2025

IEHP DIRECT STARS

Incentive Program

IEHP DualChoice

Contact: *QualityPrograms@iehp.org*

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PROGRAM OVERVIEW

This program guide provides an overview of the 2025 IEHP Direct Stars Incentive Program for Primary Care Physicians (PCPs). The 2025 IEHP Direct Stars Incentive Program has been designed to reward PCPs for high-quality care provided to IEHP Direct DualChoice (D-SNP) Members. IEHP encourages all PCPs to attend IEHP Provider Quality Incentive meetings held throughout the year to support their efforts to maximize earnings in this program.

If you would like more information about the 2025 IEHP's Direct Stars Incentive Program, email the Quality Team at QualityPrograms@iehp.org or call the IEHP Provider Relations Team at (909) 890-2054.

☑ Program Structure

There are two ways to maximize your earnings in the 2025 IEHP Direct Stars Program:

1) Core Performance Measures
2) Quality Bonus Services

Core Performance Measures

Appendix 1 provides a list of the 13 measures in the 2025 IEHP Direct Stars Incentive Program and includes thresholds and benchmarks associated with the respective star ratings:

- Advance Care Planning
- Annual Wellness Visit
- Care for Older Adults – Functional Status Assessment
- Care for Older Adults – Medication Review
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetes Care - Kidney Health Evaluation
- Diabetes Eye Exam
- Flu Vaccine
- Glycemic Status
- Post Discharge Follow-Up
- Transitions of Care - Medication Reconciliation Post Discharge
- Breast Cancer Screening

Quality Bonus Services

Providers can now earn additional incentive dollars through the 2025 IEHP Direct Stars Program leveraging the new Quality Bonus Services! Appendix 4 includes details on participation eligibility, incentive amounts, payment schedule and service descriptions for the 9 Quality Bonus Services in the program:

- Blood Pressure Control
- Care for Older Adults - Medication Review
- Colorectal Cancer Screening
- Diabetes Care - Kidney Health Evaluation
- Flu Vaccine
- HbA1c Control
- Post Discharge Follow- Up
- Statin Initiation for Diabetes or Cardiovascular Disease
- 3 Month Supply Prescription Conversion

CORE PROGRAM

For IEHP Direct Stars Program

☑ Eligibility and Participation

Provider Eligibility

To be eligible for incentive payments in the 2025 IEHP Direct Stars Incentive Program, PCPs must meet the following criteria:

- Primary Care Physicians (PCPs), Federally Qualified Health Centers (FQHCs), Indian Health Facilitates (IHFs) and Rural Health Clinics (RHCs) must have an IEHP Direct D-SNP contract with IEHP.
- Have at least 30 IEHP Direct D-SNP Members assigned as of December 2025.
- Have at least 10 IEHP Direct D-SNP Members in the denominator as of December 2025 for each measure to qualify for scoring.
- Have at least three measures meet the minimum denominator requirement to calculate a star rating.
- Must have an average assigned Membership risk adjustment factor score of 1.0 or higher.

Member Eligibility

The eligible population for this program includes only IEHP Direct D-SNP Members.

☑ Minimum Data Requirements

Encounter Data

Encounter data is foundational to performance measurement and essential to success in the IEHP Direct Stars Incentive Program. Complete, timely, and accurate encounter data should be submitted through normal reporting channels for all services rendered to IEHP Direct D-SNP Members. Please use the appropriate codes listed in Appendix 2 to meet measure requirements.

Program Terms and Conditions

- Good Standing: A Provider currently contracted with the 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 the Plan at the time of program application or at the time additional funds may be payable, and has demonstrated the intent, in the 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, the Plan may determine that a Provider is not in good standing based on relevant quality, payment or other business concerns.
- Participation in the IEHP Direct Stars Incentive 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, whether that agreement is entered into before or after the date of this communication.
- There is no guarantee that future funding for, or payment under, any IEHP Provider will 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 Direct Stars Incentive Program, participants agree to fully and forever release and discharge IEHP from all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by IEHP of the IEHP Direct Stars Incentive Program.
- The determination of IEHP regarding performance scoring and payments under the IEHP Direct Stars Incentive Program is final.
- As a condition of receiving payment under the IEHP Direct Stars Incentive 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

The annual budget for the 2025 IEHP Direct Stars Incentive Program for PCPs is $1 million. Providers are eligible to receive financial rewards for performance excellence and meeting the CMS Star rating requirements. Financial rewards are based on a star rating system, increasing financial rewards as Providers reach each level of higher performance. The incentive payment for the 2025 performance period will be distributed via a monthly Per Member Per Month (PMPM) Quality Payment beginning in July 2026 and continuing through June 2027 and paid based on your IEHP Direct D-SNP monthly Membership.

☑ Scoring Methodology

Payments will be awarded to PCPs based on individual performance in reaching established Quality Goals (e.g., star ratings for each measure). The measures within the IEHP Direct Stars Incentive Program follow the Centers for Medicare and Medicaid (CMS) specifications (including HEDIS® measure criteria). The eligible population is defined as the set of Members who meet the denominator criteria specified in each measure by NCQA. For each measure, the measure score reflects the proportion of the eligible population that complies with the numerator criteria.

☑ Payment Methodology

PCP performance for each measure will be given a star value (i.e., a measure score). Measure scores are applied based on threshold cut points that are assigned per measure. Providers with an overall star rating of at least 3.0 or greater will be eligible to earn incentive dollars in this program. Providers with an overall star rating of 2.5 stars or below will not be eligible for an incentive in this program.

Providers with at least three quality measures that meet the minimum denominator size (10 or more Members) will be considered for payment calculation.

Calculating the Star Rating

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

Star Rating Performance Score =
Sum (measure star rating * measure weight) / Sum of measure weights

Note:

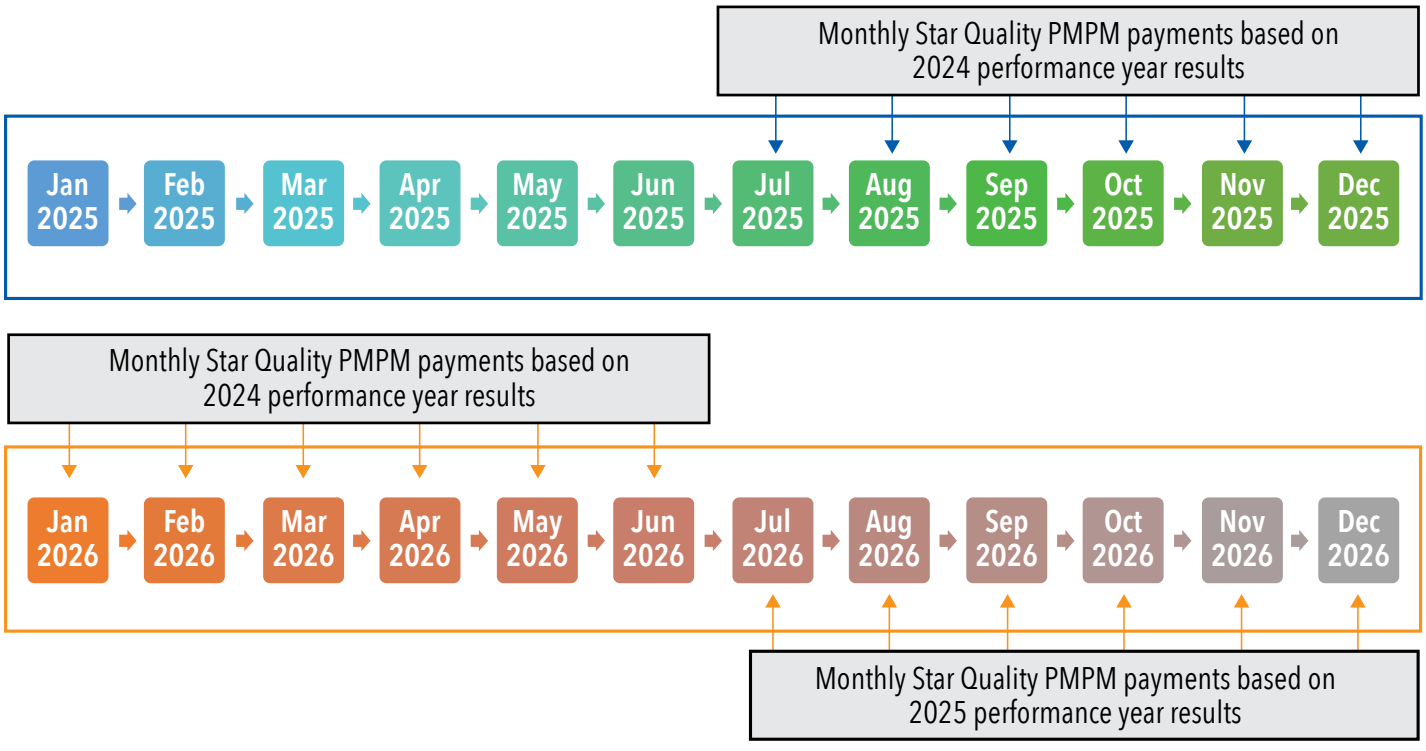
- Star rating will determine Star Quality PMPM awarded to Provider
- Overall star rating follows the rounding rules found in the 2025 IEHP Direct Stars Incentive Program - Incentive Payments table below.

