - On- Call Physician Access♦	All	10% reduction in non-compliance	20% reduction in non-compliance	85%	90%	1.0
Access	After Hours Availability - Life- Threatening Emergency Calls♦	All			85%	90%	1.0
Access	Appointment Availability- Urgent♦	All			85%	90%	1.0
Access	Appointment Availability- Routine♦	All			85%	90%	1.0
Access	Potentially Avoidable ED Visits	All	≤ 8.28%	NA	NA	NA	1.0
Patient Experience	Member Satisfaction Survey - Access to Care Needed Right Away	All	83%*	85%**	88%***	NA	1.5
Patient Experience	Member Satisfaction Survey - Access to Routine Care	All	80%*	82%**	86%***	NA	1.5
Patient Experience	Member Satisfaction Survey - Coordination of Care	All	85%*	87%**	91%***	NA	1.5

* *Tier 1 goals set at the 50th percentile as published in the 2024 (MY 2023) NCQA Quality Compass*

** *Tier 2 goals set at the 66th percentile as published in the 2024 (MY 2023) NCQA Quality Compass*

*** *Tier 3 goals set at the 90th percentile as published in the 2024 (MY 2023) NCQA Quality Compass*

[1] *Tier 3 goals set at the 75th percentile as published in the 2024 (MY 2023) NCQA Quality Compass*

[2] *Tier 4 goals set at the 90th percentile as published in the 2024 (MY 2023) NCQA Quality Compass*

[3] *The Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes measure is a combination of two measures (Statin Therapy Received for Patients with Cardiovascular Disease and Statin Therapy Received for Patients with Diabetes). The denominators and numerators for this combined measure will be calculated to produce one rate for this measure. The minimum denominator requirement for this measure is 10 eligible Members.*

[4] *Reporting Only Measure. Not eligible for incentive dollars*

† *Tier 1: If baseline is at or above 50th percentile: Goal is the 50th percentile, Tier 2: If baseline is at or above 50th percentile: Goal is the 50th percentile plus 1%.*

♦ *There is no minimum denominator requirement for the following measures: After Hours Availability-On-Call Physician Access, After Hours Availability-Life Threatening Emergency Calls, Appointment Availability-Urgent, Appointment Availability-Routine.*

The goals in Appendix 1 may be adjusted once measurement year (2023) 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.

2024 50TH PERCENTILE RATES		
Domain	**Measure Name**	**50th Percentile Rate**
Clinical Quality	Asthma Medication Ratio	66%
Clinical Quality	Colorectal Cancer Screening	38%
Clinical Quality	Controlling Blood Pressure	64%
Clinical Quality	Diabetes Care - Blood Pressure Control <140/90	69%
Clinical Quality	Glycemic Status Assessment for Patients with Diabetes (GSD)	57%
Clinical Quality	Diabetes Care - Kidney Health Evaluation	36%
Clinical Quality	Developmental Screening	31%
Clinical Quality	Flu Vaccine in Adults	16%
Clinical Quality	Adult Pneumococcal Vaccine	44%
Clinical Quality	Adult Td/Tdap Vaccine	38%
Clinical Quality	Adult Zoster Vaccine	11%
Clinical Quality	Post Discharge Follow Up	59%
Clinical Quality	Statin Therapy Received for Patients with Cardiovascular Disease and Diabetes	73%
Behavioral Health	Social Determinants of Health Identification Rate	15%
Behavioral Health	Screening for Clinical Depression in Primary Care	31%
Behavioral Health	Substance Use Assessment in Primary Care	10%
Behavioral Health	Substance Use in Primary Care Adolescents	10%
Behavioral Health	Antidepressant Medication Management	53%
Clinical Quality	Breast Cancer Screening	53%
Clinical Quality	Cervical Cancer Screening	57%
Clinical Quality	Chlamydia Screening in Women	56%
Clinical Quality	Timeliness of Prenatal Care	85%
Clinical Quality	Postpartum Care	80%
Clinical Quality	Child and Adolescent Well-Care Visits	52%
Clinical Quality	Childhood Immunizations - Combo 10	27%
Clinical Quality	Immunizations for Adolescents - Combo 2	34%
Clinical Quality	Lead Screening for Children	64%
Clinical Quality	Well-Child Visits First 15 Months of Life	60%
Clinical Quality	Well-Child Visits First 30 Months of Life	69%
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Counseling for Physical Activity	68%
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents -Counseling for Nutrition	72%
Clinical Quality	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents -BMI Percentile	83%
Clinical Quality	Initial Health Appointment	52%

The 50th percentile goals are based on a combination of national and network performance and may be adjusted higher or lower based on network trends.

APPENDIX 2: *Core Measures Overview*

☑ Population: Adult

Asthma Medication Ratio (AMR)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 5-64 years of age and identified as having persistent asthma, who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 5-64 years of age as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) and the year prior to the measurement year (2023) with no more than one month gap in continuous enrollment with IEHP during the measurement year (2024) and no more than one month gap in continuous enrollment in the year prior to the measurement year (2023).
    3. Members who had two events of persistent asthma, with at least one event occurring in the measurement year (2024) **and** at least one event occurring in the year prior to the measurement year (2023).

       Examples of persistent asthma events:
        - At least one (1) emergency department visit or acute hospital inpatient encounter with a principal diagnosis of asthma.
        - At least one (1) acute hospital inpatient discharge with a principal diagnosis of asthma on the claim.
        - At least four (4) outpatient visits, that occurred on different dates of services, with any diagnosis of asthma and had at least two (2) asthma medications dispensed (any controller or reliever medication).
        - At least four (4) asthma medications dispensed (any controller or reliever medications).

Denominator: Members 5-64 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a medication ratio of 0.50 or greater during the measurement year (2024).

ASTHMA CONTROLLER MEDICATIONS:	
Description	**Prescription**
Antibody inhibitors	Omalizumab
Anti-interleukin-4	Dupilumab
Anti-interleukin-5	Benralizumab
Anti-interleukin-5	Mepolizumab
Anti-interleukin-5	Reslizumab
Inhaled steroid combinations	Budesonide-formoterol
Inhaled steroid combinations	Fluticasone-salmeterol
Inhaled steroid combinations	Fluticasone-vilanterol
Inhaled steroid combinations	Formoterol-mometasone
Inhaled corticosteroids	Beclomethasone
Inhaled corticosteroids	Budesonide
Inhaled corticosteroids	Ciclesonide
Inhaled corticosteroids	Flunisolide
Inhaled corticosteroids	Fluticasone
Inhaled corticosteroids	Mometasone
Leukotriene modifiers	Montelukast
Leukotriene modifiers	Zafirlukast
Leukotriene modifiers	Zileuton
Methylxanthines	Theophylline

ASTHMA RELIEVER MEDICATIONS:	
Description	**Prescription**
Short-acting, inhaled beta-2 agonists	Albuterol
Short-acting, inhaled beta-2 agonists	Levalbuterol

Colorectal Cancer Screening (COL)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 45-75 years of age who had an appropriate screening for colorectal cancer.

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 46-75 years of age as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) and the year prior (2023) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment period.

Denominator: Members who meet all the criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had one or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement year (2024).
- Flexible sigmoidoscopy during the measurement year (2024) or four years prior to the measurement year (2020).
- Colonoscopy during the measurement year (2024) or the nine years prior to the measurement year (2015).
- CT colonography during the measurement year (2024) or the four years prior to the measurement year (2020).
- Stool DNA with FIT test during the measurement year (2024) or two years prior to the measurement year (2022).

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	44389	Colonoscopy Through Stoma; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	44390	Colonoscopy Through Stoma; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	44391	Colonoscopy Through Stoma; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	44392	Colonoscopy Through Stoma; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forcep
Colorectal Cancer Screening	CPT	44394	Colonoscopy Through Stoma; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	44401	Colonoscopy Through Stoma; With Transendoscopic Stent Placement (includes Predilation)
Colorectal Cancer Screening	CPT	44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44403	Colonoscopy Through Stoma; With Endoscopic Mucosal Resection
Colorectal Cancer Screening	CPT	44404	Colonoscopy Through Stoma; With Directed Submucosal Injection(s), Any Substance
Colorectal Cancer Screening	CPT	44405	Colonoscopy through stoma; with transendoscopic balloon dilation
Colorectal Cancer Screening	CPT	44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44408	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45331	Sigmoidoscopy, Flexible; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	45332	Sigmoidoscopy, Flexible; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	45333	Sigmoidoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forceps
Colorectal Cancer Screening	CPT	45334	Sigmoidoscopy, Flexible; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	45335	Sigmoidoscopy, Flexible; With Directed Submucosal Injection(s), Any Substance
Colorectal Cancer Screening	CPT	45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45338	Sigmoidoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique
Colorectal Cancer Screening	CPT	45340	Sigmoidoscopy, Flexible; With Transendoscopic Balloon Dilation
Colorectal Cancer Screening	CPT	45341	Sigmoidoscopy, Flexible; With Endoscopic Ultrasound Examination
Colorectal Cancer Screening	CPT	45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
Colorectal Cancer Screening	CPT	45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45349	Sigmoidoscopy, Flexible; With Endoscopic Mucosal Resection
Colorectal Cancer Screening	CPT	45350	Sigmoidoscopy, Flexible; With Band Ligation(s) (e.g., Hemorrhoids)
Colorectal Cancer Screening	CPT	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45379	Colonoscopy, Flexible; With Removal Of Foreign Body(s)
Colorectal Cancer Screening	CPT	45380	Colonoscopy, Flexible; With Biopsy, Single Or Multiple
Colorectal Cancer Screening	CPT	45381	Colonoscopy, Flexible; With Directed Submucosal Injection(s), Any Substance
Colorectal Cancer Screening	CPT	45382	Colonoscopy, Flexible; With Control Of Bleeding, Any Method
Colorectal Cancer Screening	CPT	45384	Colonoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Hot Biopsy Forceps
Colorectal Cancer Screening	CPT	45385	Colonoscopy, Flexible; With Removal Of Tumor(s), Polyp(s), Or Other Lesion(s) By Snare Technique
Colorectal Cancer Screening	CPT	45386	Colonoscopy, Flexible; With Transendoscopic Balloon Dilation
Colorectal Cancer Screening	CPT	45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45390	Colonoscopy, Flexible; With Endoscopic Mucosal Resection
Colorectal Cancer Screening	CPT	45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
Colorectal Cancer Screening	CPT	45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
Colorectal Cancer Screening	CPT	45393	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45398	Colonoscopy, Flexible; With Band Ligation(s) (e.g., Hemorrhoids)
Colorectal Cancer Screening	CPT	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
Colorectal Cancer Screening	CPT	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	74263	Computed Tomographic (ct) Colonography, Screening, Including Image Postprocessing
Colorectal Cancer Screening	CPT	81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
Colorectal Cancer Screening	CPT	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
Colorectal Cancer Screening	CPT	82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, one to three simultaneous determinations
Colorectal Cancer Screening	HCPCS	G0104	Colorectal Cancer Screening; Flexible Sigmoidoscopy
Colorectal Cancer Screening	HCPCS	G0105	Colorectal Cancer Screening; Colonoscopy On Individual At High Risk
Colorectal Cancer Screening	HCPCS	G0121	Colorectal Cancer Screening; Colonoscopy On Individual Not Meeting Criteria For High Risk
Colorectal Cancer Screening	HCPCS	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, one to three simultaneous determinations

**These are the codes that IEHP will use to determine the numerator compliance for the Colorectal Cancer Screening measure. These codes would be submitted by the testing Provider, not the PCP.*

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 during the measurement year (2024) with no more than one gap in continuous enrollment 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.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
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.
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.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
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.
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 (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, 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 (eg, 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 (eg, 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 (t1015)

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

Diabetes Care - Blood Pressure Control <140/90 (BPD)

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the eligible population
- Update to the exclusions

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-75 years of age and have a diagnosis of diabetes (type 1 and type 2), whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 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. 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:
        - At least two outpatient visits, observation visits, telephone visits, e-visits or virtual check-ins, Emergency Department (ED), nonacute inpatient encounter or nonacute inpatient discharges on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.
        - At least one acute inpatient encounter with a diagnosis of diabetes without telehealth.
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (2024) or the year prior to the measurement year (2023).
        - At least one acute inpatient with a diagnosis of diabetes on the discharge claim. To identify an acute inpatient discharge:
            - Identify all acute and nonacute inpatient stays
            - Exclude nonacute inpatient stays
            - Identify the discharge date for the stay
- Members who meet 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 who are 18-75 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a Blood Pressure reading that was adequately controlled <140/90 mm Hg. The latest Blood Pressure reading will be used to determine compliance. If there are multiple BPs on the same date of service, the lowest systolic and lowest diastolic Blood Pressure reading on that date will be used as a representative Blood Pressure reading. **Provider must bill one diastolic code and one systolic code.**

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

Glycemic Status Assessment for Patients with Diabetes (GSD)

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the Measure Title
- Update to the Measure Description
- 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).

Diabetes Care - Kidney Health Evaluation (KED)

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the eligible population
- Update to the exclusions

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age and have a diagnosis of diabetes (type 1 and type 2), who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
  1. Members who are 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 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 basis during the measurement year (2024) or the year prior to the measurement year (2023).
- Members who meet any of the following criteria are excluded:
  1. Members in hospice.
  2. Members with evidence of End-stage Renal Disease (ESRD) any time in the Members history on or before December 31 of the measurement year (2024).
  3. Members receiving palliative care.
  4. Members who expired at any time during the measurement year (2024).
  5. Member who had dialysis any time during the member's history on or prior to December 31 of the measurement year (2024).
  6. Members 66 years of age and older as of December 31 of measurement year (2024) with both frailty and advanced illness.

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

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who received both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year (2024), on the same or different dates of service. **The following is required for compliance in this measure:**

- At least one estimated glomerular filtration rate (eGFR).
- At least one urine albumin-creatinine ratio (uACR):
    - Quantitative urine albumin lab test **AND** urine creatinine lab test that are 4 days or less apart.
      OR
    - Urine albumin-creatinine ratio lab test.

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
Estimated Glomerular Filtration Rate	CPT	80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
Estimated Glomerular Filtration Rate	CPT	80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	80069	Renal function panel this panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
Estimated Glomerular Filtration Rate	CPT	82565	Creatinine; Blood
Estimated Glomerular Filtration Rate	LOINC	50044-7	Glomerular Filtration Rate/1.73 Sq M.predicted Among Females [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (mdrd)
Estimated Glomerular Filtration Rate	LOINC	50210-4	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Cystatin C-based Formula
Estimated Glomerular Filtration Rate	LOINC	50384-7	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (schwartz)
Estimated Glomerular Filtration Rate	LOINC	62238-1	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (ckd-epi)
Estimated Glomerular Filtration Rate	LOINC	69405-9	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood
Estimated Glomerular Filtration Rate	LOINC	70969-1	Glomerular Filtration Rate/1.73 Sq M.predicted Among Males [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (mdrd)
Estimated Glomerular Filtration Rate	LOINC	77147-7	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (mdrd)
Estimated Glomerular Filtration Rate	LOINC	94677-2	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine And Cystatin C-based Formula (ckd-epi)
Estimated Glomerular Filtration Rate	LOINC	98979-8	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine-based Formula (ckd-epi 2022)
Estimated Glomerular Filtration Rate	LOINC	98980-6	Glomerular Filtration Rate/1.73 Sq M.predicted [volume Rate/area] In Serum, Plasma Or Blood By Creatinine And Cystatin C-based Formula (ckd-epi 2022)

CODES TO IDENTIFY QUANTITATIVE URINE ALBUMIN LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
Quantitative Urine Albumin	CPT	82043	Albumin; Urine (e.g, Microalbumin), Quantitative
Quantitative Urine Albumin	LOINC	100158-5	Microalbumin [mass/volume] In Urine Collected For Unspecified Duration
Quantitative Urine Albumin	LOINC	14957-5	Microalbumin [mass/volume] In Urine
Quantitative Urine Albumin	LOINC	1754-1	Albumin [mass/volume] In Urine
Quantitative Urine Albumin	LOINC	21059-1	Albumin [mass/volume] In 24 Hour Urine
Quantitative Urine Albumin	LOINC	30003-8	Microalbumin [mass/volume] In 24 Hour Urine
Quantitative Urine Albumin	LOINC	43605-5	Microalbumin [mass/volume] In 4 Hour Urine
Quantitative Urine Albumin	LOINC	53530-2	Microalbumin [mass/volume] In 24 Hour Urine By Detection Limit <= 1.0 Mg/l
Quantitative Urine Albumin	LOINC	53531-0	Microalbumin [mass/volume] In Urine By Detection Limit <= 1.0 Mg/l
Quantitative Urine Albumin	LOINC	57369-1	Microalbumin [mass/volume] In 12 Hour Urine
Quantitative Urine Albumin	LOINC	89999-7	Microalbumin [mass/volume] In Urine By Detection Limit <= 3.0 Mg/l

CODES TO IDENTIFY URINE CREATININE LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
Urine Creatinine	CPT	82570	Creatinine; Other Source
Urine Creatinine	LOINC	20624-3	Creatinine [mass/volume] In 24 Hour Urine
Urine Creatinine	LOINC	2161-8	Creatinine [mass/volume] In Urine
Urine Creatinine	LOINC	35674-1	Creatinine [mass/volume] In Urine Collected For Unspecified Duration
Urine Creatinine	LOINC	39982-4	Creatinine [mass/volume] In Urine - baseline
Urine Creatinine	LOINC	57344-4	Creatinine [mass/volume] In 2 Hour Urine
Urine Creatinine	LOINC	57346-9	Creatinine [mass/volume] In 12 Hour Urine
Urine Creatinine	LOINC	58951-5	Creatinine [mass/volume] In Urine --2nd Specimen
Urine Creatinine	LOINC	58951-5	Creatinine [mass/volume] In Urine --2nd Specimen

CODES TO IDENTIFY URINE ALBUMIN-CREATININE RATIO LAB TEST:			
Service	**Code Type**	**Code**	**Code Description**
Urine Albumin-Creatinine Ratio	LOINC	13705-9	Albumin/creatinine [mass Ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	14958-3	Microalbumin/creatinine [mass Ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	14959-1	Microalbumin/creatinine [mass Ratio] In Urine
Urine Albumin-Creatinine Ratio	LOINC	30000-4	Microalbumin/creatinine [ratio] In Urine
Urine Albumin-Creatinine Ratio	LOINC	44292-1	Microalbumin/creatinine [mass Ratio] In 12 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	59159-4	Microalbumin/creatinine [ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	76401-9	Albumin/creatinine [ratio] In 24 Hour Urine
Urine Albumin-Creatinine Ratio	LOINC	77253-3	Microalbumin/creatinine [ratio] In Urine By Detection Limit <= 1.0 Mg/l
Urine Albumin-Creatinine Ratio	LOINC	77254-1	Microalbumin/creatinine [ratio] In 24 Hour Urine By Detection Limit <= 1.0 Mg/l
Urine Albumin-Creatinine Ratio	LOINC	89998-9	Microalbumin/creatinine [ratio] In Urine By Detection Limit <= 3.0 Mg/l
Urine Albumin-Creatinine Ratio	LOINC	9318-7	Albumin/creatinine [mass Ratio] In Urine

Adult Influenza Vaccine

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19 years of age and older who received an influenza vaccine between July 1 of the year prior to the measurement year (2023) and June 30 of the measurement year (2024).

- The eligible population in this measure meets all of the following criteria:
  - Continuous enrollment with IEHP in the measurement year (2024) with no more than one gap of up to 45 days during the measurement year.

Denominator: Members 19 years of age or older who meet all criteria for the eligible population.

- Anchor Date: June 30, 2024

Numerator: Members in the denominator who received an influenza vaccine between July 1, 2023-June 30, 2024.

ADULT INFLUENZA VACCINE CODE SET:			
Service	**Code Type**	**Code**	**Code Description**
Flu Vaccine	CPT	90630	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, Preservative Free, For Intradermal Use
Flu Vaccine	CPT	90653	Influenza Vaccine, Inactivated (Iiv), Subunit, Adjuvanted, For Intramuscular Use
Flu Vaccine	CPT	90654	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, Preservative Free, For Intradermal Use
Flu Vaccine	CPT	90656	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90658	Influenza Virus Vaccine, Trivalent (Iiv3), Split Virus, 0.5 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90660	Influenza Virus Vaccine, Trivalent, Live (Laiv3), For Intranasal Use
Flu Vaccine	CPT	90661	Influenza Virus Vaccine, Trivalent (Cciiv3), Derived From Cell Cultures, Subunit, Preservative And Antibiotic Free, 0.5 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90662	Influenza Virus Vaccine (Iiv), Split Virus, Preservative Free, Enhanced Immunogenicity Via Increased Antigen Content, For Intramuscular Use
Flu Vaccine	CPT	90672	Influenza Virus Vaccine, Quadrivalent, Live (Laiv4), For Intranasal Use
Flu Vaccine	CPT	90673	Influenza Virus Vaccine, Trivalent (Riv3), Derived From Recombinant Dna, Hemagglutinin (Ha) Protein Only, Preservative And Antibiotic Free, For Intramuscular Use

ADULT INFLUENZA VACCINE CODE SET:			
Service	**Code Type**	**Code**	**Code Description**
Flu Vaccine	CPT	90674	Influenza Virus Vaccine, Quadrivalent (Cciiv4), Derived From Cell Cultures, Subunit, Preservative And Antibiotic Free, 0.5 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90682	Influenza Virus Vaccine, Quadrivalent (RIV4), Derived From Recombinant DNA, Hemagglutinin (HA) Protein Only, Preservative And Antibiotic Free, For Intramuscular Use
Flu Vaccine	CPT	90686	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, Preservative Free, 0.5 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90688	Influenza Virus Vaccine, Quadrivalent (Iiv4), Split Virus, 0.5 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90689	Influenza Virus Vaccine Quadrivalent (Iiv4), Inactivated, Adjuvanted, Preservative Free, 0.25 Ml Dosage, For Intramuscular Use
Flu Vaccine	CPT	90694	Influenza Virus Vaccine, Quadrivalent (aIIV4), Inactivated, Adjuvanted, Preservative Free, 0.5 mL Dosage, For Intramuscular Use
Flu Vaccine	CPT	90756	Influenza Virus Vaccine, Quadrivalent (Cciiv4), Derived From Cell Cultures, Subunit, Antibiotic Free, 0.5ml Dosage, For Intramuscular Use

Adult Zoster Vaccine

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 50 years of age and older, who received the appropriate herpes zoster vaccine in the measurement year (2024).

- The eligible population in this measure meets all of the following criteria:
  - 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).

Denominator: Members 50 years of age and older in the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who were administered the herpes zoster vaccine by meeting one of the criteria below:

1) Members who received at least one dose of the herpes live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart), any time on or after the Member's 50th birthday and before or during the measurement year (2024).

   OR

2) Members who had anaphylaxis from the herpes zoster vaccine any time before or during the measurement year (2024).

CODES TO IDENTIFY ZOSTER VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
Zoster Vaccine	CPT	90736	Zoster (shingles) vaccine (HZV), live, for subcutaneous injection;Includes Zostavax
Zoster Vaccine	CPT	90750	Zoster (shingles) vaccine (HZV), recombinant, subunit, adjuvanted, for intramuscular use

Adult Pneumococcal Vaccine

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 66 years of age and older, who received the pneumococcal vaccine by the end of the measurement year (2024).

- The eligible population in this measure meets all of the following criteria:
  - o 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).

Denominator: Members 66 years of age, or older, in the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who were administered the pneumococcal vaccine by meeting one of the criteria below:

1) Members in the denominator who received at least one dose of an adult pneumococcal vaccine on or after the Member's 19th birthday and before or during the measurement year (2024).

   OR

2) Members who had anaphylaxis from the pneumococcal vaccine any time before or during the measurement year (2024).

CODES TO IDENTIFY ADULT PNEUMOCOCCAL VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
Adult Pneumococcal Vaccine Procedure	CPT	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use; Includes Prevnar 13
Adult Pneumococcal Vaccine Procedure	CPT	90671	Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use;Includes Vaxneuvance
Adult Pneumococcal Vaccine Procedure	CPT	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
Adult Pneumococcal Vaccine Procedure	CPT	90732	Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use; Includes Pneumovax 23
Adult Pneumococcal Vaccine Procedure	HCPCS	G0009	Administration of pneumococcal vaccine

Adult Td/Tdap Vaccine

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19 years of age and older, who received the tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap) vaccine in the measurement year (2024).

- The eligible population in this measure meets all of the following criteria:
    - o 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).

Denominator: Members 19years of age and older in the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who were administered the Td/Tdap vaccine by meeting one of the criteria below:

1) Members in the denominator who received at least one Td vaccine or one Tdap vaccine between 9 years prior to the measurement year (2015) and the end of the measurement year (2024).

   OR

2) Members with a history of at least one of the of the following any time before or during the measurement year (2024):
    - Members who had anaphylaxis from the diphtheria, tetanus, or pertussis vaccine.
    - Members who had encephalitis due to the diphtheria, tetanus, or pertussis vaccine.

CODES TO IDENTIFY TD/TDAP VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
Td Vaccine	CPT	90714	Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use;Includes TDVAX; Includes Tenivac
Tdap Vaccine	CPT	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use;Includes Adacel; Includes Boostrix

Post Discharge Follow-Up

Methodology: IEHP-Defined Measure

Measure Description: The percentage of Members, 18 years and older who have follow-up visits with a Provider within required timeframes. For this measure, two rates are calculated and the average of both rates are used as the final score.

Rate 1: Follow-Up Visit High-Risk Members – this measure assesses the percentage of Members identified as "high-risk" who were discharged from an acute or nonacute inpatient stay during the measurement year (2024) who also had a follow up visit with a provider within seven days of discharge.

- Anchor Date: Assigned Provider at the end of the 7 day follow-up window.

Rate 2: Follow-Up Visit with non-High-Risk Members - this measure assesses the percentage of members identified as "rising and low risk" who were discharged from an acute or nonacute inpatient stay during the measurement year (2024) who also had a follow-up visit with a provider within 30 days of discharge.

- Anchor Date: Assigned Provider at the end of the 30 day follow-up window.

As part of IEHPs population health strategy, all IEHP Members are designated a risk level based on all available utilization and diagnostic data available to the Plan. Members fall into one of the three categories: High, Rising and Low Risk. IEHP employs the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx (MRx) model (CDPS+MRx), a combined diagnostic and pharmacy model, to identify high-, rising- and low-risk members. The system was developed by the University of California, San Diego, and has been adopted by the Department of Health Care Services (DHCS) of the State of California for use in its rate setting methodology with Medi-Cal Managed Care Plans (MCPs).

CDPS+MRx uses clinical and pharmaceutical data from the prior 12 months to generate predictive risk scores for the next 12 months.

The CDPS+MRx system measures the morbidity burden of patient populations based on age, gender, and diagnostic markers.

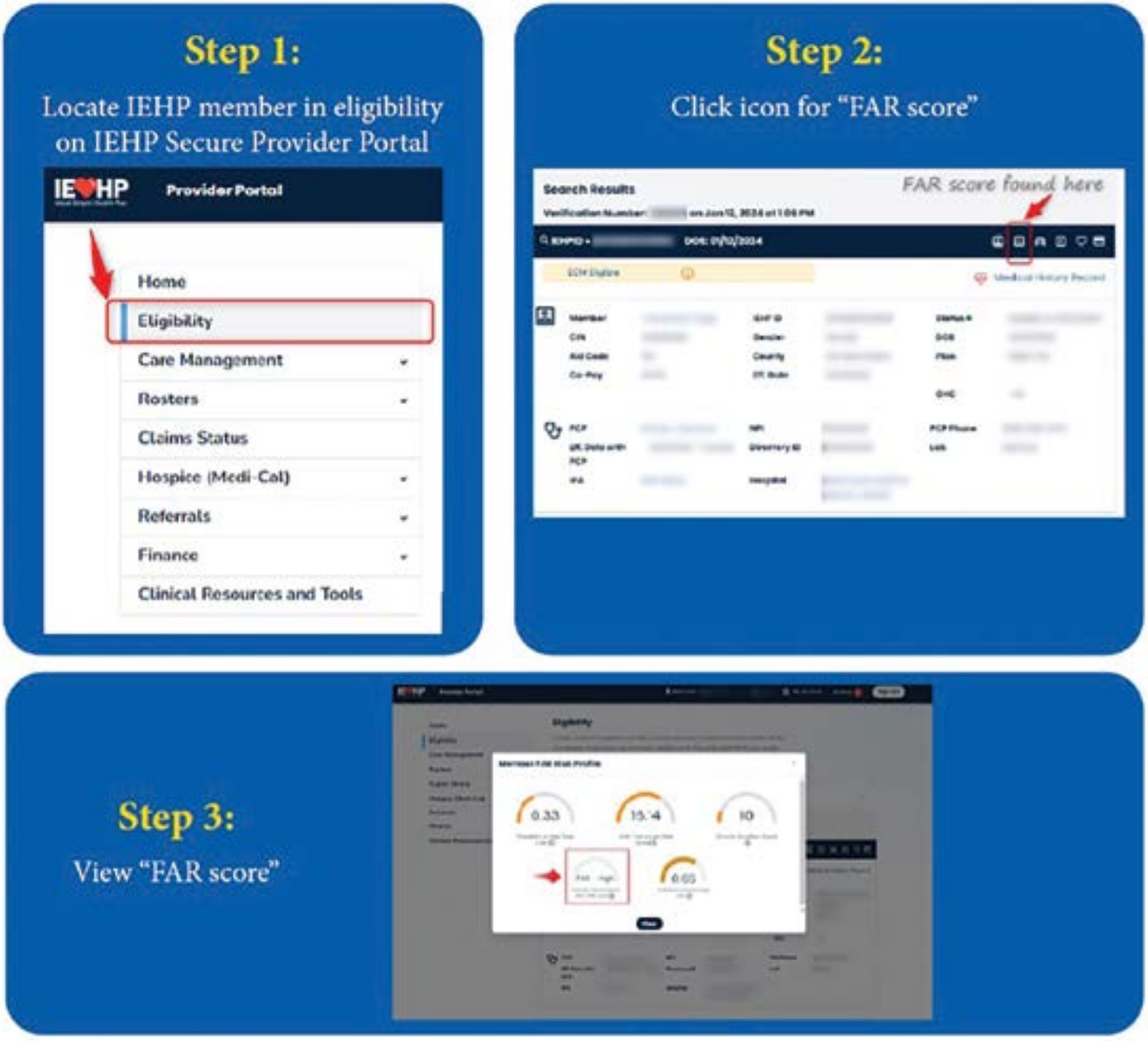
For member stratification, IEHP uses the CDPS+MRx risk scores, along with other inputs including Social Determinants of Health (SDOH) indices, and other clinical indicators to further stratify members into high, rising, and low risk tiers.

- The eligible population in this measure meets all of the following criteria:
    1. Members who are 18 years of age, or older, by December 31, 2024

2. To be eligible for this measure, IEHP Members must be enrolled with IEHP on the date of the discharge through 30 days after the discharge (31 total days).
3. Discharged to home from an acute or nonacute inpatient hospital stay during the measurement year (2024)

This risk score is available for every IEHP Member on the IEHP Provider Portal and can be accessed by following these steps:

To view an IEHP Member's risk score, Providers can log into the secure IEHP Provider Portal and follow these steps:



CODES TO IDENTIFY FOLLOW-UP VISIT:			
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.
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.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
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.
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	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.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
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
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.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
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 (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, 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 (eg, 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 (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99495*	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge Medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge.
Office Visit	CPT	99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of high complexity during the service period face-to-face visit, within seven calendar days of discharge.
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 (g0402)
Office Visit	HCPCS	G0438	Annual Wellness Visit; Includes A Personalized Prevention Plan Of Service (pps), Initial Visit (g0438)
Office Visit	HCPCS	G0439	Annual Wellness Visit, Includes A Personalized Prevention Plan Of Service (pps), Subsequent Visit (g0439)
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 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 7 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	98970	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	98971	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	98972	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
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
Online Assessment	CPT	99421	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	99422	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	99423	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
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
Online Assessment	HCPCS	G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 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
Online Assessment	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 next 24 hours or soonest available appointment

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	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 7 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
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

**Code can only be applied to follow-up visits for non-high risk Members.*

Note: Visits with an Urgent Care will not be accepted for the Post Discharge Follow-Up measure.

The following are excluded from the measure:

1. Hospice
2. Skilled Nursing Facility
3. Deliveries

Statin Therapy Received for Patients with Cardiovascular Disease (SPC)

Methodology: HEDIS®

Measure Description: The percentage of men who are 21-75 years of age and women who are 40-75 years of age during the measurement year (2024), who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Men who are 21-75 years of age as of December 31 of the measurement year (2024).
    2. Women who are 40-75 years of age as of December 31 of the measurement year (2024).
    3. Continuous enrollment with IEHP during the measurement year (2024) and the year prior (2023) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment with IEHP period.

Denominator: Men who are 21-75 years of age and women who are 40-75 who meet all criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had at least one dispensing event for high-intensity or moderate-intensity statin medication during the measurement year (2024).

HIGH AND MODERATE-INTENSITY STATIN MEDICATIONS:	
Description	**Prescription**
High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1-4 mg

Statin Therapy Received for Patients with Diabetes (SPD)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 40-75 years of age during the measurement year (2024) with diabetes who did not have clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who 40-75 years as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) and the year prior (2023) with no more than one gap in continuous enrollment with IEHP of up to 45 days during each year of the continuous enrollment with IEHP period.

Denominator: Members who are 40-75 years of age who meet all criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had at least one dispensing event for any intensity statin medication during the measurement year (2024).

HIGH, MODERATE AND LOW-INTENSITY STATIN MEDICATIONS:	
Description	**Prescription**
High-intensity statin therapy	Atorvastatin 40-80 mg
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg
High-intensity statin therapy	Rosuvastatin 20-40 mg
High-intensity statin therapy	Simvastatin 80 mg
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	Atorvastatin 10-20 mg
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg
Moderate-intensity statin therapy	Simvastatin 20-40 mg
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg
Moderate-intensity statin therapy	Pravastatin 40-80 mg
Moderate-intensity statin therapy	Lovastatin 40 mg
Moderate-intensity statin therapy	Fluvastatin 40-80 mg
Moderate-intensity statin therapy	Pitavastatin 1-4 mg
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg
Low-intensity statin therapy	Fluvastatin 20 mg
Low-intensity statin therapy	Lovastatin 10-20 mg
Low-intensity statin therapy	Pravastatin 10-20 mg
Low-intensity statin therapy	Simvastatin 5-10 mg

Use of Imaging Studies for Low Back Pain (LBP)

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the exclusions

Methodology: HEDIS®

Measure Description: The percentage of Members 18 - 75 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/ eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

- Index Episode Start Date (IESD). The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
- A period of 180 days (six months) prior to the IESD when the member had no claims/ encounters with any diagnosis of low back pain.