Calculating Overall Star Quality PMPM Incentive

2025 IEHP DIRECT STARS INCENTIVE PROGRAM – INCENTIVE PAYMENTS:		
Initial Star Rating*	**Overall Star Rating**	**Star Quality PMPM Amount**
≥ 0.750000 and < 1.250000	1.0 Stars	**Not eligible for incentive dollars**
≥ 1.250000 and < 1.750000	1.5 Stars	
≥ 1.750000 and < 2.250000	2.0 Stars	
≥ 2.250000 and < 2.750000	2.5 Stars	
≥ 2.750000 and < 3.250000	3.0 Stars	$ 5.00
≥ 3.250000 and < 3.750000	3.5 Stars	$ 8.00
≥ 3.750000 and < 4.250000	4.0 Stars	$ 10.00
≥ 4.250000 and < 4.750000	4.5 Stars	$ 12.00
≥ 4.750000 and ≤ 5.000000	5.0 Stars	$ 14.00

**The results of the initial star rating calculations are rounded to the nearest half star.*

☑ Incentive Payout Timeline



APPENDIX 1: 2025 IEHP Direct Stars Incentive Program Measures

2025 IEHP Direct Stars Incentive Program Star Performance Goals

Measure Name	Star 1 Rate	Star 2 Rate	Star 3 Rate	Star 4 Rate	Star 5 Rate	Weight
Advance Care Planning[1]	<16%	≥16% to <43%	≥43% to <60%	≥60% to <98%	≥98%	1
Annual Wellness Visit[2]	<83%	≥83% to <91%	≥91 to <93%	≥93% to <97%	≥97%	3
Care for Older Adults – Functional Status Assessment[3]	<64%	≥64% to <87%	≥87% to <94%	≥94% to <99%	≥99%	1
Care for Older Adults – Medication Review*	<53%	≥53% to <80%	≥80% to <92%	≥92% to <98%	≥98%	1
Colorectal Cancer Screening*	<53%	≥53% to <65%	≥65% to <75%	≥75% to <83%	≥83%	1
Post Discharge Follow-Up[2]	<74%	≥74% to <86%	≥86% to <91%	≥91% to <94%	≥94%	1
Transitions of Care – Med Rec Post Discharge*	<42%	≥42% to <57%	≥57% to <73%	≥73% to <87%	≥87%	1
Glycemic Status ≤ 9.0%*	<49%	≥49% to <72%	≥72% to <84%	≥84% to <90%	≥90%	3
Flu Vaccine[1]	<8%	≥8% to <33%	≥33% to <49%	≥49% to <70%	≥70%	1
Controlling High Blood Pressure*	<69%	≥69% to <74%	≥74% to <80%	≥80% to <85%	≥85%	3
Breast Cancer Screening*	<53%	≥53% to <67%	≥67% to <75%	≥75% to <82%	≥82%	1
Diabetes Care - Kidney Health Evaluation[1]	<35%	≥35%to <53%	≥53% to <63%	≥63% to <79%	≥79%	1
Diabetes Eye Exam*	<57%	≥57% to <70%	≥70% to <77%	≥77% to <83%	≥83%	1

** Medicare 2025 Part C & D Star Rating Technical Notes*
1 Goals set by 2024 (MY 2023) NCQA Medicare Quality Compass
2 Goals set by 2024 (MY 2023) Proxy Measure Total Quality Compass
3 Goals set by 2024 (MY 2023) Audit Means Percentile

APPENDIX 2: 2025 IEHP Direct Stars Incentive Program Measures Overview

Advance Care Planning

Methodology: HEDIS®

Measure Description: The percentage of Members 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and Members 81 years of age and older who had Advance Care Planning during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 66 years of age and older as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had evidence of Advance Care Planning during the measurement year (2025).

CODES TO IDENTIFY ADVANCED CARE PLANNING:			
Service	**Code Type**	**Code**	**Code Description**
Advance Care Planning	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Advance Care Planning	CPT	99497	Advance Care Planning, including the explanation and discussion of Advance Directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
Advance Care Planning	CPT-CAT-II	1123F	Advance Care Planning discussed and documented Advance Care Plan or surrogate decision maker documented in the medical record (DEM) (GER, PALL CR).
Advance Care Planning	CPT-CAT-II	1124F	Advance Care Planning discussed and documented in the medical record, Patient did not wish or was not able to name a surrogate decision maker or provide an Advance Care Plan (DEM) (GER, PALL CR).
Advance Care Planning	CPT-CAT-II	1157F	Advance Care Plan or similar legal document present in the medical record (COA).
Advance Care Planning	CPT-CAT-II	1158F	Advance Care Planning discussion documented in the medical record (COA).
Advance Care Planning	HCPCS	S0257	Counseling and discussion regarding Advance Directives or End-of-Life Care Planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service).
Advance Care Planning	ICD10CM	Z66	Do not resuscitate

Annual Wellness Visit

Methodology: IEHP-Defined

Measure Description: The percentage of Members 18 years of age and older who received an annual wellness visit during the measurement year (2025). An annual wellness visit may include the following:

- Administer Health Risk Assessment (HRA) including demographic data, health status assessment, psychosocial & behavioral risk, ADLs, IADLs
- Establish medical and family history
- Establish current Providers and prescriptions
- Obtain height, weight, blood pressure, BMI and other routine measurements
- Assess cognitive function
- Review risk factors for depression
- Assess functional ability and patient safety
- Review and establish risk factors and treatment options
- Establish a written screening schedule for appropriate preventive services
- Provide personalize health advice
- Offer advance care planning services as needed

Denominator: Members 18 years of age and older.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had an annual wellness visit during the measurement year (2025).

CODES TO IDENTIFY ANNUAL WELLNESS VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Annual Wellness Visits	HCPCS	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
Annual Wellness Visits	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Annual Wellness Visits	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.

Care for Older Adults – Functional Status Assessment

Methodology: HEDIS®

Measure Description: The percentage of Members 66 years of age and older who had a functional status assessment during the measurement year (2025). A functional status assessment may include the following:

1. Documentation of Activities of Daily Living Assessed (ADL) **OR** at least **FIVE** of the following were **assessed**: bathing, dressing, eating, transferring, using toilet, walking.