Exclude Members with any of the following:

- In *hospice* or using hospice services during the measurement period (2024).
- *Cancer*. Cancer any time during the Member's history through 28 days after the IESD.
- *Recent trauma*. Trauma any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- *Intravenous drug abuse*. IV drug abuse any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- *Neurologic impairment*. Neurologic impairment any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- *HIV*. HIV any time during the Member's history through 28 days after the IESD.
- *Spinal infection*. Spinal infection any time during the 12 months (one year) prior to the IESD through 28 days after the IESD.
- *Major organ transplant*. Major organ transplant any time in the Member's history through 28 days after the IESD.
- *Prolonged use of corticosteroids*. 90 consecutive days of corticosteroid treatment any time during the 12 months (one year) prior to and including the IESD.
- *Osteoporosis.* Osteoporosis therapy or a dispensed prescription to treat osteoporosis any time during the Member's history through 28 days after the IESD.
- *Fragility fracture.* Fragility fracture any time during the three months (90 days) prior to the IESD through 28 days after the IESD.
- *Lumbar surgery.* Lumbar surgery any time during the Member's history through 28 days after the IESD.
- *Spondylopathy.* Spondylopathy any time during the Member's history through 28 days after the IESD.

- *Palliative care.* Members receiving palliative care during the measurement year (2024).
- Members who expired at any time during the Measurement year (2024).
- Members 66 years of age and older as of December 31 of measurement year (2024) with both frailty and advanced illness.

Denominator: All Members aged 18-75 as of December 31 of the measurement year (2024) with a principal diagnosis of uncomplicated low back pain during the measurement year (2024).

Numerator: Members in the denominator who received an imaging study with a diagnosis of uncomplicated low back pain on the IESD or in the 28 days following the IESD.

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	M47.26	Other Spondylosis With Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M47.27	Other Spondylosis With Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M47.28	Other Spondylosis With Radiculopathy, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M47.816	Spondylosis Without Myelopathy Or Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M47.817	Spondylosis Without Myelopathy Or Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M47.818	Spondylosis Without Myelopathy Or Radiculopathy, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M47.896	Other Spondylosis, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M47.897	Other Spondylosis, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M47.898	Other Spondylosis, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M48.061	Spinal Stenosis, Lumbar Region Without Neurogenic Claudication
Uncomplicated Low Back Pain	ICD10CM	M48.062	Spinal Stenosis, Lumbar Region With Neurogenic Claudication
Uncomplicated Low Back Pain	ICD10CM	M48.07	Spinal Stenosis, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M48.08	Spinal Stenosis, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M51.16	Intervertebral Disc Disorders With Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M51.17	Intervertebral Disc Disorders With Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M51.26	Other Intervertebral Disc Displacement, Lumbar Region

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	M51.27	Other Intervertebral Disc Displacement, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M51.36	Other Intervertebral Disc Degeneration, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M51.37	Other Intervertebral Disc Degeneration, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M51.86	Other Intervertebral Disc Disorders, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M51.87	Other Intervertebral Disc Disorders, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M53.2X6	Spinal Instabilities, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M53.2X7	Spinal Instabilities, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M53.2X8	Spinal Instabilities, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M53.3	Sacrococcygeal Disorders, Not Elsewhere Classified
Uncomplicated Low Back Pain	ICD10CM	M53.86	Other Specified Dorsopathies, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M53.87	Other Specified Dorsopathies, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M53.88	Other Specified Dorsopathies, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M54.16	Radiculopathy, Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M54.17	Radiculopathy, Lumbosacral Region
Uncomplicated Low Back Pain	ICD10CM	M54.18	Radiculopathy, Sacral And Sacrococcygeal Region
Uncomplicated Low Back Pain	ICD10CM	M54.30	Sciatica, Unspecified Side
Uncomplicated Low Back Pain	ICD10CM	M54.31	Sciatica, Right Side
Uncomplicated Low Back Pain	ICD10CM	M54.32	Sciatica, Left Side
Uncomplicated Low Back Pain	ICD10CM	M54.40	Lumbago With Sciatica, Unspecified Side
Uncomplicated Low Back Pain	ICD10CM	M54.41	Lumbago With Sciatica, Right Side
Uncomplicated Low Back Pain	ICD10CM	M54.42	Lumbago With Sciatica, Left Side

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	M54.5	Low Back Pain
Uncomplicated Low Back Pain	ICD10CM	M54.89	Other Dorsalgia
Uncomplicated Low Back Pain	ICD10CM	M54.9	Dorsalgia, Unspecified
Uncomplicated Low Back Pain	ICD10CM	M99.03	Segmental And Somatic Dysfunction Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.04	Segmental And Somatic Dysfunction Of Sacral Region
Uncomplicated Low Back Pain	ICD10CM	M99.23	Subluxation Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.33	Osseous Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.43	Connective Tissue Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.53	Intervertebral Disc Stenosis Of Neural Canal Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.63	Osseous And Subluxation Stenosis Of Intervertebral Foramina Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.73	Connective Tissue And Disc Stenosis Of Intervertebral Foramina Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.83	Other Biomechanical Lesions Of Lumbar Region
Uncomplicated Low Back Pain	ICD10CM	M99.84	Other Biomechanical Lesions Of Sacral Region
Uncomplicated Low Back Pain	ICD10CM	S33.100A	Subluxation Of Unspecified Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.100D	Subluxation Of Unspecified Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.100S	Subluxation Of Unspecified Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.110A	Subluxation Of L1/l2 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.110D	Subluxation Of L1/l2 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.110S	Subluxation Of L1/l2 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.120A	Subluxation Of L2/l3 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.120D	Subluxation Of L2/l3 Lumbar Vertebra, Subsequent Encounter

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	S33.120S	Subluxation Of L2/l3 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.130A	Subluxation Of L3/l4 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.130D	Subluxation Of L3/l4 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.130S	Subluxation Of L3/l4 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.140A	Subluxation Of L4/l5 Lumbar Vertebra, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.140D	Subluxation Of L4/l5 Lumbar Vertebra, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.140S	Subluxation Of L4/l5 Lumbar Vertebra, Sequela
Uncomplicated Low Back Pain	ICD10CM	S33.5XXA	Sprain Of Ligaments Of Lumbar Spine, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.6XXA	Sprain Of Sacroiliac Joint, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.8XXA	Sprain Of Other Parts Of Lumbar Spine And Pelvis, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S33.9XXA	Sprain Of Unspecified Parts Of Lumbar Spine And Pelvis, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.002A	Unspecified Injury Of Muscle, Fascia And Tendon Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.002D	Unspecified Injury Of Muscle, Fascia And Tendon Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.002S	Unspecified Injury Of Muscle, Fascia And Tendon Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.012A	Strain Of Muscle, Fascia And Tendon Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.012D	Strain Of Muscle, Fascia And Tendon Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.012S	Strain Of Muscle, Fascia And Tendon Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.092A	Other Injury Of Muscle, Fascia And Tendon Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.092D	Other Injury Of Muscle, Fascia And Tendon Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.092S	Other Injury Of Muscle, Fascia And Tendon Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.82XA	Other Specified Injuries Of Lower Back, Initial Encounter

CODES TO IDENTIFY UNCOMPLICATED LOW BACK PAIN:			
Service	**Code Type**	**Code**	**Code Description**
Uncomplicated Low Back Pain	ICD10CM	S39.82XD	Other Specified Injuries Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.82XS	Other Specified Injuries Of Lower Back, Sequela
Uncomplicated Low Back Pain	ICD10CM	S39.92XA	Unspecified Injury Of Lower Back, Initial Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.92XD	Unspecified Injury Of Lower Back, Subsequent Encounter
Uncomplicated Low Back Pain	ICD10CM	S39.92XS	Unspecified Injury Of Lower Back, Sequela

CODES TO IDENTIFY IMAGING STUDIES:			
Service	**Code Type**	**Code**	**Code Description**
Imaging Study	CPT	72010	Radiologic Examination Spine Entire Survey Study Anteroposterior And Lateral
Imaging Study	CPT	72020	Radiologic Examination Spine Single View Specify Level
Imaging Study	CPT	72040	Radiologic Examination, Spine, Cervical; 2 Or 3 Views
Imaging Study	CPT	72050	Radiologic Examination, Spine, Cervical; 4 Or 5 Views
Imaging Study	CPT	72070	Radiologic Examination, Spine; Thoracic, 2 Views
Imaging Study	CPT	72072	Radiologic Examination, Spine; Thoracic, 3 Views
Imaging Study	CPT	72074	Radiologic Examination, Spine; Thoracic, Minimum Of 4 Views
Imaging Study	CPT	72080	Radiologic Examination, Spine; Thoracolumbar Junction, Minimum Of 2 Views
Imaging Study	CPT	72081	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); One View
Imaging Study	CPT	72082	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); 2 Or 3 Views
Imaging Study	CPT	72083	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); 4 Or 5 Views
Imaging Study	CPT	72084	Radiologic Examination, Spine, Entire Thoracic And Lumbar, Including Skull, Cervical And Sacral Spine If Performed (eg, Scoliosis Evaluation); Minimum Of 6 Views
Imaging Study	CPT	72052	Radiologic Examination Spine Cervical Complete Including Oblique And Flexion And/or Extension Studies
Imaging Study	CPT	72100	Radiologic Examination Spine Lumbosacral Two Or Three Views
Imaging Study	CPT	72110	Radiologic Examination Spine Lumbosacral Minimum Of Four Views
Imaging Study	CPT	72114	Radiologic Examination Spine Lumbosacral Complete Including Bending Views

CODES TO IDENTIFY IMAGING STUDIES:			
Service	**Code Type**	**Code**	**Code Description**
Imaging Study	CPT	72120	Radiologic Examination Spine Lumbosacral Bending Views Only Minimum Of Four Views
Imaging Study	CPT	72125	Computed Tomography, Cervical Spine; Without Contrast Material
Imaging Study	CPT	72126	Computed Tomography, Cervical Spine; With Contrast Material
Imaging Study	CPT	72127	Computed Tomography, Cervical Spine; Without Contrast Material, Followed By Contrast Material(s) And Further Sections
Imaging Study	CPT	72128	Computed Tomography, Thoracic Spine; Without Contrast Material
Imaging Study	CPT	72129	Computed Tomography, Thoracic Spine; With Contrast Material
Imaging Study	CPT	72130	Computed Tomography, Thoracic Spine; Without Contrast Material, Followed By Contrast Material(s) And Further Sections
Imaging Study	CPT	72131	Computerized Axial Tomography Lumbar Spine Without Contrast Material
Imaging Study	CPT	72132	Computerized Axial Tomography Lumbar Spine With Contrast Material
Imaging Study	CPT	72133	Computerized Axial Tomography Lumbar Spine Without Contrast Material Followed By Contrast Material(s) And Further Sections
Imaging Study	CPT	72141	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Cervical Without Contrast Material
Imaging Study	CPT	72142	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Cervical With Contrast Material(s)
Imaging Study	CPT	72146	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Thoracic Without Contrast Material
Imaging Study	CPT	72147	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Thoracic With Contrast Material(s)
Imaging Study	CPT	72148	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Lumbar Without Contrast Material
Imaging Study	CPT	72149	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Lumbar With Contrast Material(s)
Imaging Study	CPT	72156	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(s) An
Imaging Study	CPT	72157	Magnetic Resonance (eg, Proton) Imaging, Spinal Canal And Contents, Without Contrast Material, Followed By Contrast Material(s) And Further Sequences; Thoracic
Imaging Study	CPT	72158	Magnetic Resonance (e.g., Proton) Imaging Spinal Canal And Contents Without Contrast Material Followed By Contrast Material(s) An
Imaging Study	CPT	72200	Radiologic Examination Sacroiliac Joints Less Than Three Views
Imaging Study	CPT	72202	Radiologic Examination Sacroiliac Joints Three Or More Views
Imaging Study	CPT	72220	Radiologic Examination Sacrum And Coccyx Minimum Of Two Views
Imaging Study	CPT	99457	Remote Physiologic Monitoring Treatment Management Services, 20 Minutes Or More Of Clinical Staff/physician/other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/caregiver During The Month

Substance Use Assessment in Primary Care

Methodology: IEHP-Defined Quality Measure

Measure Description: The percentage of Members 18 years and older who were screened for substance use during the measurement year (2024).

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	CPT	99408	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g., Audit DAST) and Brief Intervention (SBI) Services 15 to 30 Minutes
Substance Use Assessment in Primary Care	CPT	99409	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g., Audit DAST) and Brief Intervention (SBI) Services Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0442	Annual Alcohol Misuse Screening 15 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0443	Brief Face-to-Face Behavioral Counseling for Alcohol Misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPCS	H0001	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPCS	H0049	Alcohol and/or Drug Screening
Substance Use Assessment in Primary Care	HCPCS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

Denominator: All Members aged 18 years and older during the measurement year (2024). Member counted only once in the denominator.

- Anchor Date: December 31, 2024

Numerator: Members who were screened for substance use at least once during the measurement year (2024).

Examples of Substances Use Assessment in Primary Care screening tools include but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
    - The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening

- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population

☑ Population: Adult and Adolescent

Antidepressant Medication Management (AMM)

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18 years of age or older who had a diagnosis of major depression, remained on antidepressant medication treatment and who were treated with antidepressant medication.

- Two rates are reported:
    1. Effective Acute Phase Treatment: The percentage of Members who remained on an antidepressant medication for at least 84 days (12 weeks).
    2. Effective Continuation Phase Treatment: The percentage of Members who remained on an antidepressant medication for at least 180 days (six months).
- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18 years and older as of the Index Prescription Start Date (IPSD).
    2. Continuous enrollment with IEHP 105 days prior to the index prescription start date through 231 days after the index prescription start date.
    3. Filled a prescription for an antidepressant medication during the intake period (starting May 1, 2023, through April 30, 2024).
    4. Has at least one of the following 60 days prior and 60 days after the prescription date:
        - Diagnosis of major depression in an inpatient setting
        - Diagnosis of major depression in an outpatient setting
    5. Must have no prior prescriptions for antidepressant medications in the prior 105 days.

Rate 1

Denominator: Members who are 18 years of age or older who meet all criteria for the eligible population.

- Anchor Date: Index prescription start date

Numerator: Members in the denominator that had at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the Index Prescription Start Date (IPSD) through 114 days after the IPSD (115 total days).

Rate 2

Denominator: Members who are 18 years of age or older who meet all criteria for the eligible population.

- Anchor Date: Index prescription start date

Numerator: Members in the denominator that had at least 180 days (six months) of treatment with antidepressant medication beginning on the Index Prescription Start Date (IPSD) through 231 days after the IPSD (232 total days).

ANTIDEPRESSANT MEDICATION:		
Description	**Prescription**	
Miscellaneous Antidepressants	• Bupropion • Vortioxetine	• Vilazodone
Monoamine Oxidase Inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine
Phenylpiperazine Antidepressants	• Nefazodone • Trazodone	
Psychotherapeutic Combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine	• Fluoxetine-olanzapine
SNRI Antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine
SSRI Antidepressants	• Citalopram • Escitalopram • Fluoxetine	• Fluvoxamine • Paroxetine • Sertraline
Tetracyclic Antidepressants	• Maprotiline	• Mirtazapine
Tricyclic Antidepressants	• Amitriptyline • Amoxapine • Clomipramine • Desipramine • Doxepin (>6mg)	• Imipramine • Nortriptyline • Protriptyline •Trimipramine

Screening for Clinical Depression in Primary Care

Summary of Changes to the Global Quality P4P Program Guide:

- Measure tools updated

Methodology: IEHP-Defined Quality Measure

Measure Description: The percentage of Members ages 12 and older screened for clinical depression during the measurement year (2024) with the result of the screening documented by the Provider. For this measure, two rates are calculated, and the average of both rates is used as the final score.

Rate 1: *Screening for Clinical Depression* - This measure assesses the percentage of Members aged 12 and older who were screened for clinical depression during a PCP visit using an age appropriate standardized tool during the measurement year (2024).

Denominator: All Members aged 12 years and older with a PCP visit in the measurement year (2024). Member counted only once in the denominator.

PRIMARY CARE PROVIDER VISIT CODES:			
Service	**Code Type**	**Code**	**Code Description**
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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.

PRIMARY CARE PROVIDER VISIT CODES:			
Service	**Code Type**	**Code**	**Code Description**
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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.
Screening for Clinical Depression in Primary Care	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 12-17 years).
Screening for Clinical Depression in Primary Care	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; age 18-39 years.
Screening for Clinical Depression in Primary Care	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; age 40-64 years.
Screening for Clinical Depression in Primary Care	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; age 65 years and older.
Screening for Clinical Depression in Primary Care	CPT	99394	Periodic comprehensive preventive medicine; re-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, established patient; adolescent (age 12-17 years).

PRIMARY CARE PROVIDER VISIT CODES:			
Service	**Code Type**	**Code**	**Code Description**
Screening for Clinical Depression in Primary Care	CPT	99395	Periodic comprehensive preventive medicine; re-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, established patient; age 18-39 years.
Screening for Clinical Depression in Primary Care	CPT	99396	Periodic comprehensive preventive medicine; re-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, established patient; age 40-64 years.
Screening for Clinical Depression in Primary Care	CPT	99397	Periodic comprehensive preventive medicine; re-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, established patient; age 65 years and older.
Screening for Clinical Depression in Primary Care	CPT	99446	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.
Screening for Clinical Depression in Primary Care	CPT	99447	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.
Screening for Clinical Depression in Primary Care	CPT	99448	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.
Screening for Clinical Depression in Primary Care	CPT	99449	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.
Screening for Clinical Depression in Primary Care	HCPCS	G0402	Initial preventive physical examination face-to-face visits services limited to new beneficiary during the first 12 months.
Screening for Clinical Depression in Primary Care	HCPCS	G0438	Annual wellness visit includes a personalized prevention plan of service (PPS) initial visit.
Screening for Clinical Depression in Primary Care	HCPCS	G0439	Annual wellness visit includes a personalized prevention plan of service (PPS) subsequent visit.

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.

Numerator: Members screened for clinical depression using an age appropriate standardized tool during the measurement year (2024).

CODES TO IDENTIFY SCREENING FOR CLINICAL DEPRESSION:			
Service	**Code Type**	**Code**	**Code Description**
Perinatal Depression Screening (Negative for Depressive Symptoms Result)	CPT	3351F	Negative screen for depressive symptoms as categorized by using a standardized depression screening/assessment tool
Perinatal Depression Screening (Mild for Depressive Symptoms Result)	CPT	3353F	Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool
Perinatal Depression Screening (Major Depressive Symptoms Result)	CPT	3090F	Major depressive disorder, severe without psychotic features
Perinatal Depression Screening (Major Depressive Symptoms with Psychotic Features Result)	CPT	3091F	Major depressive disorder, severe with psychotic features
Screening for Clinical Depression in Primary Care	HCPCS	G0444	Annual depression screening, 15 minutes.
Screening for Clinical Depression in Primary Care	HCPCS	G8431	Screening for depression is documented as being positive and a follow-up plan is documented.
Screening for Clinical Depression in Primary Care	HCPCS	G8510	Negative screen for clinical depression using a standardized tool patient not eligible/appropriate for follow-up plan.
Screening for Clinical Depression in Primary Care	HCPCS	G8511	Screening for depression documented as positive, follow-up plan not documented, reason not given.

Rate 2: *Appropriate Documentation of Depression Screening Result* - This measure assesses the percent of Members in the measurement year (2024) screened for clinical depression who also had the result recorded and a follow-up plan documented, indicated on the date of the encounter. The clinical depression screening tool must be an age-appropriate standardized tool.

Denominator: Same as rate 1.

Numerator: Members screened for clinical depression with a recorded result and follow-up plan if indicated, on the date of the encounter using an age appropriate standardized tool during the measurement year (2024).

CODES TO IDENTIFY DOCUMENTATION OF DEPRESSION SCREENING RESULT:			
Service	**Code Type**	**Code**	**Code Description**
Screening for Clinical Depression in Primary Care	HCPCS	G8431	Positive screen for clinical depression using a standardized tool and a follow-up plan is documented.
Screening for Clinical Depression in Primary Care	HCPCS	G8510	Negative screen for clinical depression using a standardized tool patient not eligible/appropriate for follow-up plan.

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the Member population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include:

Instruments for Adolescents <17 years of age

- Patient Health Questionnaire (PHQ-9)®
- Patient Health Questionnaire Modified for Teens (PHQ-9M)®
- Patient Health Questionnaire-2 (PHQ-2)®1
- Beck Depression Inventory-Fast Screen (BDI-FS)®1,2
- Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)
- Edinburgh Postnatal Depression Scale (EPDS)
- PROMIS Depression

Instruments for Adults 18 years and older

- Patient Health Questionnaire (PHQ-9)®
- Patient Health Questionnaire-2 (PHQ-2)®1
- Beck Depression Inventory-Fast Screen (BDI-FS)®1,2
- Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)
- Edinburgh Postnatal Depression Scale (EPDS)
- PROMIS Depression
- Beck Depression Inventory (BDI-II)
- Duke Anxiety—Depression Scale (DUKE-AD)®2
- Geriatric Depression Scale Short Form (GDS)1
- Geriatric Depression Scale Long Form (GDS)
- My Mood Monitor (M-3)®
- Clinically Useful Depression Outcome Scale (CUDOS)

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Methodology: HEDIS®

Measure Description: The percentage of Members 12 years of age and older screened for clinical depression during the measurement year (2024) using a standardized instrument and, if screened positive, received follow-up care in the measurement year (2024). For this measure, two rates are calculated, and the average of both rates is used as the final score.

- The eligible population in this measure meets the following criteria:
  - 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).
- Members who meet any of the following criteria are excluded:
  - Members in hospice during the measurement year (2024).
  - Members who expire at any time during the measurement year (2024).
  - Members with depression that started during the prior measurement year (2023).
  - Members with a history of bipolar disorder at any time during the member's history through the end of the prior measurement year (2023).

Rate 1 : *Depression Screening* - This measure assesses the percentage of Members aged 12 and older who were screened for clinical depression using an age-appropriate standardized tool during the measurement year (2024).

Denominator: All Members aged 12 years and older during the measurement year (2024). Member counted only once in the denominator.

Numerator: Members with a documented result for depression screening, using an age-appropriate standardized tool performed with a PCP during the measurement year (2024).

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Duke Anxiety—Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥30
Geriatric Depression Scale Short Form (GDS)[1]	48545-8	Total score ≥5
Geriatric Depression Scale Long Form (GDS)	48544-1	Total score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10
My Mood Monitor (M-3)®	71777-7	Total score ≥5
PROMIS Depression	71965-8	Total score (T Score) ≥60
Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31

Rate 2 : *Follow-Up on Positive Screen* - This measure assesses the percentage of Members aged 12 and older who received follow-up care within 30 days of a documented positive depression screen finding during the measurement year (2024).

Denominator: All Members aged 12 years and older with a documented positive depression screen result during the measurement year (2024).

Numerator: Members who screened positive and received follow-up care on or up to 30 days after the date of the first positive screen (31 total days) in the measurement year (2024).
A follow-up on or up to 30 days after the first positive screen may include any of the following:

- An outpatient★, e-visit★, telephone★, or virtual check-in★ follow-up visit★ with a diagnosis of depression or other behavioral health conditions◆.
- An encounter for depression case management● that documents assessment for symptoms■ or diagnosis of depression or other behavioral health conditions◆.
- An encounter for behavioral health▲, including assessment, therapy, collaborative care, or medication management.
- A dispensed antidepressant medication◈.

OR

Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Refer to the Depression Screening and Follow-Up for Adolescents and Adults (DSF-E): Positive Screen Follow-Up Code List on the IEHP website at: https://www.providerservices.iehp.org/en/programs-and-services/provider-incentive-programs/pay-for-performance-program. This list includes codes that identify follow-up care, for members who screen positive, on or up to 30 days after the date of the first positive screen. Please reference the superscripts in this list with the specifications described in the Follow-Up on Positive Screen numerator description.

Social Determinants of Health Screening Rate

Methodology: IEHP-Defined Equity Measure

Measure Description: The percentage of Members who were screened for social determinants of health during the measurement year (2024).

Eligible population in this measure meet the following criteria:

1. 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).

Denominator: All Members during the measurement year (2024).

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who were screened for social determinants of health in the measurement year (2024).

CODES TO IDENTIFY SOCIAL DETERMINANTS OF HEALTH SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	CPT	96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
Social Determinants of Health	CPT	96161	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.
Social Determinants of Health	HCPCS	G9919	Screening performed and positive and provision of recommendations.
Social Determinants of Health	HCPCS	G9920	Screening performed and negative.

Examples of Social Determinants of Health screening instruments include but are not limited to:

FOOD INSECURITY INSTRUMENTS:
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool
American Academy of Family Physicians (AAFP) Social Needs Screening Tool
Health Leads Screening Panel®1
Hunger Vital Sign™1 (HVS)
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1
Safe Environment for Every Kid (SEEK)®1
U.S. Household Food Security Survey [U.S. FSS]
U.S. Adult Food Security Survey [U.S. FSS]
U.S. Child Food Security Survey [U.S. FSS]
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]
We Care Survey
WellRx Questionnaire

HOUSING INSTABILITY AND HOMELESSNESS INSTRUMENTS:
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool
American Academy of Family Physicians (AAFP) Social Needs Screening Tool
Children's Health Watch Housing Stability Vital Signs™1
Health Leads Screening Panel®1
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1
We Care Survey
WellRx Questionnaire
Accountable Health communities (AHC) Health - Related Social Needs (HRSN Screening Tool)
American Academy and Family Physicians (AAFP) Social Needs Screening Tool

TRANSPORTATION INSECURITY INSTRUMENTS:
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool
American Academy of Family Physicians (AAFP) Social Needs Screening Tool
Comprehensive Universal Behavior Screen (CUBS)
Health Leads Screening Panel®1
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1
PROMIS®1
WellRx Questionnaire

Social Determinants of Health Identification Rate

Methodology: IEHP-Defined Equity Measure

Measure Description: The percentage of Members who were screened for social determinants of health during the measurement year (2024) and who had at least one social determinant of health identified.

Eligible population in this measure meet the following criteria:

1. 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).

Denominator: All Members during the measurement year (2024).

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who were screened for social determinants in the measurement year (2024) and had a social determinant identified.

CODES TO IDENTIFY PRIORITY SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:			
Service	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	ICD10CM	Z55.0	Illiteracy and low-level literacy
Social Determinants of Health	ICD10CM	Z58.6	Inadequate drinking-water supply
Social Determinants of Health	ICD10CM	Z59.00	Homelessness unspecified
Social Determinants of Health	ICD10CM	Z59.01	Sheltered homelessness
Social Determinants of Health	ICD10CM	Z59.02	Unsheltered homelessness
Social Determinants of Health	ICD10CM	Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Social Determinants of Health	ICD10CM	Z59.3	Problems related to living in residential institution
Social Determinants of Health	ICD10CM	Z59.41	Food insecurity
Social Determinants of Health	ICD10CM	Z59.48	Other specified lack of adequate food
Social Determinants of Health	ICD10CM	Z59.7	Insufficient social insurance and welfare support
Social Determinants of Health	ICD10CM	Z59.811	Housing instability, housed, with risk of homelessness
Social Determinants of Health	ICD10CM	Z59.812	Housing instability, housed, homelessness in past 12 months
Social Determinants of Health	ICD10CM	Z59.819	Housing instability, housed unspecified
Social Determinants of Health	ICD10CM	Z59.89	Other problems related to housing and economic circumstances
Social Determinants of Health	ICD10CM	Z60.2	Problems related to living alone
Social Determinants of Health	ICD10CM	Z60.4	Social exclusion and rejection (physical appearance, illness, or behavior)

CODES TO IDENTIFY PRIORITY SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:			
Service	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	ICD10CM	Z62.810	Personal history of physical and sexual abuse in childhood
Social Determinants of Health	ICD10CM	Z62.819	Personal history of unspecified abuse in childhood
Social Determinants of Health	ICD10CM	Z63.0	Problems in relationship with spouse or partner
Social Determinants of Health	ICD10CM	Z63.4	Disappearance and death of family member (assumed death, bereavement)
Social Determinants of Health	ICD10CM	Z63.5	Disruption of family by separation and divorce (marital estrangement)
Social Determinants of Health	ICD10CM	Z63.6	Dependent relative needing care at home
Social Determinants of Health	ICD10CM	Z63.72	Alcoholism and drug addiction in family
Social Determinants of Health	ICD10CM	Z65.1	Imprisonment and other incarceration
Social Determinants of Health	ICD10CM	Z65.2	Problems related to release from prison
Social Determinants of Health	ICD10CM	Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

CODES TO IDENTIFY ADDITIONAL SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:				
Service	**Category**	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	Problems related to education & literacy	ICD10CM	Z55.0	Illiteracy and low-level literacy
Social Determinants of Health		ICD10CM	Z55.1	Schooling unavailable and unattainable
Social Determinants of Health		ICD10CM	Z55.2	Failed school examinations
Social Determinants of Health		ICD10CM	Z55.3	Underachievement in school
Social Determinants of Health		ICD10CM	Z55.4	Educational maladjustment and discord with teachers and classmates
Social Determinants of Health		ICD10CM	Z55.9	Problems related to education and literacy, unspecified
Social Determinants of Health	Problems related to employment & unemployment	ICD10CM	Z56.0	Unemployment, unspecified
Social Determinants of Health		ICD10CM	Z56.1	Change of job
Social Determinants of Health		ICD10CM	Z56.2	Threat of job loss
Social Determinants of Health		ICD10CM	Z56.4	Discord with boss and workmates
Social Determinants of Health		ICD10CM	Z56.5	Uncongenial work environment
Social Determinants of Health		ICD10CM	Z56.6	Other physical and mental strain related to work
Social Determinants of Health		ICD10CM	Z56.81	Sexual harassment on the job

CODES TO IDENTIFY ADDITIONAL SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:				
Service	**Category**	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	Problems related to employment & unemployment	ICD10CM	Z56.82	Military deployment status
Social Determinants of Health		ICD10CM	Z56.9	Unspecified problems related to employment
Social Determinants of Health	Occupational exposure to risk factors	ICD10CM	Z57.0	Occupational exposure to noise
Social Determinants of Health		ICD10CM	Z57.1	Occupational exposure to radiation
Social Determinants of Health		ICD10CM	Z57.2	Occupational exposure to dust
Social Determinants of Health		ICD10CM	Z57.31	Occupational exposure to environmental tobacco smoke
Social Determinants of Health		ICD10CM	Z57.39	Occupational exposure to other air contaminants
Social Determinants of Health		ICD10CM	Z57.4	Occupational exposure to toxic agents in agriculture
Social Determinants of Health		ICD10CM	Z57.5	Occupational exposure to toxic agents in other industries
Social Determinants of Health		ICD10CM	Z57.6	Occupational exposure to extreme temperature
Social Determinants of Health		ICD10CM	Z57.7	Occupational exposure to vibration
Social Determinants of Health		ICD10CM	Z57.8	Occupational exposure to other risk factors
Social Determinants of Health		ICD10CM	Z57.9	Occupational exposure to unspecified risk factor
Social Determinants of Health	Problems related to housing and economic circumstances	ICD10CM	Z58.6	Inadequate drinking-water supply
Social Determinants of Health		ICD10CM	Z59.00	Homelessness unspecified
Social Determinants of Health		ICD10CM	Z59.01	Sheltered homelessness
Social Determinants of Health		ICD10CM	Z59.02	Unsheltered homelessness
Social Determinants of Health		ICD10CM	Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Social Determinants of Health		ICD10CM	Z59.2	Discord with neighbors, lodgers and landlord
Social Determinants of Health		ICD10CM	Z59.3	Problems related to living in residential institution
Social Determinants of Health		ICD10CM	Z59.41	Food insecurity
Social Determinants of Health		ICD10CM	Z59.48	Other specified lack of adequate food

CODES TO IDENTIFY ADDITIONAL SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:				
Service	**Category**	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	Problems related to housing and economic circumstances	ICD10CM	Z59.5	Extreme poverty
Social Determinants of Health		ICD10CM	Z59.6	Low income
Social Determinants of Health		ICD10CM	Z59.7	Insufficient social insurance and welfare support
Social Determinants of Health		ICD10CM	Z59.811	Housing instability, housed, with risk of homelessness
Social Determinants of Health		ICD10CM	Z59.812	Housing instability, housed, homelessness in past 12 months
Social Determinants of Health		ICD10CM	Z59.819	Housing instability, housed unspecified
Social Determinants of Health		ICD10CM	Z59.89	Other problems related to housing and economic circumstances
Social Determinants of Health		ICD10CM	Z59.9	Problem related to housing and economic circumstances, unspecified
Social Determinants of Health	Problems related to social environment	ICD10CM	Z60.0	Problems of adjustment to life transitions (life phase, retirement)
Social Determinants of Health		ICD10CM	Z60.2	Problems related to living alone
Social Determinants of Health		ICD10CM	Z60.3	Acculturation difficulty (migration, social transplantation)
Social Determinants of Health		ICD10CM	Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
Social Determinants of Health		ICD10CM	Z60.5	Target of (perceived) adverse discrimination and persecution
Social Determinants of Health		ICD10CM	Z60.8	Other problems related to social environment
Social Determinants of Health		ICD10CM	Z60.9	Problem related to social environment, unspecified
Social Determinants of Health	Problems related to upbringing	ICD10CM	Z62.0	Inadequate parental supervision and control
Social Determinants of Health		ICD10CM	Z62.1	Parental overprotection
Social Determinants of Health		ICD10CM	Z62.21	Child in welfare custody (non-parental family member, foster care)
Social Determinants of Health		ICD10CM	Z62.22	Institutional upbringing (orphanage or group home)
Social Determinants of Health		ICD10CM	Z62.29	Other upbringing away from parents
Social Determinants of Health		ICD10CM	Z62.3	Hostility towards and scapegoating of child
Social Determinants of Health		ICD10CM	Z62.6	Inappropriate (excessive) parental pressure

CODES TO IDENTIFY ADDITIONAL SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:				
Service	**Category**	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	Problems related to upbringing	ICD10CM	Z62.810	Personal history of physical and sexual abuse in childhood
Social Determinants of Health		ICD10CM	Z62.811	Personal history of psychological abuse in childhood
Social Determinants of Health		ICD10CM	Z62.812	Personal history of neglect in childhood
Social Determinants of Health		ICD10CM	Z62.813	Personal history of forced labor or sexual exploitation in childhood
Social Determinants of Health		ICD10CM	Z62.819	Personal history of unspecified abuse in childhood
Social Determinants of Health		ICD10CM	Z62.820	Parent-biological child conflict
Social Determinants of Health		ICD10CM	Z62.821	Parent-adopted child conflict
Social Determinants of Health		ICD10CM	Z72.3	Lack of physical exercise
Social Determinants of Health		ICD10CM	Z62.822	Parent-foster child conflict
Social Determinants of Health		ICD10CM	Z62.890	Parent-child estrangement NEC
Social Determinants of Health		ICD10CM	Z62.891	Sibling rivalry
Social Determinants of Health		ICD10CM	Z62.898	Other specified problems related to upbringing
Social Determinants of Health		ICD10CM	Z62.9	Problem related to upbringing, unspecified
Social Determinants of Health	Other problems related to primary support group, including family circumstances	ICD10CM	Z63.0	Problems in relationship with spouse or partner
Social Determinants of Health		ICD10CM	Z63.1	Problems in relationship with in-laws
Social Determinants of Health		ICD10CM	Z63.31	Absence of family member due to military deployment
Social Determinants of Health		ICD10CM	Z63.32	Other absence of family member
Social Determinants of Health		ICD10CM	Z63.4	Disappearance/death of family member (assumed death, bereavement)
Social Determinants of Health		ICD10CM	Z63.5	Disruption of family by separation and divorce (marital estrangement)
Social Determinants of Health		ICD10CM	Z63.6	Dependent relative needing care at home
Social Determinants of Health		ICD10CM	Z63.71	Stress on family due to return of family from military deployment