   OR

2. Documentation of Instrumental Activities of Daily Living Assessed (IADL) **OR** at least **FOUR** of the following were **assessed**: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.

   OR

3. Result of a Standardized Functional status assessment tool *(not limited to the following)*:
   - SF-36®.
   - Assessment of Living Skills and Resources (ALSAR).
   - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
   - Edmonton Frail Scale.
   - Extended ADL (EADL) Scale.
   - Independent Living Scale (ILS).

- Eligible population in this measure meets all of the following criteria:
  1. Members who are 66 years of age and older as of December 31 of the measurement year (2025).
  2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had a functional status assessment at least once during the measurement year (2025).

CODES TO IDENTIFY FUNCTIONAL STATUS ASSESSMENT:			
Service	**Code Type**	**Code**	**Code Description**
Functional Status Assessment	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Functional Status Assessment	CPT-CAT-II	1170F	Functional status assessed (COA) (RA).
Functional Status Assessment	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Functional Status Assessment	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.

Care for Older Adults – Medication Review

Methodology: HEDIS®

Measure Description: The percentage of Members 66 years of age and older who received at least one medication review conducted by a Provider or Clinical Pharmacist during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 66 years of age and older as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who received at least one medication review conducted by a Provider during the measurement year (2025).

Either of the following meets numerator criteria:

- Provider must bill a code for one medication review and one medication list that occurred on the same date of service.
  OR
- Provider must bill a code for transitional care management services.

CODES TO IDENTIFY MEDICATION REVIEW:			
Service	**Code Type**	**Code**	**Code Description**
Medication Review	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.
Medication Review	CPT	99605	Medication Therapy Management Service(S) Provided By A Pharmacist, Individual, Face-To-Face With Patient, With Assessment And Intervention If Provided; Initial 15 Minutes, New Patient
Medication Review	CPT	99606	Medication Therapy Management Service(S) Provided By A Pharmacist, Individual, Face-To-Face With Patient, With Assessment And Intervention If Provided; Initial 15 Minutes, Established Patient
Medication Review	CPT	90863	Pharmacologic Management, Including Prescription And Review Of Medication, When Performed With Psychotherapy Services (List Separately In Addition To The Code For Primary Procedure)
Medication Review	CPT-CAT-II	1160F	Review Of All Medications By A Prescribing Practitioner Or Clinical Pharmacist (Such As, Prescriptions, Otcs, Herbal Therapies And Supplements) Documented In The Medical Record (COA)

CODES TO IDENTIFY MEDICATION LIST:			
Service	**Code Type**	**Code**	**Code Description**
Medication List	CPT-CAT-II	1159F	Medication list documented in medical record (COA)
Medication List	HCPCS	G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

CODES TO IDENTIFY TRANSITIONAL CARE:			
Service	**Code Type**	**Code**	**Code Description**
Transitional Care	CPT	99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge
Transitional Care	CPT	99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge

Colorectal Cancer Screening

Methodology: HEDIS®

Measure Description: The percentage of Members who are 45-75 years of age who had 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 and older as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 45-75 years of age.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had appropriate screening for colorectal cancer during the measurement year (2025).

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	0464U	Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result
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 forceps
Colorectal Cancer Screening	CPT	44394	Colonoscopy through stoma; with removal of tumor(s), polyp(S), or other lesion(s) by snare technique
Colorectal Cancer Screening	CPT	44401	Colonoscopy through stoma; 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	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 ballon 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) (e.g., 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) (e.g., 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

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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)
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

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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; without contrast material(s) including non-contrast images, if performed
Colorectal Cancer Screening	CPT	74263	Computed tomographic (CT) colonography, diagnostic, 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 (e.g., patient was provided three cards or single triple card for consecutive collection)
Colorectal Cancer Screening	CPT	82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 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 by the PCP.

Controlling High Blood Pressure

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) is controlled (<140/90 mmHg) during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18 - 85 years of age and older as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 18-85 years of age with a diagnosis of hypertension.

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had a BP reading taken during the measurement year (2025) in any of the following settings: office visits, e-visits or telephone visits. The most recent BP of the measurement year (2025) will be used to determine compliance with this measure. The Provider must bill one diastolic code, one systolic code and one visit type code.

CODES TO IDENTIFY BLOOD PRESSURE SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
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	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	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)
Blood Pressure Screening	CPT-CAT-II	3077F	Most recent systolic blood pressure greater than or equal to 140 Mm Hg (HTN, CKD, CAD) (DM)

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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
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.
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 total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Office Visit	CPT	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
Office Visit	CPT	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Office Visit	CPT	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
Office Visit	CPT	99341	Home or residence 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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
Office Visit	CPT	99342	Home or residence 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Office Visit	CPT	99344	Home or residence 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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
Office Visit	CPT	99345	Home or residence 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 total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.
Office Visit	CPT	99347	Home or residence 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
Office Visit	CPT	99348	Home or residence 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Office Visit	CPT	99349	Home or residence 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 total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Office Visit	CPT	99350	Home or residence 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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
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.

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

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99456	Work-related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
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.
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.

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.

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 – Kidney Health Evaluation

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age and have a diagnosis of diabetes (type 1 or 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 (2025).

- 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 (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP of up to 45 days during the measurement year (2025).
    3. Members who meet any of the following criteria during the measurement year (2025) or the year prior to the measurement year (2024). 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 (2025) or the year prior to the measurement year (2024).
        - Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year (2025) or the year prior to the measurement year (2024) and have at least one diagnosis of diabetes during the measurement year (2025) or the year prior to the measurement year (2024).
- 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 (2025).
    3. Members receiving palliative care.
    4. Members who expired at any time during the measurement year (2025).
    5. Members who had dialysis any time during the member's history on or prior to December 31 of the measurement year (2025).
    6. Members 66-80 years of age and older as of December 31 of measurement year (2025) with both frailty and advanced illness.
    7. Members 81 years of age and older as of December 31 with at least two indications of frailty on different dates of service during the measurement year (2025).

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

- Anchor Date: December 31, 2025

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 (2025), 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)
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)

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
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	LOINC	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 2021)
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 2021)
Estimated Glomerular Filtration Rate	LOINC	102097-3	Glomerular Filtration Rate/1.73 sq M.predicted [volume Rate/area] In Serum, Plasma or Blood by Creatinine, Cystatin C And Urea- based formula (CKiD)

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

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

Diabetes Eye Exam

Methodology: HEDIS®

Measure Description: The percentage of Members 18-75 years of age and have a diagnosis of diabetes (type 1 or 2) who had an eye exam (retinal) performed during the measurement year (2025).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years of age as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 18-75 years of age who have a diagnosis of diabetes (type 1 or 2).

- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had an eye exam (retinal) performed during the measurement year (2025).