CODES TO IDENTIFY ADDITIONAL SOCIAL DETERMINANTS OF HEALTH SCREENING IDENTIFICATION FACTORS:				
Service	**Category**	**Code Type**	**Code**	**Code Description**
Social Determinants of Health	Other problems related to primary support group, including family circumstances	ICD10CM	Z63.72	Alcoholism and drug addiction in family
Social Determinants of Health		ICD10CM	Z63.79	Other stressful events affecting family/ household (ill/disturbed member)
Social Determinants of Health		ICD10CM	Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
Social Determinants of Health		ICD10CM	Z63.9	Problem related to primary support group, unspecified
Social Determinants of Health		ICD10CM	Z81.8	Family history of other mental and behavioral disorders
Social Determinants of Health		ICD10CM	Z91.89	Other specified personal risk factors, not elsewhere classified
Social Determinants of Health	Problems related to psychosocial circumstances	ICD10CM	Z64.0	Problems related to unwanted pregnancy
Social Determinants of Health		ICD10CM	Z64.1	Problems related to multiparity
Social Determinants of Health		ICD10CM	Z64.4	Discord with counselors
Social Determinants of Health	Problems related to other psychosocial circumstances	ICD10CM	Z65.0	Conviction in civil and criminal proceedings without imprisonment
Social Determinants of Health		ICD10CM	Z65.1	Imprisonment and other incarceration
Social Determinants of Health		ICD10CM	Z65.2	Problems related to release from prison
Social Determinants of Health		ICD10CM	Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
Social Determinants of Health		ICD10CM	Z65.4	Victim of crime and terrorism
Social Determinants of Health		ICD10CM	Z65.5	Exposure to disaster, war and other hostilities
Social Determinants of Health		ICD10CM	Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)
Social Determinants of Health		ICD10CM	Z65.9	Problem related to unspecified psychosocial circumstances
Social Determinants of Health	Transportation Insecurity	ICD10CM	Z59.82	Excessive transportation time, inaccessible transportation, inadequate transportation, lack of transportation, unaffordable transportation, unreliable transportation, unsafe transportation

☑ Population: Women

Breast Cancer Screening (BCS)

Methodology: HEDIS®

Measure Description: The percentage of members 50-74 years of age who had a mammogram to screen for breast cancer any time on or between October 1, two years prior to the measurement year (2022) and December 31 of the measurement year (2024).

- The eligible population in the measure meets all of the following criteria:
  1. Members 52-74 years as of December 31 of the measurement year (2024).
  2. Continuous enrollment with IEHP from October 1, two years prior to the measurement year (2022) through December 31 of the measurement year (2024), with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment with IEHP. No gaps in enrollment are allowed from October 1 through December 31, two years prior to the measurement year (2022).

CODES USED TO IDENTIFY MAMMOGRAPHY:			
Service	**Code Type**	**Code**	**Code Description**
Breast Cancer Screening	CPT	77061	Digital Breast Tomosynthesis Unilateral
Breast Cancer Screening	CPT	77062	Digital Breast Tomosynthesis Bilateral
Breast Cancer Screening	CPT	77063	Screening Digital Breast Tomosynthesis Bilateral (list Separately In Addition To Code For Primary Procedure)
Breast Cancer Screening	CPT	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
Breast Cancer Screening	CPT	77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
Breast Cancer Screening	CPT	77067	Screening Mammography Bilateral (Two-view Film Study Of Each Breast Including Computer-aided Detection (CAD)

- Members who meet 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 who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period (2024).
  5. Members 66 years of age and older as of December 31 of measurement year (2024) with both frailty and advanced illness.

Denominator: Members 52-74 years of age who meet the criteria for the eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had one or more mammograms any time on or between October 1, two years prior to the measurement year (2022), and December 31, of the measurement year (2024).

Cervical Cancer Screening (CCS)

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the measure description

Methodology: HEDIS®

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

- Members ages 21-64 who had cervical cytology performed every three years.
- Members ages 30-64 who had cervical high-risk human papillomavirus (hrHPV) testing performed every five years.
- Members ages 30-64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing performed every five years.
- The eligible population in the measure meets all of the following criteria:
    1. Members 24-64 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 enrollment of up to 45 days.

CODES TO IDENTIFY CERVICAL CYTOLOGY:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	88141	Cytopathology Cervical Or Vaginal (any Reporting System) Requiring Interpretation By Physician (List separately in addition to code for technical service.)
Cervical Cancer Screening	CPT	88142	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Automated Thin Layer Preparation Manual screening under Physician supervision
Cervical Cancer Screening	CPT	88143	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Automated Thin Layer Preparation; manual screening Under Physician Supervision: With manual screening and rescreening Under Physician Supervision

CODES TO IDENTIFY CERVICAL CYTOLOGY:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	88147	Cytopathology Smears Cervical Or Vaginal Screening By Automated System Under Physician Supervision
Cervical Cancer Screening	CPT	88148	Cytopathology Smears Cervical Or Vaginal Screening By Automated System With Manual Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88150	Cytopathology Slides Cervical Or Vaginal Manual Screening Under Physician Supervision
Cervical Cancer Screening	CPT	88152	Cytopathology Slides Cervical Or Vaginal With Manual Screening And Computer-assisted Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88153	Cytopathology Slides Cervical Or Vaginal With Manual Screening And Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88164	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) Manual Screening Under Physician Supervision
Cervical Cancer Screening	CPT	88165	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) With Manual Screening And Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88166	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) With Manual Screening And Computer-assisted Rescreening Under Physician Supervision
Cervical Cancer Screening	CPT	88167	Cytopathology Slides Cervical Or Vaginal (the Bethesda System) With Manual Screening And Computer-assisted Rescreening Using cell selection and review Under Physician Supervision
Cervical Cancer Screening	CPT	88174	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Automated Thin Layer Preparation
Cervical Cancer Screening	CPT	88175	Cytopathology Cervical Or Vaginal (any Reporting System) Collected In Preservative Fluid Screening Automated By System
Cervical Cancer Screening	HCPCS	G0123	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, Screening By Cytotechnologist Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0124	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, Requiring Interpretation By Physician
Cervical Cancer Screening	HCPCS	G0141	Screening Cytopathology Smears, Cervical Or Vaginal, Performed By Automated System, With Manual Rescreening, Requiring Interpretation By Physician
Cervical Cancer Screening	HCPCS	G0143	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, With Manual Screening And Rescreening By Cytotechnologist Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0144	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, With Screening By Automated System, Under Physician Supervision

CODES TO IDENTIFY CERVICAL CYTOLOGY:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	HCPCS	G0145	Screening Cytopathology, Cervical Or Vaginal (any Reporting System), Collected In Preservative Fluid, Automated Thin Layer Preparation, With Screening By Automated System And Manual Rescreening Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0147	Screening Cytopathology Smears, Cervical Or Vaginal, Performed By Automated System Under Physician Supervision
Cervical Cancer Screening	HCPCS	G0148	Screening Cytopathology Smears, Cervical Or Vaginal, Performed By Automated System With Manual Rescreening
Cervical Cancer Screening	HCPCS	P3000	Screening Papanicolaou Smear, Cervical Or Vaginal, Up To Three Smears, By Technician Under Physician Supervision
Cervical Cancer Screening	HCPCS	P3001	Screening Papanicolaou Smear, Cervical Or Vaginal, Up To Three Smears, Requiring Interpretation By Physician
Cervical Cancer Screening	HCPCS	Q0091	Screening Papanicolaou Smear; Obtaining, Preparing And Conveyance Of Cervical Or Vaginal Smear To Laboratory

CODES TO IDENTIFY HPV TESTS:			
Service	**Code Type**	**Code**	**Code Description**
Cervical Cancer Screening	CPT	87624	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Human Papilloma Virus (HPV) High-risk Types (e.g., 16 18 31 33 35 39 45 51 52 56 58 59 68)
Cervical Cancer Screening	CPT	87625	Infectious Agent Detection By Nucleic Acid (DNA or RNA) Human Papilloma Virus (HPV) Types 16 And 18 Only Includes Type 45, If Performed
Cervical Cancer Screening	HCPCS	G0476	Infectious Agent Detection By Nucleic Acid (DNA or RNA); Human Papilloma Virus (HPV), High-risk Types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) For Cervical Cancer Screening, Must Be Performed In Addition To Pap Test (g0476)

- Members who meet 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 who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix.

Denominator: Members 24-64 years of age who meet the criteria for eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who received a timely screening for cervical cancer.

Chlamydia Screening in Women (CHL)

Methodology: HEDIS®

Measure Description: The percentage of women 16-24 years of age who identified as sexually active and who 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	• Nonoxynol 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).

Timeliness of Prenatal Care (PPC)

Methodology: HEDIS®

Measure Description: The percentage of deliveries on or between October 8, 2023, and October 7, 2024, that received a prenatal care visit as a Member of IEHP in the first trimester, or on the IEHP enrollment start date or within 42 days of enrollment in the organization.

- The eligible population in this measure meets all of the following criteria:
    1. Continuous enrollment with IEHP 43 days prior to delivery through 60 days after delivery with no allowable gap.
    2. Anchor Date: Date of delivery
    3. Members who delivered a live birth on or between October 8, 2023, and October 7, 2024. Multiple births- Women who had two separate deliveries (different dates of service) between October 8, 2023, and October 7, 2024, count twice. Women who had multiple live births during one pregnancy count once.
- Members in hospice are excluded.
- Members who expire any time during the measurement year (2024).

Denominator: Deliveries on or between October 8, 2023, and October 7, 2024.

Numerator: Members in the denominator who had a prenatal care visit as a Member of IEHP in the first trimester, or on the IEHP enrollment start date or within 42 days of enrollment.

- Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:
    - o A bundled service where the organization can identify the date when prenatal care was initiated
    - o A visit for prenatal care in the first trimester, or on the IEHP enrollment start date or within 42 days of enrollment

CODES TO IDENTIFY STAND ALONE PRENATAL VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Prenatal Visit	CPT-CAT-II	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
Prenatal Visit	CPT-CAT-II	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)

CODES TO IDENTIFY STAND ALONE PRENATAL VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Prenatal Visit	CPT-CAT-II	0502F	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]
Prenatal Visit	CPT	99500	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring
Prenatal Visit	HCPCS	H1000	Prenatal care, at-risk assessment
Prenatal Visit	HCPCS	H1001	Prenatal care, at-risk enhanced service; antepartum management
Prenatal Visit	HCPCS	H1002	Prenatal care, at risk enhanced service; care coordination
Prenatal Visit	HCPCS	H1003	Prenatal care, at-risk enhanced service; education
Prenatal Visit	HCPCS	H1004	Prenatal care, at-risk enhanced service; follow-up home visit

Postpartum Care (PPC)

Methodology: HEDIS®

Measure Description: The percentage of deliveries of live births on or between October 8, 2023, and October 7, 2024, that had a postpartum visit on or between 7 and 84 days after delivery.

- The eligible population in this measure meets all of the following criteria:
    1. Continuous IEHP enrollment 43 days prior to delivery through 60 days after delivery.
    2. Anchor Date: Date of delivery
    3. Members who delivered a live birth on or between October 8, 2023, and October 7, 2024. Multiple births- Women who had two separate deliveries (different dates of service) between October 8, 2023, and October 7, 2024, count twice. Women who had multiple live births during one pregnancy count once.
- Members in hospice are excluded.
- Members who expired any time during the measurement year (2024).

Denominator: Members who delivered a live birth on or between October 8, 2023, and October 7, 2024.

Numerator: Members in the denominator who had a postpartum visit on or between 7 and 84 days after delivery.

- Any of the following meet criteria:
  - A postpartum visit
  - Cervical cytology
  - A bundled service where the organization can identify the date when a postpartum care was rendered

CODES TO IDENTIFY STAND ALONE POSTPARTUM VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Postpartum Care	CPT	57170	Diaphragm or cervical cap fitting with instructions
Postpartum Care	CPT	58300	Insertion of intrauterine device (IUD)
Postpartum Care	CPT	59430	Postpartum Care Only Separate Procedure
Postpartum Care	CPT	99501	Home visit for postnatal assessment and follow-up care
Postpartum Care	CPT-CAT-II	0503F	Postpartum care visit (Prenatal)
Postpartum Care	HCPCS	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
Postpartum Care	ICD10CM	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Postpartum Care	ICD10CM	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Postpartum Care	ICD10CM	Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear
Postpartum Care	ICD10CM	Z30.430	Encounter for insertion of intrauterine contraceptive device
Postpartum Care	ICD10CM	Z39.1	Encounter for care and examination of lactating mother
Postpartum Care	ICD10CM	Z39.2	Encounter for routine postpartum follow-up

☑ 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).

Childhood Immunizations (CIS) – Combo 10

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the exclusions

Methodology: HEDIS®

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

- Combo 10 includes the timely completion of the following antigens:
  - DTaP; IPV; MMR; HiB; HepB; VZV; PCV; HepA; Rotavirus; Flu
- The eligible population in this measure meets all of the following criteria:
  1. Children who turn 2 during the measurement year (2024).
  2. Continuous enrollment with IEHP 365 days prior to the child's second birthday through the Member's second birthday with no more than one gap in enrollment of up to 45 days during the 365 days prior to the child's second birthday through the Member's second birthday.

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
DTaP	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
DTaP	CPT	90698	Diphtheria Tetanus Toxoids And Acellular Pertussis Vaccine And Hemophilus Influenza B Vaccine And Activated Poliovirus Vaccine, (DTaP-IPV/Hib), For Intramuscular Use
DTaP	CPT	90700	Diphtheria Tetanus Toxoids And Acellular Pertussis Vaccine (DTaP) For Intramuscular Use

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
DTaP	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), For Intramuscular Use
IPV	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
IPV	CPT	90698	Diphtheria Tetanus Toxoids And Acellular Pertussis Vaccine And Hemophilus Influenza B Vaccine and activated poliovirus vaccine, (DTaP-IPV/HiB), For Intramuscular Use
IPV	CPT	90713	Poliovirus Vaccine Inactivated (IPV) For Subcutaneous Use
IPV	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), For Intramuscular Use
MMR	CPT	90707	Measles Mumps And Rubella Virus Vaccine (MMR) Live For Subcutaneous Use
MMR	CPT	90710	Measles Mumps Rubella And Varicella Vaccine (MMRV) Live For Subcutaneous Use
HiB	CPT	90644	Meningococcal Conjugate Vaccine, Serogroups C & Y And Hemophilus Influenzae Type B Vaccine (HiB-mency), four dose schedule, when administered to children six weeks-18 months of age, for intramuscular use
HiB	CPT	90647	Hemophilus Influenza B Vaccine (HiB) Prp-omp Conjugate (Three Dose Schedule) For Intramuscular Use
HiB	CPT	90648	Hemophilus Influenza B Vaccine (HiB) prp-t Conjugate (Four Dose Schedule) For Intramuscular Use
HiB	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
HiB	CPT	90698	Diphtheria Tetanus Toxoids And Acellular Pertussis Vaccine And Hemophilus Influenza B Vaccine and activated poliovirus vaccine, (DTaP-IPV/HiB), for intramuscular use
HiB	CPT	90748	Hepatitis B And Hemophilus Influenza B Vaccine (HepB-HiB) For Intramuscular Use
HepB	CPT	90697	Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
HepB	CPT	90723	Diphtheria Tetanus Toxoids Acellular Pertussis Vaccine Hepatitis B, and Inactivated poliovirus vaccine (DTaP-HepB-IPV), For Intramuscular use
HepB	CPT	90740	Hepatitis B Vaccine Dialysis Or Immunosuppressed Patient Dosage (Three Dose Schedule) For Intramuscular Use
HepB	CPT	90744	Hepatitis B Vaccine Pediatric/adolescent Dosage (Three Dose Schedule) For Intramuscular Use
HepB	CPT	90747	Hepatitis B Vaccine Dialysis Or Immunosuppressed Patient Dosage (Four Dose Schedule) For Intramuscular Use

CHILDHOOD IMMUNIZATION CODE SET:			
Antigen	**Code Type**	**Code**	**Code Description**
HepB	CPT	90748	Hepatitis B And Hemophilus Influenza B Vaccine (HepB-HiB) For Intramuscular Use
HepB	HCPCS	G0010	Administration Of Hepatitis B Vaccine
VZV	CPT	90710	Measles Mumps Rubella And Varicella Vaccine (MMRV) Live For Subcutaneous Use
VZV	CPT	90716	Varicella Virus Vaccine Live For Subcutaneous Use
PCV	CPT	90670	Pneumococcal Conjugate Vaccine 13 Valent For Intramuscular Use
PCV	CPT	90671	Pneumococcal Conjugate Vaccine, 15 Valent (pcv15), For Intramuscular Use
PCV	CPT	90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use
PCV	HCPCS	G0009	Administration Of Pneumococcal Vaccine
HepA	CPT	90633	Hepatitis A Vaccine Pediatric/adolescent Dosage-2 Dose Schedule For Intramuscular Use
Rotavirus - Two Dose*	CPT	90681	Rotavirus Vaccine Human Attenuated Two Dose Schedule Live For Oral Use.
Rotavirus - Three Dose**	CPT	90680	Rotavirus Vaccine Tetravalent Live For Oral Use
Flu	CPT	90655	Influenza Virus Vaccine, Trivalent (IIV3), Split Virus, Preservative Free, 0.25ml Dosage, For Intramuscular Use
Flu	CPT	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use
Flu	CPT	90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
Flu	CPT	90660	Influenza virus vaccine, trivalent, live (LAIV3) for intranasal use
Flu	CPT	90661	Influenza Virus Vaccine Derived From Cell Cultures Subunit Preservative And Antibiotic Free For Intramuscular Use
Flu	CPT	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
Flu	CPT	90673	Influenza Virus Vaccine Trivalent Derived From Recombinant DNA (RIV3) Hemagglutinin (HA) Protein Only Preservative And Antibiotic
Flu	CPT	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
Flu	CPT	90685	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus Preservative Free, 0.25 mL dosage, for Intramuscular Use
Flu	CPT	90686	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus Preservative Free, 0.5 mL dosage, for Intramuscular Use
Flu	CPT	90687	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus, 0.25 mL dosage, for Intramuscular Use
Flu	CPT	90688	Influenza Virus Vaccine Quadrivalent (II4V) Split Virus, 0.5 mL dosage, for Intramuscular Use
Flu	CPT	90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular
Flu	CPT	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use
Flu	HCPCS	G0008	Administration Of Influenza Virus Vaccine

**Rotavirus - Two Dose: At least two doses of the two-dose rotavirus vaccine on different dates of services.*

***Rotavirus - Three Dose: At least three doses of the three-dose rotavirus vaccine on different dates of service.*

- Members who meet any of the following criteria are excluded:
    1. Members in hospice.
    2. Members who expired at any time during the measurement year (2024).
    3. Members who had a contraindication to a childhood vaccine on or before their second birthday .

Denominator: Children 2 years of age in the eligible population.

- Anchor Date: Child's 2nd birthday

Numerator: Members in denominator who show timely completion of all antigens in Combo10.

- All immunization series must be at least 14 days apart.

Developmental Screening

Methodology: CMS Child Core Set

Measure Description: The percentage of children who are screened for the risk of developmental, behavioral, and social delays using a standardized screening tool, in the 12 months before or on their first, second or third birthday in the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Children turning ages 1-3 as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP for 12 months prior to the child's first, second or third birthday with no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second or third birthday.

Denominator: Children who turn ages 1, 2 or 3 by December 31 of the measurement year (2024).

- Anchor Date: Child's birthday in the measurement year

Numerator: Children who were screened for risk of developmental, behavioral, and social delays on or before the child's first, second or third birthday.

Examples of developmental screening tools include but are not limited to:

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS)
- Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

CODES TO IDENTIFY DEVELOPMENTAL SCREENING			
Service	**Code Type**	**Code**	**Code Description**
Developmental Screening	CPT	96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen) with scoring and documentation, per standardized instrument

Note: The Bright Futures schedule for Developmental Screening is at 9 months, 18 months and 30 months.

Lead Screening in Children (LSC)

Methodology: HEDIS®

Measure Description: The percentage of children who are 2 years of age and had one or more capillary or venous lead blood tests for lead poisoning, by their second birthday.

- The eligible population in this measure meets all the following criteria:
    1. No more than one gap in enrollment of up to 45 days during the 365 days before the child's second birthday through the child's second birthday.
    2. Continuous enrollment with IEHP 365 days before the child's second birthday through the child's second birthday.
- Members in hospice are excluded.
- Members who expire at any time during the measurement year (2024).

Denominator: Children who turn 2 years old during the measurement year (2024).

- Anchor Date: Child's second birthday.

Numerator: At least one lead capillary or venous blood test on or before the child's second birthday.

CODES TO IDENTIFY LEAD SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Lead Screening	CPT	83655	Lead

Immunizations for Adolescents (IMA) – Combo 2

Summary of Changes to the 2024 Global Quality P4P Program Guide:

- Update to the exclusions

Methodology: HEDIS®

Measure Description: The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate; one tetanus, diphtheria toxoids and acellular pertussis (Tdap); and two or three doses of the human papillomavirus (HPV) vaccine on or before their 13th birthday. The measure calculates a rate for each vaccine and a combination rate.

- At least one dose of meningococcal conjugate vaccine on or between the Member's 11th and 13th birthdays.
- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the Member's 10th and 13th birthdays.
- At least two HPV vaccines, with different dates of service on or between the Member's 9th and 13th birthdays.
  - There must be at least 146 days between the first and second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.

    OR

    At least three HPV vaccines, with different dates of service on or between the Member's 9th and 13th birthdays.
- The eligible population in this measure meets all of the following criteria:
  1. Adolescents who turn 13 years of age during the measurement year (2024).
  2. Continuous enrollment with IEHP 365 days prior to the Member's 13th birthday through the Member's 13th birthday with no more than one gap in enrollment of up to 45 days during the 365 days prior to the 13th birthdays through the Member's 13th birthday.

CODES TO IDENTIFY MENINGOCOCAL:			
Antigen	**Code Type**	**Code**	**Code Description**
Meningococcal Conjugate	CPT	90619	Meningococcal Conjugate Vaccine, Serogroups A, C, W, Y, Quadrivalent Tetanus Toxoid Carrier (MenACWY-TT), For Intramuscular Use
Meningococcal Conjugate	CPT	90733	Meningococcal Polysaccharide Vaccine, Serogroups A, C, Y, W-135, Quadrivalent (mpsv4), For Subcutaneous Use
Meningococcal Conjugate	CPT	90734	Meningococcal Conjugate Vaccine Serogroups A, C, Y and W-135, Quadrivalent (MCV4 or MenACWY), For Intramuscular Use

CODES TO IDENTIFY TDAP:			
Antigen	**Code Type**	**Code**	**Code Description**
Tdap	CPT	90715	Tetanus Diphtheria Toxoids And Acellular Pertussis Vaccine (Tdap) When Administered To Individuals Seven Years Or Older For Intramuscular Use

CODES TO IDENTIFY HPV:			
Antigen	**Code Type**	**Code**	**Code Description**
HPV	CPT	90649	Human Papilloma Virus (HPV) Vaccine Types 6 11 16 18 Quadrivalent (4vHPV), two or three Dose Schedule, For Intramuscular Use
HPV	CPT	90650	Human Papilloma Virus (HPV) Vaccine Types 16, 18 Bivalent (2vHPV) two or three Dose Schedule, For Intramuscular Use
HPV	CPT	90651	Human Papilloma Virus Vaccine 6 11 16 18 31 33 45 52 58, Nonavalent (9vHPV) two or three Dose Schedule, For Intramuscular Use

- Members who meet any of the following criteria are excluded:
    1. Members in hospice.
    2. Members who expired at any time during the measurement year (2024).

Denominator: Adolescents 13 years of age who meet all the criteria for eligible population.

- Anchor Date: Child's 13th birthday

Numerator: Members in the denominator who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday during the measurement year (2024).

- All immunization series must be at least 14 days apart.

Substance Use Assessment in Primary Care for Adolescents

Methodology: IEHP-Defined Quality Measure

Measure Description: The percentage of Members 11-17.99 years of age who were screened for substance use during the measurement year (2024).

Denominator: All Members 11-17.99 years of age during the measurement year (2024). Member counted only once in the denominator.

- Anchor Date: December 31, 2024

Numerator: Members who were screened for substance use at least once during the measurement year (2024).

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	CPT	99408	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services 15 to 30 Minutes
Substance Use Assessment in Primary Care	CPT	99409	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0442	Annual Alcohol Misuse Screening 15 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0443	Brief Face-To-Face Behavioral Counseling for Alcohol Misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPCS	H0001	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPCS	H0049	Alcohol and/or Drug Screening
Substance Use Assessment in Primary Care	HCPCS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

Examples of Substances Use Assessment in Primary Care for Adolescents screening tools include but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco, Alcohol, Prescription medication and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
    - The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening

- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population

Well-Child Visits in the First 15 Months of Life (W30)

Methodology: HEDIS®

Measure Description: The percentage of Members who turned 15 months old during the measurement year (2024) and had six or more well-child visits.

- The eligible population in this measure meets all of the following criteria:
    1. Children who turn 15 months old during the measurement year (2024).
    2. Member must be enrolled with IEHP by 31 days after birth and maintain continuous enrollment between 31 days and 15 months of age with no more than one gap in enrollment of up to 45 days.

Denominator: Members who turned 15 months old during the measurement year (2024) who meet all criteria for eligible population.

- Anchor Date: Child's 15th month birthday

Numerator: Members who received six or more well-child visits on or before the child's 15th month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the Practitioner assigned to the child.

- All visits must be at least 14 days apart.

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Care Visit	CPT	99381	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)
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	99391	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)
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	99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
Well-Care Visit	ICD10CM	Z00.110	Health Examination For Newborn Under 8 Days Old
Well-Care Visit	ICD10CM	Z00.111	Health Examination For Newborn 8 To 28 Days Old
Well-Care Visit	ICD10CM	Z00.121	Encounter For Routine Child Health Examination With Abnormal Findings (Health check (routine) for child over 28 days old)
Well-Care Visit	ICD10CM	Z00.129	Encounter For Routine Child Health Examination Without Abnormal Findings (Health check (routine) for child over 28 days old)
Well-Care Visit	ICD10CM	Z76.1	Encounter For Health Supervision And Care Of Foundling
Well-Care Visit	ICD10CM	Z76.2	Encounter For Health Supervision And Care Of Other Healthy Infant And Child

Well-Child Visits in the First 30 Months of Life (W30)

Methodology: HEDIS®

Measure Description: The percentage of children who turned 30 months old during the measurement year (2024) and had two or more well-child visits with a PCP within the 15-30 months of life.

- Eligible population in this measure meets all of the following criteria:
    1. Children who turn 30 months old during the measurement year (2024).
    2. Member must be enrolled with IEHP by 15 months after birth and maintain continuous enrollment between 15 months and 30 months of age with no more than one gap in enrollment of up to 45 days.

Denominator: Members who turn 30 months old during the measurement year (2024) who meet all criteria for eligible population.

- Anchor Date: Child's 30th month birthday (Calculate the 30th-month birthday as the second birthday plus 180 days).

Numerator: Members in the denominator who received two or more well-child visits between the child's 15 month plus 1 day and 30 months of life. The well-child visit must occur with a PCP, but the PCP does not have to be the Practitioner assigned to the child.

- All visits must be at least 14 days apart

CODES TO IDENTIFY WELL-CARE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Well-Child Visits in the First 30 Months of Life	CPT	99381	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 one year)
Well-Child Visits in the First 30 Months of Life	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 one through four years)
Well-Child Visits in the First 30 Months of Life	CPT	99391	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 one year)
Well-Child Visits in the First 30 Months of Life	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 one through four years)
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z00.121	Encounter For Routine Child Health Examination With Abnormal Findings
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z00.129	Encounter For Routine Child Health Examination Without Abnormal Findings
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z00.2	Encounter For Examination For Period Of Rapid Growth In Childhood
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z76.1	Encounter For Health Supervision And Care Of Foundling
Well-Child Visits in the First 30 Months of Life	ICD10CM	Z76.2	Encounter For Health Supervision And Care Of Other Healthy Infant And Child

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

Methodology: HEDIS®

Measure Description: The percentage of Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year (2024). Report each of the three indicators below:

- BMI percentile documentation*
- Counseling for nutrition
- Counseling for physical activity
- The eligible population in this measure meets all of the following criteria:
    1. Members who are 3-17 years of age 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 up to 45 days.
    3. An outpatient visit with a PCP or an OB/GYN during the measurement year (2024).

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

CODES TO IDENTIFY BMI PERCENTILE:		
Code	**Code Type**	**Description**
Z68.51	ICD10	Body Mass Index (BMI) Pediatric, Less Than 5th Percentile For Age
Z68.52	ICD10	Body Mass Index (BMI) Pediatric, 5th Percentile To Less Than 85th Percentile For Age
Z68.53	ICD10	Body Mass Index (BMI) Pediatric, 85th Percentile To Less Than 95th Percentile For Age
Z68.54	ICD10	Body Mass Index (BMI) Pediatric, Greater Than Or Equal To 95th Percentile For Age

CODES TO IDENTIFY COUNSELING FOR PHYSICAL ACTIVITY:		
Code	**Code Type**	**Description**
G0447	HCPCS	Face-to-face Behavioral Counseling For Obesity, 15 Minutes
S9451	HCPCS	Exercise Classes, Non-Physician Provider, Per Session
Z02.5	ICD10	Encounter For Examination For Participation In Sport
Z71.82	ICD10	Exercise Counseling

CODES TO IDENTIFY COUNSELING FOR NUTRITION:		
Code	**Code Type**	**Description**
97802	CPT	Medical Nutrition Therapy Initial Assessment And Intervention Individual Face-to-face With The Patient Each 15 Minutes
97803	CPT	Medical Nutrition Therapy Reassessment And Intervention Individual Face-to-face With The Patient Each 15 Minutes
97804	CPT	Medical Nutrition Therapy Group (Two Or More Individual(s)) Each 30 Minutes
G0270	HCPCS	Medical Nutrition Therapy; Reassessment And Subsequent Intervention(s) Following Second Referral In Same Year For Change In Diagnosis, Medical Condition Or Treatment Regimen (including Additional Hours Needed For Renal Disease), Individual, Face-to-face
G0271	HCPCS	Medical Nutrition Therapy, Reassessment And Subsequent Intervention(s) Following Second Referral In Same Year For Change In Diagnosis, Medical Condition, Or Treatment Regimen (including Additional Hours Needed For Renal Disease), Group (Two Or More Individuals)
G0447	HCPCS	Face-to-face Behavioral Counseling For Obesity, 15 Minutes (G0447)
S9449	HCPCS	Weight Management Classes, Non-Physician Provider, Per Session (S9449)
S9452	HCPCS	Nutrition Classes, Non-Physician Provider, Per Session (S9452)
S9470	HCPCS	Nutritional Counseling, Dietitian Visit (S9470)
Z71.3	ICD10	Dietary Counseling And Surveillance

Members who meet any of the following criteria are excluded:

1. Members in hospice.
2. Members who have a diagnosis of pregnancy any time during the measurement year (2024).
3. Members who expired at any time during the measurement year (2024).

Denominator: Members 3-17 years of age who meet all the criteria for eligible population.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had evidence of BMI percentile, counseling of nutrition or physical activity 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, 3 0-39 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

After Hours Availability On-Call Physician Access

Methodology: IEHP-Defined Provider Access After Hours Survey

Measure Description: The Provider After Hours measure assesses Provider office call handling protocols for after hours access. IEHP conducts a one time annual call campaign to assess Provider network compliance. Physician offices are compliant if during the call, they followed the protocol below:

- The caller was provided with instructions on how to connect to Doctor, on-call physician or covering nurse after hours OR was connected directly to Doctor, on-call physician or covering nurse.
- Provider must inform the Member to expect a call back within 30 minutes.

Measure Support: The Provider Access After Hours call campaign is conducted annually to assess the after hours accessibility of Providers within the IEHP network. Specifically, the calls assess the after hours call handling protocol of contracted Primary Care.

This measure is used to monitor Provider compliance with IEHP's Access Standards in policy 9A, ensuring that IEHP Members have appropriate guidance and access if care is needed from their Providers after office hours.

Anchor Date: December 31, 2024

After Hours Availability Emergency Calls

Methodology: IEHP-Defined Provider Access After Hours Survey

Measure Description: The Provider After Hours measure assesses Provider office call handling protocols for life-threatening emergency calls. IEHP conducts a one time annual call campaign to assess Provider network compliance. Physician offices are compliant if during the call, they followed the protocol below:

- The caller was instructed to dial 9-1-1 OR instructed to go to the nearest Emergency Room.

Measure Support: The Provider Access After Hours call campaign is conducted annually to assess the after hours accessibility of Providers within the IEHP network. Specifically, the calls assess the after hours call handling protocol of contracted Primary Care.

This measure is used to monitor Provider compliance with IEHP's Access Standards in policy 9A, ensuring that IEHP Members have appropriate guidance and access if care is needed from their Providers after office hours.

Anchor Date: December 31, 2024

Appointment Availability – Urgent Visits

Methodology: Department of Managed Health Care (DMHC) Model Provider Appointment Availability Survey (PAAS)

Measure Description: The type of appointment and the acceptable time frames to access care are listed below. A Provider is compliant if they meet the following Appointment Access timeframe:

PCP Appointment

- Urgent: ≤ 48 Hours

Measure Support: The purpose of the Appointment Availability measure is to assess the appointment access for Primary Care Physicians.

Anchor Date: December 31, 2024

Appointment Availability – Routine Visits

Methodology: Department of Managed Health Care (DMHC) Model Provider Appointment Availability Survey (PAAS)

Measure Description: The type of appointment and the acceptable time frames to access care are listed below. A Provider is compliant if they meet the following Appointment Access timeframe:

PCP Appointment

- Routine: ≤ 10 days

Measure Support: The purpose of the Appointment Availability measure is to assess the appointment access for Primary Care Physicians.

Anchor Date: December 31, 2024

Access to Care Needed Right Away

Methodology: IEHP's Monthly Member Satisfaction Survey

Measure Description: In the last six months, when you needed care right away, how often did you get care as soon as you needed?

- Valid response: never, sometimes, usually, always
- Target response: usually, always

Measure Support: To help identify opportunities to improve customer service, IEHP conducts a monthly Member Satisfaction Survey between June-December annually. Member survey responses are analyzed and shared at the PCP and IPA level.