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT	65091	Evisceration of ocular contents; without implant
Diabetes Eye Care	CPT	65093	Evisceration of ocular contents; with implant
Diabetes Eye Care	CPT	65101	Enucleation of eye; without implant
Diabetes Eye Care	CPT	65103	Enucleation of eye; with implant, muscles not attached to implant
Diabetes Eye Care	CPT	65105	Enucleation of eye; with implant, muscles attached to implant
Diabetes Eye Care	CPT	65110	Exenteration of orbit (does not include skin graft), removal of orbital contents; only
Diabetes Eye Care	CPT	65112	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
Diabetes Eye Care	CPT	65114	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
Diabetes Eye Care	CPT	92002	Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program; intermediate, new patient

CODES TO IDENTIFY DIABETES EYE CARE:			
Diabetes Eye Care	CPT	92004	Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
Diabetes Eye Care	CPT	92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
Diabetes Eye Care	CPT	92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
Diabetes Eye Care	CPT	92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
Diabetes Eye Care	CPT	92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited
Diabetes Eye Care	CPT	92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
Diabetes Eye Care	CPT	92137	Computerized ophthalmic diagnostic imaging (eg, optical coherence tomography [OCT]), posterior segment, with interpretation and report, unilateral or bilateral; retina, including OCT angiography
Diabetes Eye Care	CPT	92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral
Diabetes Eye Care	CPT	92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92230	Fluorescein angioscopy with interpretation and report
Diabetes Eye Care	CPT	92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92250	Fundus photography with interpretation and report
Diabetes Eye 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Diabetes Eye 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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye 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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
Diabetes Eye 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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
Diabetes Eye 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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Diabetes Eye 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 total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
Diabetes Eye Care	CPT-CAT-II	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT-CAT-II	2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)
Diabetes Eye Care	HCPCS	S3000	Diabetic indicator; retinal eye exam, dilated, bilateral
Diabetes Eye Care	HCPCS	S0620	Routine ophthalmological examination including refraction; new patient
Diabetes Eye Care	HCPCS	S0621	Routine ophthalmological examination including refraction; established patient

**A retinal or dilated eye exam must be completed by an eye care professional (Optometrist or Ophthalmologist) during the measurement year (2025).*

Flu Vaccine

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19 years of age and older, who received an influenza vaccine on or between July 1 of the year prior to the measurement year (2024) and June 30 of the measurement year (2025).

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

- Anchor Date: June 30, 2025

Numerator: Members in the denominator who received an influenza vaccine on or between July 1, 2024 –June 30, 2025.

CODES TO IDENTIFY FLU VACCINE:			
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
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

CODES TO IDENTIFY FLU VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
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

Glycemic Status ≤ 9.0%

Methodology: HEDIS®

Measure Description: The percentage of Members 18-75 years of age diagnosed with diabetes (type 1 or 2) who had a recent glycemic status (hemoglobin Alc (HbA1c) or glucose management indicator (GMII) ≤ 9.0%.

- Glycemic Status (≤ 9.0%)
- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years of age as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2025).

Denominator: Members 18-75 years of age who have a diagnosis of diabetes (type 1 or 2).

- Anchor Date: December 31, 2025

Numerator: Members in the denominator with the most recent glycemic status assessment that has a result of ≤ 9.0% during the measurement year (2025).

CODES TO IDENTIFY GLYCEMIC STATUS RESULTS:			
Service	**Code Type**	**Code**	**Code Description**
Glycemic Status Result	CPT	83036	Hemoglobin; glycosylated (A1c)
Glycemic Status Result	CPT	83037	Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use
Glycemic Status Result	CPT-CAT-II	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
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% (DM)
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% (DM)

Post Discharge Follow-Up

Methodology: IEHP-Defined

Measure Description: The percentage of Members who had a follow-up visit with a Provider within seven days of a hospital discharge from an acute or non-acute inpatient stay during the measurement year (2025).

Denominator: All acute and non-acute inpatient discharges during the measurement year (2025).

Numerator: Members in the denominator who had a follow-up visit with a Provider within seven days of the hospital discharge. A Provider for this measure is defined as a Primary Care Provider or Specialty Care Provider. A Provider or non-Provider (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care or specialty care medical services. Licensed practical nurses and registered nurses are not considered PCPs or Specialists. Specialty Care Providers are included as qualifying Providers if the Provider offers ongoing care to the Member. Clinical Pharmacist are not considered Providers for this measure.

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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
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.
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 total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
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 total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
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 total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Office Visit	CPT	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
Office Visit	CPT	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Office Visit	CPT	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Office Visit	CPT	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
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.

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

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 minutes (List separately in addition to code for primary procedure)
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

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
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 minutes (List separately in addition to code for primary procedure)
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 previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
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

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

Transitions of Care – Medication Reconciliation Post Discharge

Methodology: HEDIS®

Measure Description: The percentage of Members 18 years of age and older whose medication records were updated within 30 days after a hospital discharge.

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18 years of age and older as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP during the measurement year (2025) with the date of discharge through 30 days after discharge (31 total days).

Denominator: Members 18 years or older.

- Discharges will be counted from January 1 through December 1 of the measurement year (2025).
- Anchor Date: December 31, 2025

Numerator: Members in the denominator whose medication records were updated within 30 days after a hospital discharge.

CODES TO IDENTIFY MEDICATION RECONCILIATION POST DISCHARGE:			
Service	**Code Type**	**Code**	**Code Description**
Medication Reconciliation	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Medication Reconciliation	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. At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge.
Medication Reconciliation	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. High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge.
Medication Reconciliation	CPT-CAT-II	1111F	Discharge medications reconciled with the current medication list in outpatient medical record (COA) (GER).

Breast Cancer Screening

Summary of Changes to the IEHP Direct Stars Program Guide:

- Update to measure description

Methodology: HEDIS®

Measure Description: The percentage of Members 40-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer during the past two measurement years (2024 and 2025).

- The eligible population in the measure meets all of the following criteria:
    1. Members 42-74 years as of December 31 of the measurement year (2025).
    2. Continuous enrollment with IEHP from October 1 two years prior to the measurement year (2023) through December 31 of the measurement year (2025) 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 two years prior to the measurement year (2023) through December 31 two years prior to the measurement year (2023).

Denominator: Members 40-74 years of age.

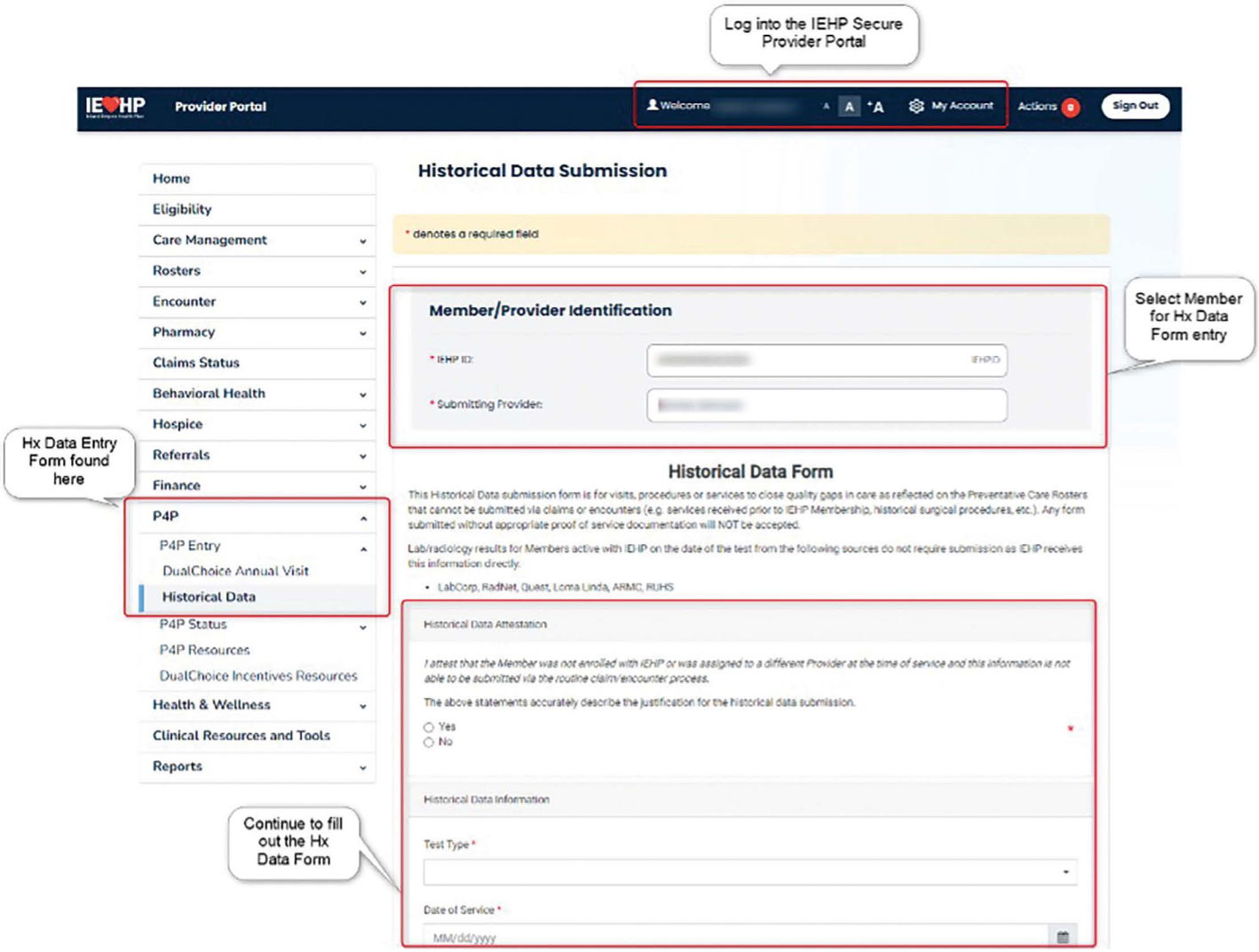
- Anchor Date: December 31, 2025

Numerator: Members in the denominator who had a mammogram to screen for breast cancer during the past two measurement years (2024 and 2025).

CODES TO IDENTIFY MAMMOGRAPHY:			
Service	**Code Type**	**Code**	**Code Description**
Breast Cancer Screening	CPT	77061	Diagnostic digital breast tomosynthesis; unilateral
Breast Cancer Screening	CPT	77062	Diagnostic 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 (2-view study of each breast), including computer-aided detection (CAD) when performed

APPENDIX 3: Historical (Hx) Data Form

The IEHP Historical (Hx) Data Form is located in the secure Provider Portal. Providers seeking to submit medical records to close quality gaps in care can enter Member information and upload documentation via an online process. As a reminder, this process 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.). Please see below for more details.



Note: All Historical Data submissions for the 2025 performance year must be submitted to IEHP no later than December 31, 2025.

QUALITY BONUS SERVICES

For IEHP Direct Stars Program

IEHP Direct Stars Quality Bonus Service

The 2025 IEHP Direct Stars Program includes the Quality Bonus Services listed below:

1. Blood Pressure Control
2. Care for Older Adults - Medication Review
3. Colorectal Cancer Screening
4. Diabetes Care - Kidney Health Evaluation
5. Flu Vaccine
6. HbA1c Control
7. Post Discharge Follow-Up
8. Statin Initiation for Diabetes or Cardiovascular Disease
9. 3 Month Supply Prescription Conversion

See Appendix 4 for service details.

Eligibility and Participation

To be eligible for the Quality Bonus Services, Providers must be contracted with IEHP as a Direct D-SNP Primary Care Physician (PCP).

NOTE: Federally Qualified Health Centers (FQHCs), Indian Health Facilities (IHFs) and Rural Health Clinics (RHCs) are **only** eligible for selected Quality Bonus Services:

- Statin Initiation for Diabetes or Cardiovascular Disease
- 3 Month Supply Prescription Conversion

See Appendix 4 for additional details.

☑ Financial Overview

Eligible Providers will receive an incentive payment for each qualified Quality Bonus Service rendered. Table 1 below indicates the amount a Provider will receive per qualified service.

TABLE 1. PAYMENT PER INCENTIVE SERVICE:	
Incentive Service	**Payment Amount***
Blood Pressure Control	$50
Care for Older Adults - Medication Review	$25
Colorectal Cancer Screening	$50
Diabetes Care - Kidney Health Evaluation	$50
Flu Vaccine	$25
HbA1c Control	$50
Post Discharge Follow-Up	$50
Statin Initiation for Diabetes or Cardiovascular Disease	$45
3 Month Supply Prescription Conversion	$45

**Members must be active with IEHP on the date the service was completed.*

Payment Timeline

The quality bonus services will be paid following the Quality Bonus payment Schedule.

2025 IEHP DIRECT STARS INCENTIVE PROGRAM - QUALITY BONUS SERVICES PAYMENT SCHEDULE:		
Date of Service	**Encounter Received**	**Payment Date**
1/1/2025 - 6/30/2025	7/15/2025	8/20/2025
1/1/2025 - 7/31/2025	8/15/2025	9/20/2025
1/1/2025 - 8/31/2025	9/15/2025	10/20/2025
1/1/2025 - 9/30/2025	10/15/2025	11/20/2025
1/1/2025 - 10/31/2025	11/15/2025	12/20/2025
1/1/2025 - 11/30/2025	12/15/2025	1/20/2026
1/1/2025 - 12/31/2025	1/15/2026	2/20/2026
1/1/2025 - 12/31/2025	2/15/2026	3/20/2026
1/1/2025 - 12/31/2025	3/15/2026	4/20/2026*
1/1/2025 - 12/31/2025	3/15/2026	7/20/2026**

NOTE: The Statin Initiation for Diabetes or Cardiovascular Disease, 3 Month Supply Prescription Conversion and Blood Pressure Control services will not be included in the Quality Bonus Services monthly payment schedule.

**IEHP will issue a lump-sum payment for the Statin Initiation for Diabetes or Cardiovascular Disease and 3 Month Supply Prescription Conversion services, to qualified Providers, April 2026.*

***IEHP will issue a lump-sum payment for the Blood Pressure Control service to qualified Providers, July 2026.*

APPENDIX 4: 2025 IEHP Direct Stars Quality Bonus Services Overview

Blood Pressure Control ($50*)

Service Description: Quality bonus payment to a Provider who completes a blood pressure screening on Members ages 18-85, with a diagnosis of hypertension (HTN), and whose blood pressure (BP) was controlled (<140/90 mm Hg).

NOTE: The most recent blood pressure reading of the calendar year will be assessed for this service.

- Payment to Provider for rendering a blood pressure reading with a controlled result (<140/90 mm Hg)
- Effective dates of service: 1/1/2025 – 12/31/2025
- One payment per Provider, per Member
- Provider must bill three codes: One code billed for **systolic blood pressure level,** one code billed for **diastolic blood pressure level** and one code billed for **hypertension diagnosis**.
- *Payment for this service will be distributed July 2026

SYSTOLIC BLOOD PRESSURE LEVELS:			
Service	**Code Type**	**Code**	**Code Description**
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)

DIASTOLIC BLOOD PERSSURE LEVELS:			
Service	**Code Type**	**Code**	**Code Description**
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	3079F	Most recent diastolic blood pressure 80-89 mm Hg (HTN, CKD, CAD) (DM)

HYPERTENSION DIAGNOSIS:			
Service	**Code Type**	**Code**	**Code Description**
Blood Pressure Screening	ICD-10-CM	I10	Essential (primary) hypertension

Care for Older Adults – Medication Review ($25)

Service Description: Quality bonus payment to a Provider who conducts at least one medication review, for members 66 years of age and older.

- One payment per Provider, per Member, per year.
- Effective dates of service: 1/1/2025 – 12/31/2025
- Provider must bill a code for **one medication review** and **one medication list** that occurred on the same date of service,
  OR
  Provider must bill a code for **transitional care management services**.