Coordination of Care

Methodology: IEHP's Monthly Member Satisfaction Survey

Measure Description: In the last six months, how often did your Personal Doctor seem informed and up-to-date about the care you received from these Doctors or other health Providers?

- Valid response: never, sometimes, usually, always
- Target response: usually, always

Measure Support: To help identify opportunities to improve customer service, IEHP conducts a monthly Member Satisfaction Survey between June-December annually. Member Survey responses are analyzed and shared at the PCP and IPA level.

Rating of Access to Routine Care

Methodology: IEHP's Monthly Member Satisfaction Survey

Measure Description: In the last six months, how often did you get an appointment for a check-up or routine care at a Doctor's office or clinic as soon as you needed it?

- Valid response: never, sometimes, usually, always
- Target response: usually, always

Measure Support: To help identify opportunities to improve customer service, IEHP conducts a monthly Member Satisfaction Survey between June-December annually. Member Survey responses are analyzed and shared at the IPA level.

Potentially Avoidable Emergency Department (ED) Visits

Methodology: IEHP has developed this measure in accordance with the New York University (NYU) research conducted on classifying emergency department utilization (https://wagner.nyu.edu/community/faculty) and the California Department of Healthcare Services (DHCS) methodology for determining Low-acuity non-emergent (LANE) visits.

Measure Description: Low-acuity non-emergent (LANE) visits are visits to an emergency department (ED) in which the condition could be treated by a physician or other health care provider in a non-emergency setting or conditions that are potentially preventable or ambulatory care sensitive.

The following steps are used to determine potentially preventable emergency room visits:

Step 1: Identify all Emergency Department (ED) visits that contain potentially preventable diagnosis codes on both the facility and professional claims in the measurement year (2024).

Step 2: The following criteria is assessed to exclude ED visits:

- ED visits that resulted in an inpatient admission or observation stay
- Members under the age of 4 or over the age of 65 on the date of service
- ED visits with evaluation & management codes 99284 and 99285

Step 3: Using the primary diagnosis code on the facility component of the ED visit, preventable percentages are assigned to each ED event to account for external factors that can influence and impact variation in ED use. These "preventable percentages" for each ED visit are summed to create a final "count" of preventable ED visits based on the primary diagnosis code on the facility component of the ED visit. The attached worksheet contains the diagnosis codes and preventable percentages assigned to each code ***(https://www.providerservices.iehp.org/en/provider-central/provider-incentive-programs/pay-for-performance-program#potentially-avoidable-emergency-department)***.

Denominator: All assigned Medi-Cal Members each month of the measurement year (2024). All monthly assigned Members are summed to create a denominator. This is also called Member Months.

Numerator: The sum of the output from Step 3 noted above for Members assigned to the IPA on the date of service. This is the final count of preventable ED visits.

Rate: (Numerator / Denominator)

PROCESS MEASURES

Process Measures

Process measures allow IPAs to earn additional dollars based on performance in process metrics. IEHP is committed to reward IPAs who have high performance in quality metrics that assist in providing quality care to IEHP Members.

For the 2024 program year, IPAs can earn an additional PMPM up to $2.50 per process measure if target goals are met. Please see Appendix 3 below for measure details.

APPENDIX 3: *2024 IPA Global Quality Process Measures*

2024 GLOBAL QUALITY IPA PROCESS MEASURE LIST		
Measure Name	**Goal**	**Incentive Amount (PMPM*)**
Electronic Medical Record Connections	IPA top five (5) high volume Primary Care Physicians (PCPs) electronic medical record (EMR) systems connected directly to IEHP.	$0.25
Provider Diversity Equity Inclusion Survey	≥ 90% of IPAs assigned PCPs compliant in the completion of the Provider Diversity Equity Inclusion Survey. - PCPs must complete the DEI Survey Spring 2024.	$0.25
Equity Quality Improvement Activity #1: Reducing Health Disparities	1) Establish a Quality Improvement Activity with a plan to reduce health disparities in one of the following areas: - Hemoglobin A1c Control among Hispanics - Controlling High Blood Pressure among Blacks - Asthma Medication Ratio among Blacks - Well-Child Visits in the First 0-15 Months of Life among Blacks 2) Share the Quality Improvement Activity progress/status at Fall 2024 IPA Best Practice Meeting. 3) Share the Quality Improvement Activity outcomes at the Spring 2025 IPA Quality Improvement Activity Symposium.	$1.00
Quality Improvement Activity #2: Potentially Avoidable Emergency Department Visits or Potentially Preventable Admissions	1) Establish a Quality Improvement Activity with a plan to reduce inappropriate use of ER and acute care services and share plan with IEHP no later than April 30, 2024. 2) Share the Quality Improvement Activity progress/status at Fall 2024 IPA Best Practice Meeting. 3) Share the Quality Improvement Activity outcomes at the Spring 2025 IPA Quality Improvement Activity Symposium.	$1.00

**PMPM: Per Member Per Month*

APPENDIX 4: *Process Measure Overview*

Electronic Medical Record Connections

Methodology: IEHP-Defined Process Measure

Measure Description: The count of IPA Primary Care Physicians (PCPs) electronic medical record (EMR) systems connected directly to IEHP.

Denominator: Top five (5) high volume PCPs in the IPA's network, with at least 1,000 assigned IEHP Medi-Cal Members, as of June 30, 2024. IPAs should refer to eligibility data provided by IEHP, through the 834 eligibility file, to identify PCPs.

Numerator: Established EMR connections with eligible Providers within the denominator. Any EMR that has capability to connect to IEHP will be included.

- Connections will need to be established by December 1, 2024.
- Eligible EMR connections for the 2024 performance year will be identified as Providers who are high volume PCPs in the IPAs network, and are new EMR connections that were not established in the 2023 performance year.

NOTE: IEHP must have connection to the Providers EMR system throughout the time period the IPA is receiving the Electronic Medical Record Connections process measure Quality PMPM.

Equity Quality Improvement Activity #1: Reducing Health Disparities

Methodology: IEHP-Defined Process Measure

Measure Description: The Department of Health Care Services (DHCS) has made health equity and reducing disparities in health care a central area of focus in its Quality Strategy. The intent is for IPAs to develop a quality improvement activity with an emphasis on driving improvements in health equity and health disparities and their root causes. For this Quality Improvement Activity, IPA to choose from one of the following IEHP identified disparity populations listed below:

- Hemoglobin A1c Control among Hispanics
- Controlling High Blood Pressure among Blacks
- Asthma Medication Ratio among Blacks
- Well-Child Visits in the First 0-15 Months of Life among Blacks

Goal: Engage IPAs in quality improvement work focused on health equity and reducing health care disparities among their IEHP Medi-Cal Members.

1. Establish a Quality Improvement Activity to reduce selected health disparity (including calculated baseline rate and targeted goals).
    - Share project plan with IEHP by April 30, 2024.
2. Share Quality Improvement Activity progress at the Fall 2024 IPA Best Practice Meeting.
3. Share outcomes with IEHP by March 31, 2025.
4. Share Quality Improvement Activity outcomes at the Spring 2025 IPA Quality Improvement Activity Symposium.

Quality Improvement Activity #2: Potentially Avoidable ED Visits or Potentially Preventable Admissions

Methodology: IEHP-Defined Process Measure

Measure Description: As part of its rate development process, the Department of Health Care Services (DHCS) penalizes health plans that have a high rate of avoidable emergency room visits or potentially preventable admissions. The intent for this process measure is for IPAs to develop a quality improvement activity aimed at reducing avoidable emergency room visits or potentially preventable admissions among Members with diabetes or heart failure.

Goal: Engage IPAs in quality improvement work focused on reducing avoidable emergency room visits or potentially preventable admissions among their IEHP Medi-Cal Members with diabetes or heart failure.

1. Establish an improved quality improvement project (a continuation of the 2023 Quality Improvement Reducing Potentially Avoidable ED Visits or Potentially Preventable Admissions Activity) to reduce avoidable emergency room visits or potentially preventable admissions and calculate baseline rates. Share project details with IEHP.
    - By April 30, 2024
2. Share Quality Improvement Activity progress at the Fall 2024 IPA Best Practice Meeting.
3. Share outcomes with IEHP by March 31, 2025.
4. Share Quality Improvement Activity outcomes at the Spring 2025 IPA Quality Improvement Activity Symposium.

Provider Diversity Equity Inclusion Survey

Methodology: IEHP-Defined Process Measure

Measure Description: IEHP encourages Primary Care Physicians (PCPs) to complete the Diversity Equity Inclusion (DEI) Survey timely, Spring 2024. The purpose of this survey is to assess the IEHP PCP networks comfort in diversity, equity, and inclusion topics. The IPAs responsibility in this measure is to assist in encouraging the IPA assigned PCPs to complete the DEI Survey timely.

Goal: ≥ 90% of IPAs assigned PCPs compliant in the completion of the DEI Survey.
To be compliant, PCPs will need to complete the below milestone:

- Provider offices will be required to respond, timely, to the DEI survey. Provider responses to the DEI survey must be submitted by survey deadline May 30, 2024, to be eligible for this incentive.
- Anchor Date: May 30, 2024

PENALTY MEASURES

☑ Penalty Measures

Provider payment models have been evolving away from traditional fee-for-service and moving toward payments for quality and value. Frameworks supporting alternative payment models have been developed by the Centers for Medicare and Medicaid Services (CMS) and the Department of Healthcare Services (DHCS). IEHP is committed to investing in alternative payment models that pay for quality and provide value. In the spirit of evolving our alternative payment models, IEHP includes "risk" as a component in the Global Quality P4P Program. This movement will focus on measures that:

- Are within a Provider's scope of care and influence
- Are within a Provider's control and influence
- Bring value to the organization

IEHP will be including two penalty measures in the Global Quality P4P Program for 2024:

- PCP Encounter Data Rate
- Customer Service Grievance

Both measures represent processes within the PCP practice that are within the control of the Provider. These measures will be structured in a way that a Provider's performance will be compared to a pre-determined target for the measurement period. Provider performance that meets or exceeds the target will result in no penalty or "risk." Alternatively, Provider performance that falls below the established target will result in a financial penalty. The financial penalty will be taken from the Provider's incentive earnings for the same measurement period. Financial penalties will not exceed the value of the incentive earnings within the measurement period.

Financial penalties for the 2024 program year will be capped at no more than $0.50 PMPM.

Please see Appendix 6 for penalty details.

APPENDIX 5: *2024 IPA Global Quality P4P Program Penalty Measures*

2024 GQ P4P IPA PENALTY MEASURE LIST:		
Measure Name	**Population**	**Goal**
PCP Encounter Data Rate - SPD*	All	3
PCP Encounter Data Rate - Non-SPD*	All	2.5
Customer Service Grievance	All	≤ 3.0

*SPD: Seniors and Persons with Disabilities; Non-SPD: Non-Seniors and Persons with Disabilities

APPENDIX 6: *Penalty Measures Overview*

PCP Encounter Data Rate

Methodology: IEHP-Defined Risk Measure

Measure Description: Percentage of complete, timely and accurate encounter data submitted through standard reporting channels for all PCP services rendered to IEHP Members in the measurement year (2024).

Denominator: All assigned Medi-Cal Members each month of the measurement year (2024). All monthly assigned Members are summed to create the denominator.

Numerator: The sum of all unique PCP encounter (e.g., unique Member, Provider, date of service) in the measurement year (2024) for all assigned Members in the denominator.

Rate: A Per Member Per Year (PMPY) rate is calculated following this formula:
(Total unique PCP Encounters/Total Member Months) x 12= PMPY

Measure Support: The purpose of the IEHP PCP Encounter Data Rate measure is to ensure IEHP receives adequate PCP encounter data from IEHP-Contracted Medi-Cal Providers. Encounter data is important to performance scoring and is essential to the success of the GQ P4P Program.

Customer Service Grievance

Methodology: IEHP – Defined Risk Measure

Measure Description: IEHP strives to improve and maintain customer satisfaction for IEHP Members as defined in the IEHP Member Handbook under Member's Rights and Responsibilities: "Be treated with respect, fairness, and courtesy. IEHP recognizes your dignity and right to privacy" (Ma_22A). This measure will assess the rate of IEHPs Member dissatisfaction with their assigned Primary Care Provider (PCP) office in the measurement year (2024). The following criteria will define the Member's dissatisfaction:

Member Dissatisfaction: Member is not happy with the service received from their assigned PCP, and/or the office staff, that is not related to dissatisfaction regarding the quality of care/ medical treatment received. This includes, but is not limited to:

- Tone and manner that information is presented to the Member by the assigned PCP office staff.
- Negative verbal interactions between a Member and the assigned IEHP PCP and/or office staff.

Denominator: Total Membership in the measurement year (2024).

Numerator: Count of customer service grievances in the measurement year (2024) against the PCP and/or PCP office staff.

Exclusion Criteria: Reference to dirty carpet, color of the walls, office décor and/or anything not related to Provider/office staff and Member interaction.

Goal: Customer service grievance rate of ≤ 3.0 PTMPY

APPENDIX 7: *Historical Data Form*

HISTORICAL DATA FORM

Cover sheet **MUST** be accompanied with the *supporting medical record documentation.*

Measure Category	Test Type
Breast Cancer Screening	☐ Mammogram ☐ History of Mastectomy
Cervical Cancer Screening	☐ PAP or HPV Testing ☐ History of Total/Complete Hysterectomy [NO residual cervix]
Depression Screening for Adolescents and Adults	☐ Depression Screening ☐ Depression Screening Result
Diabetes Care	☐ HbA1c Results (in-office Point of Care Testing) ☐ Dilated Retinal Exam with Results
Wellness Visits	☐ Well Child Visits in the First 15 Months of Life ☐ Well Child Visits 3-21 Years of Age ☐ Weight Assessment and Counseling for Nutritional and Physical Activity ☐ Initial Health Assessment ☐ Immunizations Note: Immunizations submitted through the CAIR2 website (https://cair.cdph.ca.gov) do not require a Historical Data Form Submission
Children with Pharyngitis	☐ Group A Streptococcus (Strep) Test – Throat
Colorectal Cancer Screening	☐ Colonoscopy ☐ History of Colon Cancer
Chlamydia Screening in Women	☐ Test for Chlamydia
Prenatal Care	☐ Prenatal Care Visit in the First Trimester
Only measures listed above can be processed via Historical Data Form medical record submission	

Member Information

Member Name: _____

IEHP ID #: _____ DOB: _____

Provider Information

Provider Name: _____

IEHP Provider #: _____ Address: _____

City: _____ State: _____ Zip: _____

Provider Phone #: _____ Provider Fax #: _____

PLEASE FAX TO: (909) 477-8568

Attn: Inland Empire Health Plan - Quality Informatics [HEDIS] Department

NOTE: All Historical Data submissions for the 2024 performance year must be submitted to IEHP no later than December 31, 2024. The Historical Form should be utilized for the submission of visits, procedures, or services that cannot be submitted via claims or encounters (e.g., services received prior to IEHP Membership, historical surgical procedures, etc.).

Inland Empire Health Plan

IEHP 2025 MEDI-CAL ADULT MEMBER SATISFACTION SURVEY

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes ➔ ***If Yes, Go to Question 1***
☐ No

YOUR PERSONAL DOCTOR

1. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

☐ Yes
☐ No ➔ ***If No, Go to Question 14***

2. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

3. In the last 6 months, how often did your personal doctor listen carefully to you?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

4. In the last 6 months, how often did your personal doctor show respect for what you had to say?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

5. In the last 6 months, how often did your personal doctor spend enough time with you?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

6. In the last 6 months, how often did you and your personal doctor talk about all the prescribed medicines you take?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

7. In the last 6 months, when you had a scheduled visit with your doctor, did he or she have your health records or other facts about your care?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

8. In the last 6 months, did your doctor order a blood test, x-ray or other test for you?

☐ Yes
☐ No ➔ ***If No, Go to Question 10***

9. In the last 6 months, when your doctor ordered a blood test, x-ray or other test for you, how often did someone from your doctor's office give you those results?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

10. Would you send a friend to see your doctor?

- ☐ Yes
- ☐ No

11. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your "personal doctor"?

Worst personal doctor possible — Best personal doctor possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

CLERKS AND RECEPTIONISTS AT YOUR PERSONAL DOCTOR'S OFFICE

12. In the last 6 months, how often were clerks and receptionists at your personal doctor's office as helpful as you thought they should be?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

13. In the last 6 months, how often did clerks and receptionists at your personal doctor's office treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, include the care you got in person, by phone, or by video. Do not include dental visits or care you got when you stayed overnight in a hospital.

14. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments with a specialist?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 18***

15. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

16. How many specialists have you talked to in the last 6 months?

- ☐ None ➔ ***If None, Go to Question 18***
- ☐ 1 specialist
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more specialists

17. We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Worst specialist possible — Best specialist possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

YOUR ACCESS TO CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

18. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- ☐ Yes
- ☐ No → ***If No, Go to Question 20***

19. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

20. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ☐ Yes
- ☐ No → ***If No, Go to Question 22***

21. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

22. In the last 6 months, did you need care after normal office hours?

- ☐ Yes
- ☐ No → ***If No, Go to Question 25***

23. In the last 6 months, how often was it easy to get the after-hours care you thought you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

24. In the last 6 months, when you needed after-hours care, what did you do?

- ☐ Called IEHP Nurse Advice Line
- ☐ Called my personal doctor's office
- ☐ Went to the Urgent Care
- ☐ Went to the Emergency Room
- ☐ Did not get care
- ☐ Other

25. In the last 6 months, did you take any prescribed medicine?

- ☐ Yes
- ☐ No → ***If No, Go to Question 28***

26. In the last 6 months, how often was it easy to get your prescribed medicine?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

27. In the last 6 months, how often were your prescriptions not ready for you at the pharmacy due to an issue with IEHP's Prior Authorization process?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ Don't know

28. In the last 6 months, did you try to get information or help about prescriptions from IEHP's customer service?

- ☐ Yes
- ☐ No → ***If No, Go to Question 31***

29. In the last 6 months, how often did IEHP's customer service give you the information or help you needed about prescription drugs?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

30. In the last 6 months, how often did IEHP's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

31. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 33***

32. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

33. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

34. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Worst health care possible — Best health care possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

YOUR HEALTH PLAN: INLAND EMPIRE HEALTH PLAN (IEHP)

The next questions ask about your experience with your health plan.