CODES TO IDENTIFY MEDICATION REVIEW:			
Service	**Code Type**	**Code**	**Code Description**
Medication Review	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.
Medication Review	CPT	99605	Medication Therapy Management Service(S) Provided By A Pharmacist, Individual, Face-To-Face With Patient, With Assessment And Intervention If Provided; Initial 15 Minutes, New Patient
Medication Review	CPT	99606	Medication Therapy Management Service(S) Provided By A Pharmacist, Individual, Face-To-Face With Patient, With Assessment And Intervention If Provided; Initial 15 Minutes, Established Patient
Medication Review	CPT	90863	Pharmacologic Management, Including Prescription And Review Of Medication, When Performed With Psychotherapy Services (List Separately In Addition To The Code For Primary Procedure)
Medication Review	CPT-CAT-II	1160F	Review Of All Medications By A Prescribing Practitioner Or Clinical Pharmacist (Such As, Prescriptions, Otcs, Herbal Therapies And Supplements) Documented In The Medical Record (COA)

CODES TO IDENTIFY MEDICATION LIST:			
Service	**Code Type**	**Code**	**Code Description**
Medication List	CPT-CAT-II	1159F	Medication list documented in medical record (COA)
Medication List	HCPCS	G8427	Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

CODES TO IDENTIFY TRANSITIONAL CARE:			
Service	**Code Type**	**Code**	**Code Description**
Transitional Care	CPT	99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/ or caregiver within 2 business days of discharge, At least moderate level of medical decision making during the service period, Face-to-face visit, within 14 calendar days of discharge
Transitional Care	CPT	99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge

Colorectal Cancer Screening ($50)

Service Description: Quality bonus payment to a Provider for Members 45 – 75 years of age, who complete a test for colorectal cancer screening following the U.S. Preventive Services Task Force (USPSTF) recommendations and time frames. The colorectal cancer screening can include one of the following:

- Fecal Occult Blood Test (FOBT)
- FIT-DNA Test
- Flexible Sigmoidoscopy
- CT Colonography
- Colonoscopy

The following coding standard must be met to be eligible for an incentive payment for this service:

- The colorectal cancer screening review code can only be submitted after the screening results have been reviewed by the assigned Primary Care Physician participating in the IEHP Direct Stars Incentive Program. Provider can submit code 3017F after the screening results of the colorectal cancer screening have been reviewed and documented in the medical record.
- Effective dates of service: 1/1/2025 – 12/31/2025
- Maximum incentive is one per Member, per year.

COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT-CAT-II	3017F	Colorectal cancer screening results documents and reviewed (PV)

Diabetes Care – Kidney Health Evaluation ($50)

Service Description: Quality bonus payment to a Provider who completes a kidney health evaluation on members ages 18-85 , with a diagnosis of diabetes (type 1 or 2).
Note: Kidney Health Evaluation is defined by completing both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

- One payment per Provider, per Member, per year.
- Effective dates of service: 1/1/2025 – 12/31/2025
- Members must have a diagnosis of diabetes (type 1 or 2).
- **The following must be met to be eligible for an incentive payment for this service:**
  - At least one estimated glomerular filtration rate (eGFR).

    AND
  - 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)
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)

CODES TO IDENTIFY ESTIMATED GLOMERULAR FILTRATION RATE:			
Service	**Code Type**	**Code**	**Code Description**
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 2021)
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 2021)
Estimated Glomerular Filtration Rate	LOINC	102097-3	Glomerular Filtration Rate/1.73 sq M.predicted [volume Rate/area] In Serum, Plasma or Blood by Creatinine, Cystatin C And Urea- based formula (CKiD)

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	icroalbumin [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

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

Flu Vaccine ($25)

Service Description: Quality bonus payment to a Provider for each adult influenza vaccine administered for Members 19 years of age and older.

- One payment per Member, per flu season (January through June and July through December)
- Effective dates of service: 1/1/2025 – 12/31/2025
- One payment per Member per date of service allowed
- Provider must bill the antigen code for the antigen being administered

CODES TO IDENTIFY FLU VACCINE			
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
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

CODES TO IDENTIFY FLU VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
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

HbA1c Control ($50)

Service Description: Quality bonus payment to a Provider for Members 18-75 years of age, who have diabetes, and have a controlled HbA1c (≤9.0%).

- Maximum incentive is one per Member per year
- Effective dates of service: 1/1/2025 – 12/31/2025
- HbA1c testing can be completed by laboratory or point-of-care testing
- Member must have a diagnosis of diabetes
- Provider must bill **two** codes: One code billed for **HbA1c result** and one code billed for **diagnosis of diabetes**.
- Members HbA1c results must be ≤9.0%

CODES TO IDENTIFY HBA1C RESULT:			
Service	**Code Type**	**Code**	**Code Description**
HbA1c Result	CPT-CAT-II	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
HbA1c Result	CPT-CAT-II	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
HbA1c 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% (DM)

Post Discharge Follow-Up ($50)

Service Description: Quality bonus payment to a Provider for Members 18 years of age and older, have been discharged from an acute or nonacute inpatient hospital, and received a follow-up visit with their PCP within seven (7) days of hospital discharge.

To be billed, the office visit must include the following:

- Initial outreach to patient and/or caregiver within two (2) business days of discharge.
- Face-to-face visit within seven (7) calendar days of discharge.
- Visit must include a comprehensive medication reconciliation (reconcile inpatient and outpatient medications).

The following coding standard must be met to be eligible for an incentive payment for this service:

- Maximum incentive is two (2) per Member per year. Each hospital discharge must be at least 30 days apart.
- Effective dates of service: 1/1/2025 – 12/31/2025

POST DISCHARGE FOLLOW-UP OFFICE VISIT:			
Service	**Code Type**	**Code**	**Code Description**
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 2 business days of discharge, High level of medical decision making during the service period, Face-to-face visit, within 7 calendar days of discharge.

Statin Initiation for Diabetes or Cardiovascular Disease ($45*)

Service Description: Quality bonus payment to a Provider who prescribes a statin medication, and prescription dispensed**, for Members who have diabetes or cardiovascular disease.

- Maximum incentive is one per Provider, per Member qualified dispensed medication, per condition.
- Effective dates of prescription filled: 7/1/25 – 12/31/2025
- Member must have not received a statin within the prior measurement year (2024) to effective fill period.
- *Payment for this service will be distributed April 2026

TABLE 1. FILL CONVERSION – QUALIFYING MEDICATION LIST:	
Condition	**Qualifying Medications**
Cholesterol Medications in Cardiovascular Patients	atorvastatin 40-80 mg, amlodipine-atorvastatin 40-80 mg, rosuvastatin 20-40 mg, simvastatin 80 mg, ezetimibe-simvastatin 80 mg, atorvastatin 10-20 mg, amlodipine-atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, ezetimibe-simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin 40-80 mg, pitavastatin 1-4 mg Active ingredients are limited to oral formulations only.
Cholesterol Medications in Diabetics	atorvastatin (+/- amlodipine, ezetimibe), fluvastatin, lovastatin (+/- niacin), pitavastatin, pravastatin, rosuvastatin (+/- ezetimibe), simvastatin (+/- ezetimibe, niacin) Active ingredients are limited to oral formulations only. All strengths of the medications qualify.

**NOTE: FQHC, RHC and IHF Provider Clinics are eligible for the Statin Initiation for Diabetes or Cardiovascular Disease Quality Bonus Service. IEHP will pay qualified FQHC, RHC and IHF Providers, $45 incentive per eligible prescription, for Provider Clinics that reach the 80% compliance target rate for the incentive service, by December 31, 2025.*

***Member prescriptions must be dispensed from an IEHP Network Pharmacy: Riverside County, San Bernardino County*

3 Month Supply Prescription Conversion ($45*)

Service Description: Quality bonus payment to a Provider who successfully converts a 30-60 day medication supply to 100-day medication supply, for Members stable[1] on diabetic, hypertension or cholesterol medications.**

- Maximum incentive is one per Provider, per Member qualified dispensed medication, per condition.
- Effective dates of prescription filled: 7/1/25 – 12/31/2025
- *Payment for this service will be distributed April 2026

[1]Stable: meets Pharmacy Quality Alliance (PQA) requirements. Enrolled beneficiaries 18 years and older with at least two fills of diabetes, hypertension or cholesterol medication(s) on unique dates of service during the measurement period.

TABLE 2. FILL CONVERSION – QUALIFYING MEDICATION LIST:

Condition	Qualifying Medications***
Hypertension Medications	aliskiren (+/- hydrochlorothiazide), azilsartan (+/- chlorthalidone), candesartan (+/- hydrochlorothiazide), eprosartan (+/- hydrochlorothiazide), irbesartan (+/- hydrochlorothiazide), losartan (+/- hydrochlorothiazide), olmesartan (+/- amlodipine, hydrochlorothiazide), telmisartan (+/- amlodipine, hydrochlorothiazide), valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol[c]), benazepril (+/- amlodipine, hydrochlorothiazide), captopril (+/- hydrochlorothiazide), enalapril (+/- hydrochlorothiazide), fosinopril (+/- hydrochlorothiazide), lisinopril (+/- hydrochlorothiazide), moexipril (+/- hydrochlorothiazide), perindopril (+/- amlodipine), quinapril (+/- hydrochlorothiazide), ramipril, trandolapril (+/- verapamil), sacubitril/valsartan Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products. [c] There are no active NDCs for valsartan/nebivolol.
Diabetes Medications	metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin), chlorpropamide[b], glimepiride (+/- pioglitazone, rosiglitazone[b]), glipizide (+/- metformin), glyburide (+/- metformin), tolazamide, tolbutamide[b], pioglitazone (+/- alogliptin, glimepiride, metformin), rosiglitazone (+/- glimepiride[c], metformin), alogliptin (+/- metformin, pioglitazone), linagliptin (+/- empagliflozin, metformin), saxagliptin (+/-dapagliflozin, metformin), sitagliptin (+/- ertugliflozin, metformin), albiglutide[d], dulaglutide, exenatide, liraglutide, lixisenatide, semaglutide, tirzepaide, nateglinide, repaglinide (+/-metformin), bexagliflozin, canagliflozin (+/- metformin), ertugliflozin (+/- metformin, sitagliptin), dapagliflozin (+/- metformin, saxagliptin), empagliflozin (+/- linagliptin, metformin) Active ingredients are limited to oral formulations only. Excludes products indicated for weight loss. Excludes nutritional supplement/dietary management combination products. [b] There are no active NDCs for chlorpropamide, glimepiride/rosiglitazone, or tolbutamide. [c] There are no active NDCs for rosiglitazone/glimepiride. [d] No active NDCs for albiglutide.

TABLE 2. FILL CONVERSION – QUALIFYING MEDICATION LIST:	
Condition	**Qualifying Medications*** **
Cholesterol Medications	atorvastatin (+/- amlodipine, ezetimibe), fluvastatin, lovastatin (+/- niacin), pitavastatin, pravastatin, rosuvastatin (+/- ezetimibe), simvastatin (+/- ezetimibe, niacin) Active ingredients are limited to oral formulations only.

**NOTE: FQHC, RHC and IHF Provider Clinics are eligible for the 3 Month Supply Prescription Conversion (100 Day) Quality Bonus Service. IEHP will pay qualified FQHC, RHC and IHF Providers, $45 incentive per eligible prescription, for Provider Clinics that reach the 80% compliance target rate for the incentive service, by December 31, 2025.*

***Member prescriptions must be dispensed from an IEHP Network Pharmacy: Riverside County, San Bernardino County*

****All strengths of the medications qualify.*

APPENDIX 5: Provider Quality Resource

This Provider Quality Resource is designed for IEHP Providers and their staff to assist in delivering high quality health care to their members. The goal is to provide IEHP Providers and their practice staff with various online resources that will help enhance their quality care in the following focus areas: Adult Immunizations, Adult Preventive Health, Cardiovascular Disease Management, Diabetes Management, and Patient Experience.

Our goal is to provide IEHP Providers and their practice staff with a comprehensive resource for enhancing quality in the discussed healthcare topics. Collaboration between IEHP and Providers has the potential to boost IEHP's quality rating, maximizing available funds for Provider incentive programs.

To request materials for your practice, please contact the IEHP Provider Call Center at **(909)890-2054, (866) 223-4347** or email **ProviderServices@iehp.org**.

We are dedicated to supporting our Providers and working together to improve the quality of care for our community. Together, we can "heal and inspire the human spirit." Thank you for all you do to provide quality health care to IEHP Members.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Adult Immunizations	Member	Adult Immunization Brochure	Brochure educating on vaccines recommended for adults, their importance and how they work.
Adult Immunizations	Provider	CAIR2 Resource Guide	FAQs for IEHP Providers regarding CAIR2 information such as account set-up, troubleshooting, functionality, contacts, and more.
Adult Immunizations	Provider	Recommended Immunization Schedule	CDC Adult Immunization Schedule
Adult Immunizations	Member	Should you get the flu shot?	Shared decision-making guide to help Members choose whether or not to receive a flu vaccine.
Adult Immunizations	Provider	Vaccinate with Confidence	Centers for Disease Control and Prevention strategic framework to strengthen vaccine confidence and prevent outbreaks in the United States.
Adult Immunizations	Provider	Vaccine Hesitancy Among Pregnant People	Center for Disease Control and Prevention report on common themes impact vaccine confidence and ways to address/improve vaccine confidence in pregnant people.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Adult Immunizations	Member	Vaccine Information Statements (VISs)	CDC Vaccine Information Statements (VIS's) for current recommended vaccines available for children, adolescents and adults.
Adult Preventive Health	Member	BMI Calculator	Centers for Disease Control and Prevention (CDC) Body Mass Index Calculator
Adult Preventive Health	Member	Cancer Screening Resources	IEHP Cancer Screening information and resources.
Adult Preventive Health	Provider	Clinical Practice Guidelines	The tools provided on this page are meant to be used as resources to assist primary care providers in delivering care in accordance with IEHP standards.
Adult Preventive Health	Member	Community Wellness Centers	Community Wellness Centers are places where you can take free exercise classes and/or health workshops.
Adult Preventive Health	Provider	Facility Site Review (FSR) Training	Multiple Facility Site Review and Medical Record Review resources for Providers, including DHCS standards and tools, plus IEHP's addendum tools.
Adult Preventive Health	Member	Health Screenings Guide	IEHP Health Screening Guide provides information on all of the covered health screenings needed by Members at all stages of life.
Adult Preventive Health	Member	Healthy Living My Best Self	An educational guide for Members on getting to and maintaining a healthy weight.
Adult Preventive Health	Provider	Initial Health Appointment (IHA) Roster Information	The Department of Health Care Services (DHCS) requires that all newly enrolled Medi-Cal Members must receive an Initial Health Appointment (IHA).
Adult Preventive Health	Member	Interactive Self-Management Tools	Online interactive modules on various health topics such as Healthy Weight, Healthy Eating, and Physical Activity available on the IEHP Member Portal.
Adult Preventive Health	Provider	Osteoporosis or Low Bone Mass in Older Adults	NCHS Data Brief from the Centers for Disease Control and Prevention (CDC).
Adult Preventive Health	Member	Pap and HPV tests: What to Expect	Handout explaining the Pap test and the HPV (human papillomavirus) test. In English and Spanish.
Adult Preventive Health	Member	RadNet Online Appointments (myradiologyconnectportal.com)	Online scheduling service to schedule a mammogram through RadNet locations.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Adult Preventive Health	Member	The Wisdom Study	"The WISDOM Study (Women Informed to Screen, Depending on Measures of risk) is helping to end confusion about mammograms. Medical researchers from University of California need study volunteers, specifically women ages 40 to 74 years old who have not had breast cancer or DCIS (ductal carcinoma in situ). Study participants will: - Find out about their risk for breast cancer - Get clarification on screening guidelines for them, their sister, daughter, and future generations - Participate mostly from home (No extra medical visits required) - Help medical researchers discover the best guidelines for mammogram"
Cardiovascular Disease Management	Provider	AAFPHypertensionGuideline.pdf	Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP.
Cardiovascular Disease Management	Provider	AHA High Blood Pressure Toolkit (ascendeventmedia.com)	Hypertension Guideline Toolkit from the American Heart Association.
Cardiovascular Disease Management	Member	Blood Pressure Brochure	A Member brochure focusing on high blood pressure management.
Cardiovascular Disease Management	Member	Blood Pressure Fact Sheets | American Heart Association	Fact Sheets on blood pressure from the American Heart Association.
Cardiovascular Disease Management	Provider	Blood Pressure Targets in Adults with Hypertension	GuidelineCentral®
Cardiovascular Disease Management	Provider	Home Blood Pressure Monitor Coverage FAQs	Provider Communication from February 24, 2025, explaining how Providers can order home digital blood pressure monitors for use at home.
Cardiovascular Disease Management, Diabetes Management, and Adult Preventive Health	Member	Healthy Heart	An educational guide for Members on understanding cardiovascular event risk and heart health.
Diabetes Management	Provider	"Prescription" for Diabetes Prevention Program	Information about the Diabetes Prevention Program to hand to patients so that they can self-refer.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Diabetes Management	Provider	ASCVD Risk Calculator: 10-Year Risk of First Cardiovascular Event Using Pooled Cohort Equations - ClinCalc.com	The 2019 ACC/AHA guidelines recommend either a high-intensity or moderate-intensity statin regimen in patients who have an elevated ASCVD risk (≥ 5-7.5%) for primary prevention of cardiovascular disease. Use this calculator to determine cardiovascular disease risk and recommendations for statin intensity.
Diabetes Management	Provider	Community Support: Improved Referral Submission Process	Instructions for referring eligible Members to Community Supports for Medically-Supportive Food or Medically Tailored Meals within the Provider Portal
Diabetes Management	Member	Diabetes Prevention Program (DPP) - Live the Life You Love	Information about the online year-long lifestyle change program which pairs participants with a health coach to help set up and track health goals. Studies have shown that those who finish the program can lose weight and prevent Type 2 Diabetes.
Diabetes Management	Provider	Diabetes Standards of Care 2025	GuidelineCentral®
Diabetes Management	Member	Diabetes: What's Next?	Brochure on how to lead a healthy life for those diagnosed with diabetes. Available in English and Spanish.
Diabetes Management	Provider	HCPCS Coding Options for ECM and Community Supports	Coding to use to refer eligible Members to Community Supports for Medically-Supportive Food or Medically Tailored Meals.
Diabetes Management	Member	IEHP - Community Resources : Community Resource Centers :	IEHP Members can enroll in the Diabetes Self-Management workshop and Healthy Living classes at the Community Resource Centers.
Diabetes Management	Member	Staying Healthy With Diabetes	Booklet to help Members with diabetes self-management.
Diabetes Management	Provider	Transformation of Medi-Cal: Community Supports	Fact Sheet on Community Supports including Medically-Supportive Food/ Medically Tailored Meals. With a Provider referral, eligible Members with diabetes can receive deliveries of nutritious, prepared meals and healthy groceries to support their health needs. Members also receive vouchers for healthy food and/or nutrition education.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Diabetes Management and Adult Preventive Health	Provider	Comprehensive Medication Management Program	IEHP offers Medication Therapy Management to eligible Members. Services include medication therapy reviews, medication education, and disease management—including diabetes.
Diabetes Management and Cardiovascular Disease Management	Member	BMI Calculator	Centers for Disease Control and Prevention (CDC) Body Mass Index Calculator.
Diabetes Management and Cardiovascular Disease Management	Provider	Clinical Practice Guidelines	The tools provided on this page are meant to be used as resources to assist primary care providers in delivering care in accordance with IEHP standards.
Diabetes Management and Cardiovascular Disease Management	Provider	Community Support: Improved Referral Submission Process	Instructions for referring eligible Members to Community Supports for Asthma Remediation Services and Medically-Supportive Food or Medically Tailored Meals within the Provider Portal.
Diabetes Management and Cardiovascular Disease Management	Member	Community Wellness Centers	Community Wellness Centers are places where you can take free exercise classes and/or health workshops.
Diabetes Management and Cardiovascular Disease Management	Provider	Comprehensive Medication Management Program	IEHP offers Medication Therapy Management to eligible Members. Services include medication therapy reviews, medication education, and disease management—including diabetes.
Diabetes Management and Cardiovascular Disease Management	Provider	HCPCS Coding Options for ECM and Community Supports	Coding to use to refer eligible Members to Community Supports for Asthma Remediation, Medically-Supportive Food or Medically Tailored Meals.
Diabetes Management and Cardiovascular Disease Management	Member	Healthy Heart	An educational guide for Members on understanding cardiovascular event risk and heart health.
Diabetes Management and Cardiovascular Disease Management	Member	Healthy Living My Best Self	An educational guide for Members on getting to and maintaining a healthy weight.
Diabetes Management and Cardiovascular Disease Management	Provider	IEHP Academic Detailing	Information about academic detailing offered to Providers.

PROVIDER QUALITY RESOURCE:			
Focus Area	**Type**	**Resource***	**Description**
Diabetes Management and Cardiovascular Disease Management	Provider	IEHP Formulary	The IEHP Formulary is a continually updated list of Medication products designed to reflect the most appropriate, high quality and cost-effective medication therapies for all lines of buisiness.
Diabetes Management and Cardiovascular Disease Management	Provider	Journal of the American Geriatrics Society article	Beers Criteria for potentially inappropriate medication use in older adults.
Diabetes Management and Cardiovascular Disease Management	Provider	Member referral for free health education classes	Description of how to refer an IEHP member to health education classes.
Diabetes Management and Cardiovascular Disease Management	Provider	Pharmacy Mail Order Benefit for IEHP DualChoice (HMO D-SNP) & IEHP Covered (CCA) Members	Mail order prescriptions may be submitted to the mail order pharmacy electronically, or by fax so the Member can receive up to a 100-day supply of their maintenance medications per delivery.
Diabetes Management and Cardiovascular Disease Management	Provider	SortPak Pharmacy	Mail order prescriptions may be submitted to the mail order pharmacy electronically, or by fax so the Member can receive up to a 100-day supply of their maintenance medications per delivery.
Patient Experience	Member	24-Hour Nurse Advice Line	24-hour nurse advice offered by IEHP.
Patient Experience	Member	ER vs. Urgent Care Clinic	A guide for Members on when to visit the Emergency Room versus an Urgent Care Clinic.
Patient Experience	Member	IEHP - Care Options : How to Get Care	Information on ways to get care, including primary care, specialty care, and medications.
Patient Experience	Provider	Serve Well Customer Service Toolkit	A Provider toolkit on how to provide outstanding customer service to Members.
Patient Experience	Member	Urgent Care Clinics	A directory search tool of all Urgent Care Clinics within the IEHP network.

*The referenced electronic links provided in this resource are informational only. They are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by Practitioners, considering each Member's needs on an individual basis. Best practice guideline recommendations and assessment tools apply to populations of patients. Clinical judgment is necessary to appropriately assess and treat each individual Member.

NOTES

IEHP

DualChoice

iehp.org

PROVIDER RELATIONS TEAM

(909) 890-2054

Monday-Friday, 8am-5pm

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