35. In the last 6 months, did you get information or help from IEHP's customer service?

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 38***

36. In the last 6 months, how often did IEHP's customer service give you the information or help you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

37. In the last 6 months, how often did IEHP's customer service staff treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

38. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Worst health plan possible — Best health plan possible

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

ABOUT YOU

39. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

40. In general, how would you rate your overall mental or emotional health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

41. Have you had either a flu shot or flu spray in the nose in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Don't Know

42. Do you currently use tobacco? This includes smoking, vaping, or using chewing tobacco.

- ☐ Yes
- ☐ No ➔ ***If No, Go to Question 45***

43. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

44. Are you planning to quit using tobacco?

- ☐ Yes
- ☐ No

45. What is your current gender identity?

- ☐ Female
- ☐ Transgender Female/Transgender Girl/Transgender Woman/Male-to-Female (MTF)
- ☐ Male
- ☐ Transgender Male/Transgender Boy/Transgender Man/Female-to-Male (FTM)
- ☐ Non-binary
- ☐ Other: Prefer to self-describe: _____
- ☐ Prefer not to say

46. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

47. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, Not Hispanic or Latino

48. What is your race? Mark one or more.

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other

49. How would you like to get health information from your health plan about how to stay healthy? Select all that apply.

- ☐ Email
- ☐ Text
- ☐ Mobile application
- ☐ Website
- ☐ Social media (e.g., Facebook, Instagram, Twitter)

50. Some health plans help with nonmedical concerns, like housing, food, financial, and social isolation issues. In the last 6 months, did you talk with your personal doctor or someone from your health plan about getting help for any of these issues?

- ☐ Yes
- ☐ No

51. Did someone help you complete this survey?

- ☐ Yes
- ☐ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

52. How did that person help you? (*Mark one or more*)

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

Thank you for participating in our survey!
Please mail the survey back in the enclosed postage-paid, self-addressed reply envelope or send to:
Press Ganey • P.O. Box 7315
South Bend, IN 46699-0488

If you have any questions, please call 1-888-797-3605.

APPENDIX 9: *2024 IPA Global Quality P4P IPA Work Plan*

Global Quality P4P IPA Work Plan - Check List

Organizational Leadership: Key Leadership Support for Clinical Quality Improvement	
Item Number	Quality Program Elements
1	Which positions are responsible for the implementation and outcomes of the quality program? (Include names, titles, and departments of those responsible.)
2	Which Committee(s) review and approve quality program implementation, outcomes, interventions, and evaluations?
3	Describe how the position(s) and Committee(s) play a role in your organizations Quality program.
4	Describe the process to monitor and oversee quality programs.

Priority Measures Clinical Quality Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
5	Identify the Organization's clinical quality priority measures for 2024.

Priority Measures Behavioral Health Integration Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
6	Identify the Organization's behavioral health priority measures for 2024.

Access Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
7	After-Hours Availability (AHA)
	Appointment Availability (AA)

Patient Experience Domain: Quality Improvement Activities	
Item Number	Quality Program Elements
8	Coordination of Care
	Access to Routine Care
	Access to Care Needed Right Away
9	Office Staff and Physician education programs to improve patient experience
	Office Staff and Physician recognition programs to reward offices that are high performing in the area of patient experience

Provider & Member Engagement Domain	
Item Number	Quality Program Elements
10	Office and Practitioner Programs: Provider education programs and/or sharing of Quality Improvement and Best Practices between Providers
	Office Staff/Practitioner Recognition Programs for High Performance

Data Quality Domain	
Item Number	Quality Program Elements
11	Encounter Data (ENC) performance rates and validation for GQP4P measures: • Encounter Data Gate
	• SPD
	• Non-SPD
12	Monthly Submissions and Tracking of Capitated Provider-Level Encounters (error rates, PMPY benchmarks, chart audits, data completeness (capitated vendor), etc.: • Encounter Validation Report (EVR)
	• PCP Level Reports
	• Capitated Vendors
13	Leveraging health plan data: • Care Gap Rosters Provider Support: • Submitting into CAIR2 system • Responding to grievance inquiries • Connecting to Manifest MedEx
14	Supplemental Data Submission to IEHP (if applicable): • Collaboration with IEHP • IPA Contact • Timeline for Submissions • Submission of Complete Lab Results Data • IEHP Supplemental Data Template

IPA Process Measure Domain	
Item Number	Quality Program Elements
The Quality Improvement Activities listed below should be aligned with the Quality Improvement Activities in the 2024 Global Quality P4P Program Guide: - *Equity Quality Improvement Activity #1: Reducing Health Disparities* - *Quality Improvement Activity #2: Potentially Avoidable ED Visits or Potentially Preventable Admissions*	
15	Quality Improvement Program plan to reduce disparities: IPA to choose from one of the following IEHP identified disparity populations listed below: • Hemoglobin A1c Control among Hispanics • Controlling High Blood Pressure among Blacks • Asthma Medication Ratio among Blacks • Well-Child Visits in the First 0-15 Months of Life among Blacks
16	Quality Improvement Program plan to reduce inappropriate use of ED and acute care services: • Avoidable ER Visits • Preventable Admissions
17	Provider Diversity Equity Inclusion (DEI) Survey • ≥ 90% of provider offices must respond to DEI survey by 5/30/24

APPENDIX 10: *Supplemental Claim File Data Dictionary*

The Claim file contains claims for medical services. It may also contain lab services that do not have an associated result, pharmaceuticals administered in the practitioners office (usually documented by J codes in the CPT Field), and medical encounter data. The Claim file should contain one record per unique claim line and include at least one code (ICD, HCPCS, CPT, CVX).

SUPPLEMENTAL CLAIM FILE DATA DICTIONARY			
Field Name	**Data Type**	**File Order**	**Notes**
Measure_ Submeasure	Text (80)	1	HEDIS Measure or Submeasure intended to be impacted (required field)
MemberKey	Text (14)	2	IEHP Member ID (required field)
MemberFirstName	Text (50)	5	Member First Name (required field)
MemberLastName	Text (50)	6	Member Last Name (required field)
Member DOB	Date	7	The member Date of Birth in MM/DD/YYYY format (required field)
ProviderKey	Text (25)	8	The rendering provider's NPI (required field)
ClaimNumber	Text (80)	9	Used to identify the claim source for Primary Source Verification
DOS	Date	10	The beginning Date of Service for the claim in MM/DD/YYYY format (required field)
DOSThru	Date	11	The ending Date of Service for the claim in MM/DD/YYYY format
RxProviderFlag	Bit	12	Indicates that the rendering Provider has prescribing privileges for the MCO patients. Valid values are 0 (no), or 1 (yes)
CVX	Text (3)	12	A standard CVX code denoting a vaccination.
ICD10DxPri	Text (7)	13	ICD-10 diagnosis codes should contain all available alphanumeric code. Do not include the decimal. For example, V39.00XS should be coded as V3900XS
ICD10DxSec1	Text (7)	14	
ICD10DxSec2	Text (7)	15	
ICD10DxSec3	Text (7)	16	
ICD10DxSec4	Text (7)	17	
ICD10DxSec5	Text (7)	18	
ICD10DxSec6	Text (7)	19	
ICD10DxSec7	Text (7)	20	ICD-10 diagnosis codes should contain all available alphanumeric code. Do not include the decimal. For example, V39.00XS should be coded as V3900XS
ICD10DxSec8	Text (7)	21	
ICD10DxSec9	Text (7)	22	
ICD10DxSec10	Text (7)	23	
PCPFlag	Bit	24	Indicator for whether the claim provider serves as a PCP for the health plan. Refers to the provider's contractual relationship to the plan, rather than medical specialty. Valid values are 0 (no), or 1 (yes) (required field)
HCFAPOS	Text (2)	25	
TOB	Text (4)	26	Must be converted to standard 4-digit length by adding leading zeros, if necessary

SUPPLEMENTAL CLAIM FILE DATA DICTIONARY			
Field Name	**Data Type**	**File Order**	**Notes**
UBRevenueCode	Text (4)	27	Must be converted to standard 4-digit length by adding leading zeros, if necessary
HCPCSPx	Text (5)	28	
HCPCSMOD	Text (2)	29	
CPTPx	Text (5)	30	Level II CPT Codes are supported by HEDIS and should be placed in the same field as other CPT procedure codes
CPTMOD	Text (2)	31	
ICD9Px1	Text (4)	32	ICD-9 procedure codes should contain all available digits (including all preceding zeros). Do not include the period that follows the third digit. With the introduction of ICD-10 code set, IEHP will continue to support the ICD-9 code set as there are historical claims that rely on these codes (for HEDIS we recommend 3-4 years of historical claims data) in order to accurately calculate HEDIS rates.
ICD9Px2	Text (4)	33	
ICD9Px3	Text (4)	34	
ICD9Px4	Text (4)	35	
ICD9Px5	Text (4)	36	
ICD9Px6	Text (4)	37	
ICD9Px7	Text (4)	38	
ICD9Px8	Text (4)	39	
ICD9Px9	Text (4)	40	
ICD9Px10	Text (4)	41	
ICD10Px1	Text (7)	42	ICD-10 procedure codes should contain all available alphanumeric code. Do not include the decimal. For example, V39.00XS should be coded as V3900XS
ICD10Px2	Text (7)	43	
ICD10Px3	Text (7)	44	
ICD10Px4	Text (7)	45	
ICD10Px5	Text (7)	46	
ICD10Px6	Text (7)	47	
ICD10Px7	Text (7)	48	
ICD10Px8	Text (7)	49	
ICD10Px9	Text (7)	50	
ICD10Px10	Text (7)	51	
ProviderType	Text (4)	52	Use values in ProviderType column in the Provider Type Crosswalk Tab
POS	Text (2)	53	Place of Service. Also automatically built using a cross-reference. Valid values are: BC (Birthing Center), DN (Day/Night Hospitalization), ER (Emergency Room), IA (Inpatient Acute), IN (Inpatient Non-Acute), LA (Laboratory), OA (Outpatient/ Ambulatory), OC (Office/Clinic), OT (Other), RM (Mail Order Prescription Drugs), RR (Retail Pharmacy) (required field)
SubmitterName	Text (80)	54	Name of IPA or Provider Group. Required if submitting on behalf of more than one health center or provider group. Can be left blank if only a single submitter.

Supplemental Lab Claim File Data Dictionary

The LabClaim file contains claims for laboratory services and allows lab results to be stored. The LabClaim file should contain one record per unique lab service claim and include at least one code (LOINC, HCPCS, CPT, SNOMED).

SUPPLEMENTAL LAB CLAIM FILE DATA DICTIONARY			
Field Name	**Data Type**	**File Order**	**Notes**
Measure_ Submeasure	Text (80)	1	HEDIS Measure or Submeasure intended to be impacted (required field)
MemberKey	Text (30)	2	IEHP Member ID (required field)
ProviderKey	Text (25)	3	The rendering provider's NPI (required field)
ClaimNumber	Text (80)	5	Used to identify the claim source for Primary Source Verification
DOS	Date	6	The Date of Service for the claim in MM/DD/YYYY format (required field)
CPTPx	Text (5)	7	Level II CPT Codes are supported by HEDIS and should be placed in the same field as other CPT procedure codes
LOINC	Text (7)	8	LOINC codes must contain the dash character that precedes the final digit
HCPCSPx	Text (5)	9	Used for medical services, that comes in through lab claims. Only one HCPCS code per claim line is allowed. If the claim contains multiple HCPCS codes, load them as separate claims
HCPCSMod	Text (2)	10	
SNOMED	Text (25)	11	Systematized nomenclature of medicine
Result	Decimal(28,10)	12	Used to document numeric lab results
PosNegResult	Bit	13	Used to document positive/negative lab results. Valid values are 0 (negative), or 1 (positive)
SubmitterName	Text (80)	14	Name of IPA or Provider Group. Required if submitting on behalf of more than one health center or provider group. Can be left blank if only a single submitter.

PROVIDER NETWORK SUPPORT BONUS

☑ Provider Network Support Bonus

Inland Empire Health Plan (IEHP) would like to introduce the NEW 2024 Provider Network Support Bonus Program! The 2024 Provider Network Support Bonus aims to encourage IEHP Network Independent Physician Associations (IPAs) to maintain strong Provider Network Support services to ensure Provider performance is maximized and quality of care is delivered to IEHP Members.

Three (3) measures will be included in the 2024 Provider Network Support Bonus Program:

- Primary Care Physician (PCP) Provider Network Retention
- Primary Care Physician (PCP) Provider Network Retention Improvement
- Specialty Network Adequacy

☑ Eligibility and Participation

To be eligible for the 2024 Provider Network Support Bonus, IPAs must meet the following criteria:

- IPA must be a participant in the 2023 Global Quality P4P Program.
- IPA must demonstrate measure performance improvement (an increase in rate performance from the 2022 to 2023 measurement year) for 4 of the 5 following measures listed below:
    - o Child and Adolescent Well-Care Visits
    - o Childhood Immunizations – Combo 10
    - o Immunizations for Adolescents – Combo 2
    - o Well-Child Visits in the First 30 Months of Life (0-15 Months)
    - o Cervical Cancer Screening
- IPA must meet minimum performance levels (MPL) for the following MCAS measures in the 2023 performance year:
    - o Timely Prenatal Care (MPL = 84.23%)
    - o Timely Postpartum Care (MPL = 78.10%)
- IPA Operational Requirement: IPA must designate a Provider Network Support Team of two (2) or more full-time staff dedicated to all aspects of Provider Services, including Provider Relations. **Provider Services Team framework will require an attestation and submission of staffing plan by 8/31/2024**.
    - o Minimum Staffing Ratio:
        - 1 Staff per 50 PCPs
          AND
        - 1 staff per 100 Specialists

Note: Pseudo IPAs are not eligible for the Provider Network Support Bonus incentive dollars.

Financial Overview

The financial bonus incentive awarded in the 2024 Provider Network Support Bonus Program will award IPAs who meet the criteria found in the Provider Network Support Bonus Measures Overview. Financial bonus incentive will be distributed as a lump sum payment October 2024.

FINANCIAL ALLOCATION – 2024 PROVIDER NETWORK SUPPORT BONUS:		
Measures	**Percent of Bonus Payout**	**Incentive Bonus Dollars**
PCP Provider Network Retention	40%	*
PCP Provider Network Retention Improvement	30%	
Specialty Network Adequacy	30%	
Total Provider Network Support Bonus Budget		

* IPA Provider Network Support Bonus dollar allocation will be calculated October 2024. The budgeted pool amount will be determined based on 5% of the cumulative IPA capitation payment for the 7/1/2023 – 6/30/2024 measurement period.

Performance Goals

Eligible IPAs are evaluated on the 2024 Provider Network Support Bonus Program measures to determine if the IPA qualifies for the bonus payment. Please see below for details to the performance goals, payment schedule and reporting timeline.

PERFORMANCE GOALS – 2024 PROVIDER NETWORK SUPPORT BONUS:	
Measures	**2024 Performance Goals**
PCP Provider Network Retention	- IPA must retain ≥ 95% of active PCPs at the end of the measurement period (end of June 2024).
PCP Provider Network Retention Improvement	- IPA PCP retention improvement: ≥ 75% of active PCP network retention by the end of the measurement period (June 2024) compared to the prior measurement period (June 2023).
Specialty Provider Network Retention	- IPA must retain 100% of Medi-Cal CORE* Specialists per hospital network during the measurement year (7/1/2023 – 6/30/2024).

*Medi-Cal CORE Specialist: The following list of Providers are identified as a CORE Specialist: Cardiology, Dermatology, Endocrinology, Gastroenterology, General Surgery, Infectious Disease/HIV Specialist, Nephrology, Neurology, OB/GYN, Orthopedics Surgery, Otolaryngology (ENT), Ophthalmology, Oncology/Hematology, Physical Medicine and Rehabilitation and Pulmonary Medicine.

☑ Provider Network Support Bonus Measures Overview

PCP Provider Network Retention

Methodology: IEHP – Defined Measure

Measure Description: IPAs are encouraged to engage with and support their assigned PCP Network.

Goal: IPA must retain ≥ 95% of their active PCP network by the end of the measurement period (June 2024).

PCP Provider Network Retention Improvement

Methodology: IEHP – Defined Measure

Measure Description: IPAs are encouraged to engage with and support their assigned PCP Network while improving overall IPA PCP network retention.

Goal: IPA must retain ≥ 75% of their active PCP network by the end of the measurement period (June 2024) compared to the prior measurement period (June 2023).

Specialty Network Adequacy

Methodology: IEHP – Defined Measure

Measure Description: IPAs are encouraged to engage with and support their CORE Specialists Provider Network.

Goal: IPA must retain 100% of their CORE Specialists Provider Network, per hospital network, during the measurement period (7/1/2023 – 6/30/2024).

NOTES

IEHP

Inland Empire Health Plan

iehp.org

PROVIDER RELATIONS TEAM

(909) 890-2054

Monday-Friday, 8am-5pm

Follow us: