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Your Guide to Success

QUALITY MANAGEMENT, HEDIS® AND PERFORMANCE IMPROVEMENT

PROVIDER COMMUNICATIONS

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Guide to HEDIS and Managed Care Accountability Set

UPDATED TO REFLECT NCQA HEDIS 2020 AND 2021 TECHNICAL SPECIFICATIONS

We want to help you make sure your patients get the care they need to stay healthy longer. This guide helps you better understand what quality management, HEDIS[1] and performance improvements are. Additionally, it shows you the steps you can take to make sure your patients get needed preventive tests and services.

[1]https://store.ncqa.org/index.php/performance-measurement.html

Quality Management

What is quality management?

Quality management in health care works to improve patient care and reduces substandard patient outcomes. Health care quality is measurable and we use HEDIS to help us do this. It focuses on clinic procedures and processes, assessing the effectiveness of the interactions between the clinic and provider with the patient. Quality focuses on impacting the quality of health care directly.

What is performance improvement?

Performance improvement in health care involves setting goals, making system changes, measuring outcomes and making improvements. It focuses on improving performance by changing how we do things administratively. We can look into future changes and look at how we did things in the past to best improve how we can do things better.

What is continuous quality improvement?

Continuous ongoing quality improvement is a formal and planned approach to use the information and knowledge we gain from monitoring quality measures, like HEDIS, to improve the care we provide to our patients and their health outcomes. We do this by analyzing HEDIS data and patient surveys each year.

HEDIS explained

The National Committee for Quality Assurance (NCQA) measures our clinical quality performance using the Healthcare Effectiveness Data and Information Set (commonly known as HEDIS).[2]

Different types of care data is collected from various types of providers. The type of data collected varies by source. Claims are the primary source but for some measures, we request medical records to see if the patient had the test or screening done, and we may send them a survey.

Claims are collected all year and into the following year until March. That is why it is important that you submit claims in a timely manner and use the correct codes. Medical records are audited from December to May. A vendor we contract with conducts the survey.

It is important to know what the HEDIS measures are because your office receives a rating score on completion of the tests and screenings. Help keep your providers on track and make sure patients get the preventive care they need.

[2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications were developed by and are owned by NCQA. NCQA holds a copyright in these materials and may rescind or alter these materials at any time. Users of the HEDIS measures and specifications shall not have the right to alter, enhance or otherwise modify the HEDIS measures and specifications, and shall not disassemble, recompile or reverse engineer the HEDIS measures and specifications. Anyone desiring to use or reproduce the materials, subject to licensed user restrictions, without modification for an internal non-commercial purpose may do so without obtaining any approval from NCQA. Use of the Rules for Allowable Adjustments of HEDIS to make permitted adjustments of the materials does not constitute a modification. All other uses, including a commercial use, or any external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA.

The Managed Care Accountability Set (MCAS) defined

MCAS are a set of screenings and tests that the California Department of Health Care Services (DHCS) selects each year for reporting by the health plans.[3] Not all of the tests are HEDIS measures. The Centers for Medicare & Medicaid Services (CMS) select other measures from their core set for reporting.

Each year the state sets a goal called the minimum performance level (MPL) for some measures. The MPL is the minimum score the health plan and the providers must attain. For measurement year 2021, we must reach the **50th percentile for 15 measures.**

Types of data we collect

We collect data from many different sources. Listed below are the most common type of data sources:

- **Claims** – You send this type of bill for service directly to us or to the state. If you are contracted with Health Net directly, you must send the claim to us.
- **Encounter** – You send a claim to the participating physician group (PPG) and they forward a data file with this information to us. We forward the claim received to the state. We call this encounter data. It is conceptually equivalent to the paid claims for fee for service.
- **Standard data** – We collect data files directly from:
  - The immunization registry (CAIR, RIDE, SDIR).
  - Lab vendors (Quest Diagnostics™, LabCorp and others).
  - Electronic medical records (EMR) (Office Ally, NextGen and others).
  - Population health data program (i2i).
- **Non-standard data** – You may submit medical records to us directly using Cozeva, our contracted web-based data platform. If you want to learn more about Cozeva, talk to your provider engagement representative today!

TIP:

- Percentile and percentage are not the same thing. The 50th percentile is not a percentage. It is the median performance attained measured against other health plans.
- Criteria changes by measure type and may include the patient's age, sex, diagnosis, medications prescribed and more.

HEDIS and MCAS lingo

Measurement year: The year that we are collecting data.

Denominator: The total patients at your office that meet the criteria for the measure.

Numerator: All the patients at your office who had the test or screening done.

Rate: Calculated by dividing the numerator by the denominator multiplied by 100.

Exclusion: Patients excluded from getting the test or screening done. NCQA specifies the type of patients who do not need to be included. An example is a woman who had both her breasts removed. She would not need a mammogram.

[3]www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx

TIP:

- Your office could contract with multiple PPGs. Each PPG may have a different way to submit claims. Make sure to follow their procedure and send the encounter or bill of service to the correct PPG.
- Submit claims or encounters for all services given. Code correctly and make sure the medical record notes match all services billed.
- Submit all claim or encounter data timely and accurately within 30 days from the date of service or before.

Billing codes we collect

Each year, NCQA posts a directory of different billing codes they accept. These codes match the services or tests provided to the patient and are used to calculate your HEDIS rate. There are four major category of codes you will primarily use: CPT, CPT II, CVX and ICD-10.

CPT code: This is a service code. Each procedure done at the clinic is given its own unique five digit code that tells us what type of care was provided.

CPT II code: This is a performance tracking code. It tells us what the patient's test or service results are. The use of this code helps reduce requests for medical records during HEDIS chart review. A good example is the CPT II code 3051F. This code tells us that the patient's A1c is equal to 7.0 and less than 8.0.

Vaccine administered (CVX) code: This is a vaccination code that tells us what product was used when a vaccination was given.

ICD-10 code: This is used by providers to classify and code the patient's diagnoses, symptoms, abnormal findings, procedures, complaints, social circumstances, and external causes of injury or diseases.

Federally Qualified Health Centers[4]

Federally Qualified Health Centers (FQHCs) are community-based health care providers that receive funds from the Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

FQHCs may be community health centers, migrant health centers, health care for the homeless and health centers for residents of public housing.

The center must make reasonable effort to secure payment from patients for services rendered while ensuring that no patient is denied services based on inability to pay.

Federal law establishes and tells the FQHC how they get paid. When services are covered by us or the PPG, the FQHC must bill us or the provider group directly. The rate they are paid must be equal or exceed the Medi-Cal reimbursement rate.

Encounter fees generally cover all qualified services provided during a visit. This is different than when a patient sees a physician and the office bills the patient for each service individually. A good example is a face-to-face exam with a physician, screening by a nurse and lab tests that occur in one visit – these would all be paid for by the single encounter fee.

FQHCs must include the correct revenue, procedure code and modifier on the claim to differentiate that payment is covered by the managed care plan (MCP). The Medi-Cal MCP billing revenue code 0521, with procedure code T1015 and SE modifier is required. On the bill you will then choose the correct billing code set that best matches the encounter or service provided.

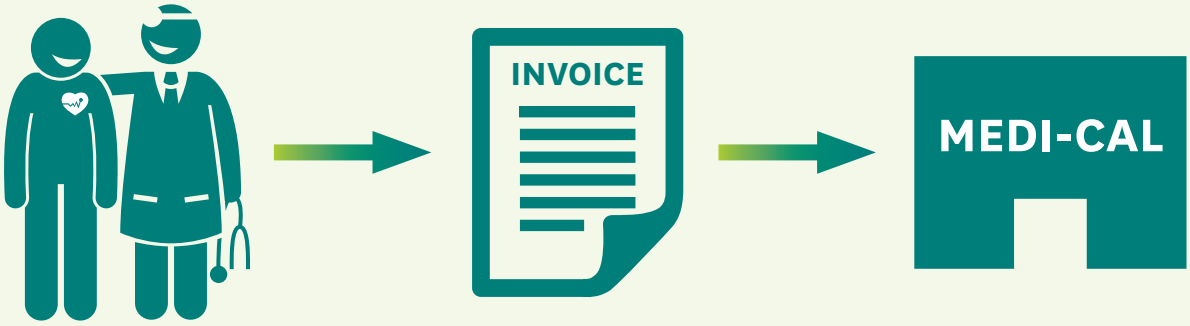
[4]https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/fqhc_2018.pdf

It is important to know that more than one visit with an FQHC practitioner on the same day, or multiple visits with the same FQHC practitioner on the same day, counts as a single visit. Exceptions include when:

- The patient suffers an illness or injury that requires additional diagnosis or treatment on the same day. For example, a patient sees their practitioner in the morning for a medical problem and later in the day falls and has to be seen again by the provider at the FQHC.
- A patient has a medical visit and a mental health visit on the same day, or a medical visit and a dental visit on the same day.

Indian Health Service (IHS) clinics may be reimbursed for up to three visits a day for one recipient as follows: a medical visit, a mental health visit and a Medi-Cal ambulatory/dental visit.

This is an example only. Please adapt to your billing situation.



John Doe visited a Rural Health Clinic (RHC) for evaluation of his recent chest pain. **He is enrolled in a Medi-Cal MCP** and the service is covered under the plan.

The RHC bills the MCP for the encounter and **submits a claim to Medi-Cal for the managed care differential rate**, with revenue code 0521, procedure code with modifier T1015SE and an informational line specific to his visit, which in this case is procedure code 99214.

Telehealth

Telehealth explained

Telehealth is a two-way communication between the provider and patient to improve a patient's health using real-time interactive telecommunication equipment.

THERE ARE TWO MAIN TYPES OF TELEHEALTH SERVICES:

1. **Synchronous telehealth:** These visits are real-time, face-to-face contact between the provider and their patient. Providers use teleconferencing, webcams, smartphones or tablets for communication.

   Example: A provider having a videoconference on Zoom with a patient to talk to them about their diabetes and discuss their blood sugar levels.

2. **Asynchronous telehealth:** These visits are in real-time and the provider exchanges information without video to diagnose and treat; there is no face-to-face interaction. Providers may use cell phones, a patient portal, and secure email or automated text messaging.

Providers that can provide such services are subject to state law. In California, they are:

- Physicians
- Clinical psychologists
- Physician assistants
- Clinical social workers
- Certified registered nurse anesthetists
- Registered dieticians/ nutrition professionals

TELEHEALTH BILLING GUIDELINES

Bill services provided using the correct codes. The table below outlines the coding and billing requirements for provider offices.

For FQHC, RHC, and IHS clinics, a place of service (POS) code is not required.

Description	Provider billing or coding requirement
Alternate terms	· Distant site · Remote site · Provider office that is performing the service
POS code	02 regardless of physician or provider location.
Billing	Bill for the actual service provided (e.g., 99214). The claim submitted must include the appropriate service code and the correct modifier.
Modifiers	02 modifier: Telehealth service code. The location where health services and health-related services are provided or received. (telehealth = telemedicine) 95 modifier: Synchronous telemedicine service via real-time interactive audio and video. GQ modifier: Asynchronous telemedicine service.

Regulations often change. Visit the provider portal at provider.healthnet.com frequently to get detailed and current billing information.

Gap-in-care reports

We give your office a report card to help providers monitor their performance on HEDIS and MCAS measures.

We have two different types of gap-in-care reports: electronic gap-in-care reports and Cozeva. Your office may receive one or both types of reports.

What are electronic gap-in-care reports?

Electronic gap-in-care reports (ECG) are monthly reports sent to you by secure email that identifies your patients with a gap in care. It is an encrypted excel file which needs a password to be opened. If you do not know your password, contact your provider engagement representative for help. The report will give you the numerator, denominator and your current score. Patients who have not received a screening or test have a care gap.

When you receive the ECG report, be sure to compare it to your medical records to determine if a gap exists.

If the gap is open and the patient did not get a test or service, then you should call the patient and schedule an appointment to see the provider.

If the gap is closed, double-check to make sure the claim was submitted correctly. If it was, discuss the variance with your provider engagement representative.

TIP: If your office uses standing orders, you may order labs and radiological services ahead of time. The patient gets the test or screening done before their appointment so the provider can review their results during their visit.

What is Cozeva?

Cozeva is a reporting and data analytics web-based platform that displays HEDIS information. We create an account for your office to track your performance, close gaps in care and estimate potential incentive payouts.

Cozeva allows you to print your own gap-in-care report. You can print patient lists and face sheets, and batch patients prior to their clinic visit.

Your office may submit progress notes or other documentation to close individual care gaps through Cozeva. A representative will review the notes you submit to make sure they are compliant. They may ask for additional information if needed. Once deemed compliant, the gap is closed.

Cozeva provides tech support via live chat or by phone for any questions you may have. **Note:** Cozeva is available only to providers that are not using Interpreta.

Language Assistance Program (LAP)

Interpreter services

We have a Language Assistance Program (LAP) to support members who have limited English proficiency (LEP), are deaf or have hearing impairments. Three kinds of service include:

Phone

- Available 24/7.
- Get an interpreter on the line upon request.
- Over 150 languages.

Face-to-face or in-person interpreters

- Over 125 languages.
- American Sign Language (ASL, PSE or SEE).
- Call 1-800-675-6110 (TTY: 711) to place the interpreter request at least five business days before the appointment.
- If less than five days from the appointment, an in-person interpreter is not guaranteed.

Additional interpreting for services

- Video remote interpreting (spoken languages and ASL) – prescheduled at least two business days before the appointment.
- Tactile interpreters.
- Certified deaf interpreters.
- Real-time captioning (in-person or remote) – prescheduled at least 24 hours before the appointment.

Request free interpreting services

- Request an interpreter as soon as the appointment is made, but not less than five business days before the appointment.
- Use phone interpreter services for same-day appointments or when an in-person interpreter is not available.
- Providers may request interpreter services for Health Net Medi-Cal patients by calling 1-800-675-6110 (TTY: 711), 24 hours a day.

Be sure language services meet standards

We do not delegate the provision of interpreter services to providers. We encourage you to use the interpreters available from us. Providing interpreting services to LEP must meet the following requirements:

- Make sure that interpreters are available at no cost to members at the time of the appointment.
- Make sure that LEP members are not subject to unreasonable delays in the delivery of services, including accessing providers after hours.
- Extend the same program and activity to all members regardless of language preference.
- Provide services to LEP members that are as effective as those provided to non-LEP members.
- Record the member's language needs, request or refusal of interpreter services in the member's medical record.
- Send requests for an alternate format or translation for utilization management (UM) documents to us within 48 hours of request from the member.
- Use qualified bilingual staff or interpreters who have been assessed to communicate with LEP members.
- Provide translated member grievance forms to members upon request.

No cost interpreter services are available

24 hours a day, seven days a week – call **1-800-675-6110 (TTY: 711).**

IHA and SHA form requirements

DHCS requires providers to administer an Initial Health Assessment (IHA) within 120 days upon member enrollment into the health plan.

The IHA may be completed by the physician, a qualified medical specialist or non-physician medical provider, including nurse practitioners, certified nurse wives or physician assistants.

THE IHA INCLUDES AT A MINIMUM:

- Physical, social and mental health history.
- Identification of high risk behaviors.
- Physical examination.
- Assessment of need for preventive screening or services and health education.
- Diagnosis and plan for treatment of any disease.
- Completion of the age-appropriate Staying Healthy Assessment (SHA) form, which is also known as the approved Individual Health Education Behavioral Assessment (IHEBA).

The provider must conduct the IHA in a language the patient or caregiver understands and must make sure that a qualified translator is available.

More details about the SHA

The SHA is a state-approved assessment tool with standardized questions that the patient or their caregiver must answer.

There are several different versions of the assessment tool. Pick the correct one based on the age of the patient. The form must be given to new patients during the IHA and periodically thereafter as the patient enters a new age category.

SHA forms are available in nine different languages, so make sure you select the language that your patient or their caregiver prefers. The forms are downloadable and located on the DHCS website at www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx.

Where to file IHA and SHA forms

After the patient or their caregiver finishes answering the questions, your role is to place the form in the patient's medical record for the provider to review.

After the provider completes their review, make sure the SHA form has the provider's name, their signature and the date clearly written on it. If the patient refuses to complete the form, double check that the provider notes the refusal in the patient's chart.

Best practices and recommendations for IHA requirements

- Schedule appointments and reminders with your patients.
- Use the DHCS approved SHA tool and follow the SHA Periodicity Table.
- Bill the correct codes for the IHA.
- Use the 120-day IHA provider reports to identify new members who need an IHA. This report is generated monthly and can be found online at provider.healthnet.com > *Provider Reports* > *Initial Health Assessment (IHA)* under *Available Reports*.
- If an established patient has changed plans, conduct an IHA with the SHA and perform an updated physical exam.
- Administer the SHA when members enter a new age group. Refer to the SHA questionnaire for age appropriate forms available at www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx.

The adult and senior SHA must be re-administered every three to five years at a minimum, and should be reviewed annually.

- Follow up with identified high-risk behaviors and needed care.
- Review patient records to fill care gaps before the appointment with patient.
- To request approval to use an electronic version of the SHA or an alternate tool, contact the Health Education Department at 1-800-804-6074 (TTY: 711).

The benefits of using the IHA and SHA forms are that they will allow the provider to quickly document HEDIS-related services.

Required documentation

DOCUMENTATION MUST INCLUDE:

- All elements of the IHA were completed within 12 months prior to the effective date of enrollment.
- Providers of an established patient can add existing physical and mental health history to the IHA, but must conduct an updated physical exam if one was not completed within the last 12 months.
- Member refuses an IHA.
- Evidence of:
  - Two call attempts and one written attempt to reach member,
  - Provider attempts to update member's contact information, and
  - Provider attempts to perform the IHA past the 120 day requirement until the IHA is completed.

Exceptions to the above must be documented in the patient's medical record, including all contacts, outreach attempts, appointment scheduling or the member's refusal to schedule an appointment.

Evidence of timely and accurate completion of IHA and SHA is determined during our facility site review and medical record review periodic audits.

More services that can be completed during patient visits

The following HEDIS-related services may be ordered or completed during the patient visit.

Children and adolescent

- Pediatric and adolescent well-care visit
- Anticipatory guidance
- Immunizations for children and adolescents
- Lead screening for children ages 2 and under
- Height, weight and body mass index (BMI) percentile
- Nutrition and physical activity assessment

Women's health

- Breast cancer screening/ mammogram
- Prenatal and postpartum care
- Pap test and HPV test
- Chlamydia screening

Chronic conditions

- Diabetes A1c testing
- Urine testing for creatinine/albumin
- Glomerular filtration rate
- Diabetic eye exam
- Blood pressure monitoring

Behavioral health

- Metabolic monitoring for children
  - Blood glucose screening
  - Cholesterol screening
- Diabetes screening for patients with schizophrenia or bipolar disorder
  - A1c test
  - Blood glucose test

We can use the SHA to close gaps in care for patients ages 3–17 for Weight Assessment and Counseling for nutrition and physical activity (WCC), nutrition counseling and physical activity counseling.

EXAMPLE 1: SHA HEDIS-COMPLIANT DOCUMENTATION AT 7–12 MONTHS[5]

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ Patient Declined the SHA
PCP Signature:		Print Name:			Date:

The **Clinic Use Only section** indicates what topics the provider discussed with the patient or caregiver and what type of assistance was provided to the patient. For it to be acceptable, **complete the following sections** for HEDIS documentation: **Counseled, Referred, Anticipatory Guidance and Follow-up Ordered.**

[5]www dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

Telehealth for IHA visits

Providers may perform IHA visits or well-care visits via telehealth; however, some components of the visit (i.e., the physical examination) cannot be conducted. This should be explained to the parents that some parts of the physical exam and/or examination must be completed in person when safe to do so.

When billing the telehealth well-care/preventive visit, the provider may only bill one time. When the patient is seen in-person, there may be no encounter/claim submitted if seen previously via telehealth.

Training

All primary care providers must take an online SHA training. We recommend that office staff take it, too. A universal training is posted on the DHCS website at www.dhcs.ca.gov/formsandpubs/forms/Documents/MMCD_SHA/GenDocs/SHA_UniversalProviderTraining.ppsx.

For more information about IHA or SHA forms or processes, please contact the Health Education Department at 1-800-804-6074 (TTY: 711).

Child and adolescent measures

Measure	Age range	Items needed	Tips and best practices
Well-Child Visits in the First 30 Months of Life (W30)	0–30 months	There are two unique measurements: 1. Six or more visits during the child's first 15 months of life. 2.Two or more visits for children between the ages of 15 months and 30 months. **Must include:** • Health history • Physical developmental history • Mental developmental history • A physical exam • Health education/anticipatory guidance Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).	This measure was previously called W15, or Well-Child Visits in the First 15 Months of Life. It is preferred that the visit be conducted in person; however, some aspects of the visit may be conducted via telehealth using audio and visual communications. Some elements must be conducted in the clinic, such as physical exam, hearing and vision testing, immunizations, and others. If the visit was completed by telehealth you may only bill for one encounter. You cannot bill for components not completed during the telehealth visit when the patient is seen later at the clinic.[6]
Childhood Immunization Status	Ages 0–2	4 DTaP 3 polio (IPV) 1 measles, mumps and rubella (MMR) 3 H influenza type B (HiB) 3 hepatitis B (HepB) 1 chicken pox (VZV) 4 pneumococcal (PCV) 1 hepatitis A (HepA) 2 or 3 rotavirus (RV) 2 influenza vaccines (flu) The Centers for Disease Control and Prevention (CDC) have a great, easy-to-read immunization schedule at www.cdc.gov/vaccines/schedules/easy-to-read/child-easyread.html.	Schedule a well-care visit at the same time as the shots. **Note:** All childhood immunizations must be completed by age 2. The LAIV (live-attenuated influenza vaccine), or nasal spray, must occur on or after the child's 2nd birthday.
Blood Lead Screening	Before they turn age 2	One or more blood lead tests before their 2nd birthday	Complete the lab test during the well-child or vaccination visit.
Metabolic Monitoring for Children and Adolescents on Antipsychotics	1–17 years	Lab tests needed for children or teens who are on two or more antipsychotic drugs are: • Blood glucose or A1c test • Cholesterol or LDL-C test • And both blood glucose and cholesterol	Draw the lab during the onsite visit, or have the patient complete testing at a lab nearby. Phone the patient or parent to ensure testing is completed.

[6]DHCS Well-Child Visits during Coronavirus (COVID-19) Pandemic letter, April 24, 2020

Child and adolescent measures (continued)

Measure	Age range	Items needed	Tips and best practices
Child and Adolescent Well-Care Visit (WCV)	Ages 3–21	A wellness exam **one time each year.** **Must include:** • Health history • Physical developmental history • Mental developmental history • A physical exam • Health education/anticipatory guidance	This measure is a combination of the last year's W34, Well-Child Visits in the 3rd, 4th, 5th, and 6th years of life, and AWC, the Adolescent Well-Child Visit. NCQA added the ages of 7–11 to the population. Telehealth visits count toward the measure! Call your patient to schedule an audio and visual visit today. *Remember:* Not all aspects of the well-child visit may be conducted via telehealth. Make sure to schedule your patient for a clinic visit to complete the components that require the provider to see the patient. Check the chart to see if the child is due for their annual wellness visit. Remind the provider to complete if they come in for a sick visit, for follow-up care or an injury, or if they come for a sports physical. We capture codes through encounters and claims received to close gaps in care. Make sure all visits are accurately billed.
Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity	Ages 3–17	An assessment completed **at least one time each year.** • Get your patient's height, weight and a BMI percentile. • Counseling for nutrition. • Counseling for physical therapy. Can complete during ANY visit in the measurement year. Make sure to code BMI percentile, nutrition and physical therapy counseling correctly. Refer to the Office Manager Quick Reference attached.	Telehealth, e-visits, and virtual check-ins count! Ask the parent, caregiver, or patient if they have a scale at home, and can calculate their height. Provide instruction on "How to." For example: stand the child against the wall and mark his/her height with a pencil. Measure from the marking to the floor with a measuring tape or ruler. Record the patient's height and weight taken that day, as stated by the patient or their parent. Calculate the BMI percentile using the information they provide. Make sure to document the height, weight, and BMI percentile in the medical record and/or document it in a growth chart.
Immunizations for Adolescents	Ages 9–13	The child must have the following shots: • One meningococcal vaccine between their 11th and 13th birthdays. • One tetanus, diphtheria and acellular pertussis (Tdap) between their 10th and 13th birthdays. • At least two HPV vaccines between their 9th and 13th birthdays, 146 days apart. **OR** • At least three HPV vaccines between their 9th and 13th birthdays. Refer to the CDC Immunization Table ages 0–18, Example 5.	Schedule to give during their annual wellness visits! Send reminder postcards and call a day before their scheduled visit. Additional HPV vaccinations must be administered by age 13.

Child and adolescent measures (continued)

Measure (cont.)	Age range	Items needed	Tips and best practices
Chlamydia screening	Ages 16–24	A urine test for chlamydia done **one time a year.** • Send the urine sample to the lab for testing. • Do testing onsite if you are able.	Obtain a urine sample from the teen female patient during the provider's visit. You can collect the urine sample during any visit, including a sick visit or annual wellness check. The provider may conduct a telehealth assessment for sexual history and current sexual practice. Once completed, the provider may order lab testing. The patient should come to the clinic to give a urine sample or go to the nearest lab.

EXAMPLE 2: BMI PERCENTILE[7]

How to determine BMI percentiles for children and teens

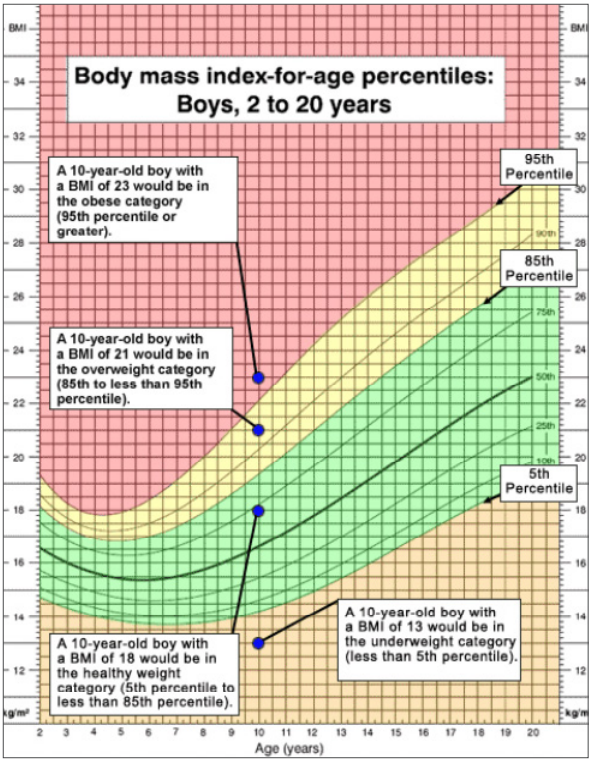
BMI: Calculate BMI by dividing an individual's weight in kilograms by the square of their height in meters or by dividing their weight in pounds by the square of their height in inches.

BMI for children and teens: We use BMI as a screening tool to identify possible weight problems for children.

For children and teens, BMI is age- and gender-specific or BMI-for-age.
BMI is calculated and expressed as a percentile which can be obtained from either a graph or a percentile calculator. These percentiles express a child's BMI relative to other children of the same gender and age.

Adapted from the CDC website, September 2015

EXAMPLE 3: BMI PERCENTILE DOCUMENTED BODY MASS INDEX[8]



[7]www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

[8]www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

EXAMPLE 4: CDC IMMUNIZATION TABLE AGES 0–18[9]

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	2nd dose			◄---------- 3rd dose ----------►												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			◄--- 4th dose ---►				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		◄-- 3rd or 4th dose, See Notes --►										
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		◄--- 4th dose ---►										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	◄---------- 3rd dose ----------►							4th dose					
Influenza (IIV)					Annual vaccination 1 or 2 doses								or	Annual vaccination 1 dose only			
or																	
Influenza (LAIV)											Annual vaccination 1 or 2 doses			Annual vaccination 1 dose only			
Measles, mumps, rubella (MMR)					See Notes		◄--- 1st dose ---►					2nd dose					
Varicella (VAR)							◄--- 1st dose ---►					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														Tdap			
Human papillomavirus (HPV)														See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos)			See Notes											1st dose		2nd dose	
Meningococcal B														See Notes			
Pneumococcal polysaccharide (PPSV23)											See Notes						

Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Recommended based on shared clinical decision-making or *can be used in this age group

No recommendation/ not applicable

[9]www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

Women's health measures

Measure	Age range	Items needed	Tips and best practices
Breast Cancer Screening	Ages 50–74	A mammogram screening done every two years. • Use a reminder system for checkups and screenings. • Call the patient to see if they completed the test. • Obtain the results and place in the medical record.	Before the patient leaves the office, schedule them for screening at an authorized mammogram imaging center near their home or place of work. Schedule a telehealth visit with the patient. The provider can talk to them about the risks and benefits of being screened now, dependent on their family history and other factors. He can also discuss the final test results with them. For patient transport, reserve pick up and drop off by calling ModivCare: 1-855-253-6863 (TTY: 711).
Cervical Cancer Screening	Ages 21–64	Three screening types are accepted: 1. Women ages 21–64 who had Pap test every three years (2018–2021). 2. Women ages 30–64 who had a Pap test and HPV test *on the same date of service* within the last five years (2016–2021). 3. Women ages 30–64 who had cervical HPV test within the last five years (2016–2021). The Pap test and/or HPV note in the medical record must include the date, type of test, and the lab results. If the Pap screening results read the specimen is inadequate or no cervical cells are present, the patient must come back to the clinic for another Pap screening. An HPV test done after the Pap test results come back do not count. This is called reflex testing. The Pap test and HPV test must be completed four or less days apart.	Call your patient at least 24–48 hours before the scheduled appointment to confirm they are coming. If they are a no-show, call them that day to reschedule. Make the appointment sooner than later to deter them from canceling again. Schedule a telehealth visit between the patient and their provider to talk about the risks and benefits of being screened now, based on family history or other factors. The provider can determine need based upon their discussion. Once completed, schedule the screening to be completed before or after the woman gets their menses.
Chlamydia Screening	Ages 16–24	A urine test for Chlamydia done a minimum of **one time a year.** • Send the urine sample to the lab for testing. • Do testing onsite if you are able.	Obtain a urine sample from the female patient during the visit. You can collect the urine sample during any visit, including a sick visit or annual wellness check. You can screen more than one time a year. The provider may conduct a telehealth assessment for sexual history and current sexual practice. Once completed, the provider can determine if lab testing is clinically indicated.

Women's health measures (continued)

Measure (cont.)	Age range	Items needed	Tips and best practices
Prenatal Care	In the first trimester on or before enrollment, or within 42 days of enrollment	The visit with the provider must happen in the first trimester or within 42 days after they join the health plan. The patient visit may be with a primary care provider or an obstetrician. Schedule the patient as early as possible if they think they are pregnant. Set aside enough time for the first visit for the provider to complete a thorough exam and to answer any question or concerns.	Phone visits, e-visits and virtual check-ins may be used to close gaps in care. If doing a telehealth visit, advise the mom-to-be to purchase a blood pressure (BP) cuff for use at home and to monitor the baby's movements. Consider BP and fetal monitoring devices if using telehealth for prenatal care. Recommend virtual prenatal classes and birthing classes. For a visit with a primary care provider, make sure that the diagnosis of pregnancy and the test results are in the chart.
Postpartum Care	On or between 7 and 84 days after delivery	The new mother should have a visit with the provider to see how she is recovering from a vaginal delivery or cesarean section. This is an important time for the mother and baby. The provider can discuss: • Contraception and birth spacing. • Infant care and how to feed the baby. • How the new mom is sleeping and any issues related to fatigue. She will have body changes. The provider can check her mood and see how she is adjusting to life with a new baby.	Phone visits, e-visits and virtual check-ins may be used to close gaps in care. May complete postpartum checks for depression screening and reproductive counseling by telehealth. Educate the mom and reinforce social distancing, handwashing and avoiding all travel. Educate pregnant women before birth how important the postpartum care visit is for her and her baby. It is a good time to screen for postpartum depression. Phone the new mom to congratulate her and schedule the postpartum visit at this time. You may also send a greeting card with a postpartum care reminder with the provider's name, phone number and/or telehealth link.

Chronic conditions measures

Measure	Age range	Items needed	Tips and best practices
Controlling Blood Pressure (CBP)	Ages 18–85	A diagnosis of hypertension documented in the problem list with a plan of care to control it. Document the patient's blood pressure in the medical record. *Remember:* The goal is to have the patient's BP controlled, which means 139/89 or less by the end of the year. Before taking the blood pressure, ask if they have taken their medication that day. Document in medical record if the patient has or has not taken their medication as prescribed. Make sure to position the patient correctly. Per the American Heart Association, make sure: 1. The patient is sitting in a chair with their back supported and feet flat on the floor. *Note: The patient should not be sitting on the exam table with their feet dangling.* 2. The patient sits quietly for at least five minutes without talking or interacting with anyone. 3. You have the right cuff size. If the person is above or below a normal height and weight, then change the cuff to match their body type. • Arm circumference 22 to 26 cm: Small adult cuff, 12 x 22 cm • Arm circumference 27 to 34 cm: Adult cuff, 16 x 30 cm • Arm circumference 35 to 44 cm: Large adult cuff, 16 x 36 cm • Arm circumference 45 to 52 cm: Adult thigh cuff, 16 x 42 cm 4. Their arm is relaxed, uncovered (not under a shirt or sweater) and supported at heart level. When billing, use the correct systolic and diastolic blood pressure reading CPT II codes found in the Office Manager Quick Reference.	Take the BP at the beginning of the visit before they see the provider and again at the end of the visit. Make sure to document both BP readings in the chart. Doing this gives a more accurate average reading. Consider switching arms. The blood pressure reading may be lower on the other arm. Record the actual number. Do not round up! Schedule their appointments around the same time of the day. BP can fluctuate during different times. Only the part of the arm where you fasten the BP cuff needs to be at heart level – not the entire arm. If the BP is high, report this to the provider and follow clinic protocol. If the BP continues to be high, ask the provider if it is safe to send the patient home. The patient's medication may need adjustment. Remind the provider that the health plan has a case management and pharmacist team that can monitor the patient's BP remotely and help to adjust their medication.
		Telehealth The patient may report their BP during a telehealth visit. You may request they take their blood pressure at the beginning and end of the visit if it is high. BP cuffs are a Medi-Cal covered benefit. Educate and assist your patient to obtain a digital BP machine to use at home. They will need to be educated on cuff size, positioning and the best monitoring device to obtain. Make sure patients do not drink coffee or drink alcohol at least 30 minutes before taking their blood pressure and that they empty their bladder. Coordinate care with case management and pharmacy services for remote monitoring devices and BP control.	Phone visits, e-visits and virtual check-ins can be used to identify the hypertension diagnosis, and to obtain the patient's BP reading. The provider can refer a patient to case management by: • Calling member services at 1-800-675-6110; or • Faxing the form directly to1-866-581-0450; or • Email to CASHP.ACM.CMA@healthnet.com The referral form is available on provider.healthnet.com in the Provider Library under Forms. Patients may self-refer to case management by calling the Health Net Medi-Cal Member Services telephone line at 1-800-675-6110, option 2 and request case management.

Chronic conditions measures (continued)

Measure (cont.)	Age range	Items needed	Tips and best practices
Diabetes Care – A1c testing	Ages 18–75	An A1c blood test done at a minimum of once a year. • If Clinical Laboratory Improvement Amendments (CLIA)-certified, test the patient's A1c while in the office and document the date, type of test and the results in the medical record. • Provide a diabetes self-management logbook so they can track their weight, blood sugar, blood pressure and the condition of their feet. • Get them involved in their care. While the patient is waiting in the exam room, provide them with some basic diabetes education or handouts to classes available in the community. If your clinic does point-of-care testing, make sure to document the date, test type and test results in the medical record. Refer to the Office Manager Quick Reference Use for correct A1c blood test CPT and CPT II billing codes.	The physician may conduct a telehealth visit to assess the patient, order lab tests and screenings, and review test results. Check the chart before the patient sees the provider to confirm all necessary screenings were done. Leave a note if you see that any tests are missing. If you use an outside lab: • Give the patient a lab slip for A1c testing before they leave. • Instruct the patient to get labs done at least one week before their scheduled appointment. • Obtain the lab test results and place them in the chart before being seen by the provider.
Diabetes Care – A1c less than 8.0 mg/dl	Ages 18–75	The A1c blood test should be less than 8.0mg/dl to indicate good control. The provider may need to adjust the patient's medication if their A1c remains elevated. Schedule routine telehealth visits between the patient and provider for medication management and attainment of A1c control.	Increase the frequency of provider visits. Provide education on importance of maintaining low blood sugar.
Diabetes Care – Eye exam	Ages 18–75	A diabetes eye exam to see if there is any damage, especially to their retina.	If a diabetic eye exam is positive, complete testing annually or more often, depending on the damage to the patient's eyes. If the diabetic eye exam is negative, complete testing every two years. The provider may order and discuss the patient's eye exam results via telehealth.
Diabetes Care – Blood pressure (BP)	Ages 18–75	BP that is in control. It should be less than 140/90. That means 139/89 or below. (Refer to Controlling Blood Pressure for information and tips.) Phone visits, e-visits and virtual check-ins may use patient-reported BP readings. Do not use patient-reported BP readings if they are seen at the clinic.	Weigh the patient and take their BP at each visit. If BP is elevated, take it again at the end of the visit. Record both measurements within the medical record.

EXAMPLE 5: DIABETES PATIENT FLOWCHART[10]

Patient	Registration desk	Assessment area	Examination room	Consultation	Assessment area	Registration desk	Pharmacy	Patient	Lab
Provider appointment	Reception	Nurse/Medical assistant	Physician/Nurse practitioner/ Physician assistant	Referrals	Nurse/Medical assistant	Reception	Pharmacist	Home	Lab tech
Call 24–48 hours to confirm patient coming Reschedule if cancels or no-show	• ID card • Member eligibility • Phone and/ or address if changed	• Weight/Height • BMI • BP <140/90 • Urine Albumin /Creatinine • Blood test, glomerular filtration rate • A1c results in chart • Lipid panel • Flu shot	• BP • BMI • Lab results • Eye exam results/order • Foot exam • Dental exam • Tobacco use • Diet and exercise • Medication management	• Nutritionist • Diabetic educator • Eye doctor • Dentist • Foot doctor • Endocrinologist • Nephrologist • Tobacco Cessation Program • Behavioral/ Substance Abuse program	• Retake BP if ≥ 140/90 • Lab screenings if not done or additional investigation • Do retinal imaging (if equipment onsite; staff certified) • Assist with referrals prior authorization and scheduling appointment	• Schedule next visit • Give lab requisition • Fax medication • E-scribe to pharmacy	• Fill or refill medication • Education • Consult provider, as needed	• Self-management plan • Blood glucose checks and log • Medications • Diet and exercise regimen • Weight monitoring • Foot care • Tobacco cessation • Follow-up referrals	• Lab work prior to next provider visit

[10]dnnyqetna.blob.core.windows.net/portals/15/3-%20Streamlining_Patient_Care.pdf?sv=2017-04-17&sr=b&si=DNNFileManagerPolicy&sig=Tjk59x5KcZe5AgtIaxlfoI6WfvgFijRNl8Ish7GTfII%3D

Chronic conditions measures (continued)

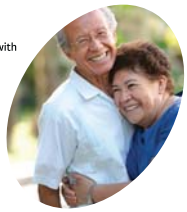
Measure (cont.)	Age range	Items needed	Tips and best practices
Kidney Health Evaluation for Patients with Diabetes (KED)	Ages 18–85	Patients with diabetes (type 1 and type 2) who received a kidney health evaluation any time during that year. It is defined as: • Blood test: An estimated glomerular filtration rate (GFR), and • Urine test: A urine albumin to creatinine ratio (ACR). The patient will need a blood sample drawn to test for a waste product called creatinine to determine their GFR. This test will tell the provider how well the kidneys are working to filter waste from the blood. Patients will also need to provide a urine sample. If the urine test is positive for protein, it should be reported to the provider, and the test repeated to confirm the results. Three positive results may indicate kidney disease.	Collect a urine sample from each patient with diabetes who comes to the clinic. The urine sample is tested for albumin, a type of protein in their urine. Telehealth may be conducted to discuss screenings, review lab test results and for implementation of a comprehensive management plan.
Asthma Medication Ratio with chronic condition	Ages 5–64	Adults and children with persistent asthma who were dispensed controller and rescue inhaler medication, and remained on them for at least 75% of their treatment. Management of patients with asthma could help reduce the need for rescue medication, as well as the costs associated with ER visits, inpatient admission, and missed school or workdays. People with asthma may be at higher risk for severe illness from viruses within the community. Telehealth, e-visits and e-consults are encouraged. Ensure patients have an adequate medication supply for at least 30 days. Health Net offers mail delivery, consider enrolling your patient into this program.	Confirm the diagnosis of asthma through spirometry testing. Develop asthma action plans with your patients and educate them on reducing asthma triggers (i.e., smoke or allergens). Develop health goals with them and customize to their needs with clear, simple instructions. Talk with the patient or parent and help them write a self-management plan that incorporates rescue inhalers into their daily routine. Make sure to schedule follow-up visits to monitor their progress. The provider may complete the visit by telehealth. Telehealth and health coaching go hand-in-hand. Be sure to review proper inhaler technique, their asthma action plan and how to deal with environmental triggers, plus how to keep asthma under control.

EXAMPLE 6: ASTHMA ACTION PLAN IN ENGLISH (PAGE 1 AND 2)

Health Net® COMMUNITY SOLUTIONS

My Asthma Action Plan

WORK WITH YOUR HEALTH CARE PROVIDER TO COMPLETE THIS ASTHMA ACTION PLAN



Because asthma often changes over time, it's important that you work with your provider to track your signs and symptoms and adjust treatment as needed. This Asthma Action Plan can help you better control your asthma. Please fill out the plan with your provider and keep it with you.

Each day, find your zone color based on your symptoms. Then follow the medication steps in the plan, as ordered by your health care provider. Controlling your asthma can help save your life!

My asthma severity

Controller medications are used daily over a long period of time. Rescue medications are used for emergency asthma attacks.

WHILE USING MY CONTROLLER MEDICATION EVERY DAY,

- ☐ I also have to use my rescue medication **less than 2 days per week. (Intermittent)**
- ☐ I also have to use my rescue medication **more than 2 days per week. (Mild persistent)**
- ☐ I also have to use my rescue medication **every day. (Moderate persistent)**
- ☐ I also have to use my rescue medication **many times every day. (Severe persistent)**

My information

My name:	Health care provider name:	Emergency contact name:
Date:	Health care provider phone #:	Emergency contact phone #:
Things that make my asthma worse:		My personal best peak flow:

! For more information, log in to **www.healthnet.com.**

FLY035497EP00 (10/19)

Coverage for every stage of life™

Use traffic light colors to help control asthma

Green is the Healthy Zone. Keep using your controller medication.
Yellow is the Caution Zone. Add rescue medication.
Red is the Danger Zone. Get emergency help now!

MY ACTION PLAN WORKSHEET

Green zone: Healthy

All of these apply:
- ☐ My breathing is good
- ☐ I have no coughing or wheezing
- ☐ I sleep through the night
- ☐ I can do my normal activities
- ☐ I rarely need my rescue medication

Peak flow meter: _____
(80% or more of my personal best)

Keep using your controller medication every day to stay well and symptom-free.

Medication(s)	Controller	Rescue	How much	How often/when
	☐	☐		
	☐	☐		
	☐	☐		

15 to 30 minutes before exercise or sports, take:

Yellow zone: Caution

Any of these apply:
- ☐ I am coughing or wheezing
- ☐ I have a hard time breathing
- ☐ I have shortness of breath
- ☐ I wake up at night due to asthma symptoms
- ☐ I have been exposed to something that makes my asthma worse
- ☐ I can do some, but not all, of my normal activities

Peak flow meter: _____
(between 50% and 79% of my personal best)

Keep using your controller medication every day and use your rescue medication as needed for quick relief.

Medication(s)	Controller	Rescue	How much	How often/when
	☐	☐		
	☐	☐		
	☐	☐		

Call your doctor to get your asthma back in control:
- If you have to use your rescue (quick relief) medication more than 2 days a week.
- If your rescue medication does not work.

You should feel better within 20–60 minutes after using the rescue medication:
- If your symptoms get worse or if you are in the yellow zone for more than 24 hours, follow the steps in the red zone!

Red zone: Danger

My asthma is getting worse fast:
- ☐ I am very short of breath
- ☐ My rescue medication is not helping
- ☐ I cannot walk/talk well
- ☐ I cannot do my normal activities

Peak flow meter: _____
(less than 50% of my personal best)

Take your controller and rescue medications and go to the emergency department or call 911 now!

Medication(s)	Controller	Rescue	How much	How often/when
	☐	☐		
	☐	☐		
	☐	☐		

Go to the emergency department or call 911 now!

EXAMPLE 7: ASTHMA ACTION PLAN IN SPANISH (PAGE 1 AND 2)

Health Net® COMMUNITY SOLUTIONS

Plan De Acción Para El Asma

TRABAJE CON SU PROVEEDOR DE ATENCIÓN DE SALUD PARA COMPLETAR ESTE PLAN DE ACCIÓN.

Puesto que, a menudo, el asma cambia con el tiempo, es importante que trabaje con su proveedor para registrar los signos y síntomas, y ajustar el tratamiento según sea necesario. Este plan de acción para el asma puede ayudarlo a controlar mejor su afección. Complete el plan junto con el proveedor y consérvelo.

Cada día, elija un color según los síntomas. Luego siga los pasos de la medicación que figuran en el plan, según lo indicado por el proveedor de atención de salud. ¡Controlar el asma puede salvar su vida!

Gravedad del asma

Los medicamentos de control se utilizan todos los días durante un largo período. Los medicamentos de rescate se utilizan en caso de ataque de asma de emergencia.

MIENTRAS TOMO EL MEDICAMENTO DE CONTROL TODOS LOS DÍAS,

- ☐ también tomo el medicamento de rescate **menos de 2 días por semana. (Intermitente)**
- ☐ también tomo el medicamento de rescate **más de 2 días por semana. (Levemente persistente)**
- ☐ también tomo el medicamento de rescate **todos los días. (Moderadamente persistente)**
- ☐ también tomo el medicamento de rescate **varias veces por día. (Gravemente persistente)**

Información personal

Mi nombre:	Proveedor de atención de salud:	Contacto de emergencia:
Fecha:	Teléfono del proveedor de atención de salud:	Teléfono del contacto de emergencia:
Factores que empeoran el asma:		Mejor puntaje de flujo espiratorio:

! Para obtener más información, inicie sesión en **www.healthnet.com.**

FLY036198SP00 (10/19)

Cobertura para cada etapa de la vida™

Use los colores del semáforo para controlar el asma.

Verde significa "área saludable". Siga tomando el medicamento de control.
Amarillo significa "área de advertencia". Tome el medicamento de rescate.
Rojo significa "área de peligro". ¡Busque ayuda de emergencia ya mismo!

HOJA INFORMATIVA DEL PLAN DE ACCIÓN

Área verde: saludable

Todas las opciones corresponden a su caso:
- ☐ Respiro bien.
- ☐ No tengo tos ni sibilancia.
- ☐ Duermo toda la noche.
- ☐ Puedo realizar actividades normales.
- ☐ Rara vez necesito el medicamento de rescate.

Medidor de flujo espiratorio máximo: _____
(80% o más de mi mejor puntaje)

Siga tomando el medicamento de control todos los días para mantenerse saludable y sin síntomas.

Medicamentos	Medicamento de control	Medicamento de rescate	Cantidad	Frecuencia/ Cuándo
	☐	☐		
	☐	☐		
	☐	☐		

15 o 30 minutos antes de realizar ejercicio o deporte, tome lo siguiente:

Área amarilla: advertencia

Alguna de las opciones corresponde a su caso:
- ☐ Tengo tos o sibilancia.
- ☐ Tengo problemas para respirar.
- ☐ Tengo dificultad para respirar.
- ☐ Me despierto de noche debido a los síntomas del asma.
- ☐ Estuve expuesto a algo que empeoró el asma.
- ☐ Puedo realizar algunas pero no todas las actividades normales.

Medidor de flujo espiratorio máximo: _____
(entre 50 % y 79 % de mi mejor puntaje)

Siga tomando el medicamento de control todos los días y tome el medicamento de rescate según sea necesario para lograr un rápido alivio.

Medicamentos	Medicamento de control	Medicamento de rescate	Cantidad	Frecuencia/ Cuándo
	☐	☐		
	☐	☐		
	☐	☐		

Llame a su médico para volver a tener el asma bajo control:
- Si tiene que tomar el medicamento de rescate (alivio rápido) más de 2 días por semana.
- Si el medicamento de rescate no funciona.

Debería sentirse mejor entre 20 y 60 minutos después de tomar el medicamento de rescate:
- Si los síntomas empeoran o se encuentra en el área amarilla durante más de 24 horas, ¡siga los pasos del área roja!

Área roja: peligro

El asma empeora rápidamente:
- ☐ Tengo mucha dificultad para respirar.
- ☐ El medicamento de rescate no funciona.
- ☐ No puedo caminar/hablar bien.
- ☐ No puedo realizar actividades normales.

Medidor de flujo espiratorio máximo: _____
(menos del 50 % de mi mejor puntaje)

Tome el medicamento de control y de rescate, y ¡diríjase al departamento de emergencias o llame al 911 ya mismo!

Medicamentos	Medicamento de control	Medicamento de rescate	Cantidad	Frecuencia/ Cuándo
	☐	☐		
	☐	☐		
	☐	☐		

¡Diríjase al departamento de emergencias o llame al 911 ya mismo!

Behavior health measures

Measure	Age range	Items needed	Tips and best practices
Antidepressant Medication Management (AMM)	Ages 18 and older	Newly diagnosed patients with depression and the provider ordered an antidepressant medication. Major depression is a serious mental illness and one of the most common psychiatric disorders. Adherence to medication is an essential component in treatment guidelines for depression. The AMM measure applies to patients ages 18 and older and on a course of a newly started medication. There are two phases of medication compliance. • Effective Acute Treatment Phase: The patient remains on the medication for at least 84 days. • Effective Continuation Phase Treatment: The patient remains on the medication for at least 180 days. Monitor for symptoms of suicide. The National Institute on Mental Health (NIMH) developed the "Ask Suicide Screening Questions (ASQ)," 4 questions in 20 seconds: www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml. If your patient is at risk for suicide and needs immediate assistance, please call 911. Remember to call the county behavioral health access line if your patient needs specialty mental health services.	**Tip: Patient education is key!** Help your patient understand that most antidepressants take at least 4–6 weeks to work. Schedule a return appointment within 30 days after prescription fill. The provider can check for any bad side effects and their response to treatment. Schedule a follow-up visit by telehealth, e-visit or by virtual check-in to make sure the patient is taking their medications as prescribed. Give them written instructions. Even if they feel better, they should not stop medications suddenly. They are at risk of recurring symptoms. If the patient cancels the appointment, call them and reschedule it. Enroll your patient in a case management program.
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Ages 1–17	We measure the percentage of children and adolescents who received: • A blood glucose test, • A blood cholesterol test, and • A blood glucose and cholesterol testing. Conduct a telehealth visit. Order the labs and have the patient complete testing at a lab nearby. Follow-up by phone to ensure the patient had the testing completed. Follow-up by telehealth to review the lab results with the patient.	Give the patient the lab slip before they leave the provider's office and arrange for them to get lab tests completed before their next provider visit. Have the lab reports available for review. Remember: You may always order lab tests and review the results with the parent during the well-child visit
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Ages 18–64	Diabetes screening test done each year for patients diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication. • Do not test patients who have a diagnosis of diabetes. • Do not test patients with no antipsychotic medication ordered. • Coordinate the care with the patient's behavioral health provider and fax lab results to them. Conduct a telehealth visit. Order the labs and have the patient complete testing at a lab nearby. Follow-up by phone to ensure the patient had the testing completed. Follow-up by telehealth to review the lab results with the patient.	It may be difficult to get the patient to come to the clinic. Consider doing A1c or glucose point-of-care testing while in the clinic. If doing point-of-care testing, make sure to document the test type, date done and results. Make sure to use the correct billing code for data capture. Educate your patient and their caregiver about: • Increased risk of diabetes with antipsychotic medications. • Importance of screening for diabetes. • Symptoms of the onset of diabetes. Call patients that cancel appointments and assist them in rescheduling as soon as possible.

Health education programs and services

Health Net Medi-Cal members have access to health education programs, services and resources to help them stay healthy. All are available at no cost to them.

To learn more about any of these programs, call the Health Education Information Line at 1-800-804-6074 (TTY: 711).

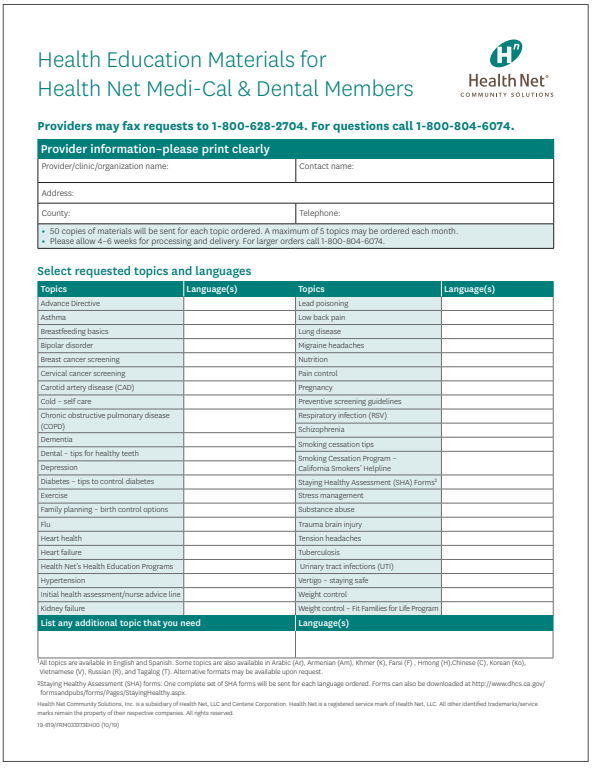
- California Smokers' Helpline
- Healthy pregnancy program
- Fit Families for Life – Be In Charge!℠ Weight Control program
- Healthy Hearts, Healthy Lives program
- myStrength online behavioral health program
- T2X: Social media website for teens and adults to learn about health
- Health education classes available on a variety of health topics

FOR MORE HEALTH EDUCATION MATERIALS:

Use the Provider Order Form for Health Education Materials to request print health education resources for your office. The form is found online in the Provider Library under *Medi-Cal > Forms and References*. Access the Provider Library directly at https://providerlibrary.healthnetcalifornia.com/.

To view more health information, access the Krames Staywell Health Library. This resource library provides more than 4,000 health sheets to help you educate your patients on how to stay healthy and healthy longer. Just click on the link, search the topic of your choice. The Krames Staywell Health Library is located at http://cahealthnet.kramesonline.com/.

EXAMPLE 8: HEALTH EDUCATION MATERIALS



Health Education Materials for
Health Net Medi-Cal & Dental Members

Health Net® COMMUNITY SOLUTIONS

Providers may fax requests to 1-800-628-2704. For questions call 1-800-804-6074.

Provider information–please print clearly	
Provider/clinic/organization name:	Contact name:
Address:	
County:	Telephone:

- 50 copies of materials will be sent for each topic ordered. A maximum of 5 topics may be ordered each month.
- Please allow 4–6 weeks for processing and delivery. For larger orders call 1-800-804-6074.

Select requested topics and languages

Topics	Language(s)	Topics	Language(s)
Advance Directive		Lead poisoning	
Asthma		Low back pain	
Breastfeeding basics		Lung disease	
Bipolar disorder		Migraine headaches	
Breast cancer screening		Nutrition	
Cervical cancer screening		Pain control	
Carotid artery disease (CAD)		Pregnancy	
Cold – self care		Preventive screening guidelines	
Chronic obstructive pulmonary disease (COPD)		Respiratory infection (RSV)	
Dementia		Schizophrenia	
Dental – tips for healthy teeth		Smoking cessation tips	
Depression		Smoking Cessation Program – California Smokers' Helpline	
Diabetes – tips to control diabetes		Staying Healthy Assessment (SHA) Forms[2]	
Exercise		Stress management	
Family planning – birth control options		Substance abuse	
Flu		Trauma brain injury	
Heart health		Tension headaches	
Heart failure		Tuberculosis	
Health Net's Health Education Programs		Urinary tract infections (UTI)	
Hypertension		Vertigo – staying safe	
Initial health assessment/nurse advice line		Weight control	
Kidney failure		Weight control – Fit Families for Life Program	
List any additional topic that you need		**Language(s)**	

[1]All topics are available in English and Spanish. Some topics are also available in Arabic (Ar), Armenian (Am), Khmer (K), Farsi (F) , Hmong (H),Chinese (C), Korean (Ko), Vietnamese (V), Russian (R), and Tagalog (T). Alternative formats may be available upon request.

[2]Staying Healthy Assessment (SHA) forms: One complete set of SHA forms will be sent for each language ordered. Forms can also be downloaded at http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx.

19-819/PRM0333735EHDD (10/19)

Additional resources

For any questions regarding our services, please contact the respective department listed below.

Provider Services: 1-888-926-4988 or 1-800-675-6110; *fax* 1-800-281-2999

Web Portal Support: 1-866-458-1047

Enrollment Service Line: 1-800-327-0502 (TTY: 711)

Cultural & Linguistic Services: 1-800-977-6750

Health Education Department: 1-800-804-6074

Interpreter Services at no cost: 1-800-675-6110

Envolve Pharmacy Solutions: 1-800-867-6564; *fax* 1-800-977-8226

Transportation (ModivCare): 1-855-253-6863

Case Management Services: 1-800-675-6110 or *fax the referral form* to 1-866-581-0450 or *email at* CASHP.ACM.CMA@healthnet.com

MHN: 1-800-289-2040

REFERRAL RESOURCE

Health Net Community Connect, powered by Aunt Bertha, is the largest online search and referral platform that provides results customized for the communities you and your health care staff serve or where members live. The referral platform allows members and providers to find free and low cost services. To use the tool, go to https://www.auntbertha.com/, enter a ZIP code and click *Search*.

Additional HEDIS and MCAS resources

The Managed Care Accountability Set (MCAS) is located at www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx.

Go to the NCQA website at www.ncqa.org/hedis/ for up-to-date HEDIS information and important training videos.

HEDIS and MCAS Coding and Billing Quick Reference

HEDIS and MCAS coding and billing quick reference

This is a quick tool to reference to help you with medical coding of the HEDIS and MCAS quality measures. Please use this as a resource at your office for billing visits and reporting services or treatments you have provided.

Child and adolescent measures

Well-Care Visits in the First 30 Months of Life (W30)	**Office visit new patient:** **CPT:** 99381, for infants under age 1 **CPT:** 99382, for children ages 1 to 4 **Office visit established patient:** **CPT:** 99391, for infants under age 1 **CPT:** 99392, for children ages 1 to 4	**ICD-10 codes:** Z00.110 Health supervision for newborn under 8 days old Z00.111 Health supervision for newborn 8 to 28 days old Z00.121 Routine child health exam with abnormal findings Z00.129 Routine child health exam without abnormal findings
Child and Adolescent Well-Care Visit (WCV)	**Office visit new patients:** **CPT:** 99382, for children ages 3 to 4 **CPT:** 99383, for children ages 5 to 11 **CPT:** 99384, for children ages 12 to 17 **CPT:** 99385, for children ages 18–21 **Office visit established patients:** **CPT:** 99392, for children ages 3 to 4 **CPT:** 99393, for children ages 5 to 11 **CPT:** 99394, for children ages 12 to 17 **CPT:** 99395, for children ages 18–21	**ICD-10 codes, ages 3–17** Z00.121 Routine child health exam with abnormal findings Z00.129 Routine child health exam without abnormal findings **ICD-10 codes, age 18 or older** Z00.00 General adult medical exam without abnormal findings Z00.01 General adult medical exam with abnormal findings
Lead Blood Screening	**Lead blood test CPT:** 83655	
Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity (WCC)	**BMI percentile:** **ICD-10** Z68.51 Pediatric less than 5th percentile for age Z68.52 Pediatric 5th percentile to less than 85th percentile for age Z68.53 Pediatric 85th percentile to less than 95th percentile for age Z58.54 Pediatric greater than or equal to 95th percentile for age **Dietary counseling:** **ICD-10** Nutrition counseling: Z71.3 **CPT** 97802 Nutrition therapy, initial assessment, individual, each 15 minutes 97803 Nutrition therapy, reassessment, individual, each 15 minutes 97804 Nutrition therapy, group (2+), each 30 minutes **Exercise counseling:** **ICD-10** Physical activity counseling: Z71.82, Sports physical: Z02.5	

Childhood Immunization Status (CIS)

Vaccine Type	CPT_Code	CPT_description	CVX Short Description	CVX Code
Dtap	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use	DTaP-Hib-IPV	120
	90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than age 7, for intramuscular use	DTaP, unspecified formulation	107
	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	DTaP-Hep B-IPV	110
		Diphtheria, tetanus toxoids and acellular pertussis vaccine	DTaP	20
		Diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis antigens	DTaP, 5 pertussis antigens	106
HIB	90644	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 6 weeks–18 months of age, for intramuscular use	Meningococcal C/Y-HIB PRP	148
	90647	Haemophilus influenzae type b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use	Hib (PRP-OMP)	49
	90648	Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use	Hib (PRP-T)	48
	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use	DTaP-Hib-IPV	120
	90748	Hepatitis B and Haemophilus influenzae type b vaccine (Hib-HepB), for intramuscular use	Hib-Hep B	51
		Haemophilus influenzae type b vaccine, conjugate unspecified formulation	Hib, unspecified formulation	17
Hep B	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	DTaP-Hep B-IPV	110
	90740	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use	Hep B, dialysis	44
	90744	Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use	Hep B, adolescent or pediatric	08
	90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use	Hep B, dialysis	44
	90748	Hepatitis B and Haemophilus influenzae type b vaccine (Hib-HepB), for intramuscular use	Hib-Hep B	51
IPV	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Haemophilus influenzae type b, and inactivated poliovirus vaccine, (DTaP-IPV/Hib), for intramuscular use	DTaP-Hib-IPV	120
	90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use	IPV	10
	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV), for intramuscular use	DTaP-Hep B-IPV	110
		Poliovirus vaccine, unspecified formulation	Polio, unspecified formulation	89

Childhood Immunization Status (CIS) (continued)

Vaccine Type (cont.)	CPT_Code	CPT_description	CVX Short Description	CVX Code
MMR	90704	Mumps virus vaccine, live, for subcutaneous use	mumps	07
	90705	Measles virus vaccine, live, for subcutaneous use	measles	05
	90706	Rubella virus vaccine, live, for subcutaneous use	rubella	06
	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	MMR	03
	90708	Measles and rubella virus vaccine, live, for subcutaneous use	M/R	04
	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	MMRV	94
PCV	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	Pneumococcal conjugate PCV 13	133
		Pneumococcal Conjugate, unspecified formulation	Pneumococcal Conjugate, unspecified formulation	152
RCV	90680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use	Rotavirus, pentavalent	116
		Rotavirus vaccine, unspecified formulation	Rotavirus, unspecified formulation	122
	90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	rotavirus, monovalent	119
Influenza flu	90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use	Influenza, seasonal, injectable, preservative free	140
	90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use	Influenza, seasonal, injectable	141
	90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	Influenza, injectable, MDCK, preservative free	153
	90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	Influenza, high dose seasonal	135
	90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	influenza, recombinant, injectable, preservative free	155
	90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use	Influenza, injectable,quadrivalent, preservative free, pediatric	161
	90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use	influenza, injectable, quadrivalent, preservative free	150
	90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use	influenza, injectable, quadrivalent	158
	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use	influenza, injectable, quadrivalent	158
	90689	Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use	influenza, injectable, quadrivalent	150
	90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	influenza, live, intranasal	111
	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	influenza, live, intranasal, quadrivalent	149

Childhood Immunization Status (CIS) (continued)

Vaccine Type (cont.)	CPT_Code	CPT_description	CVX Short Description	CVX Code
Hep A	90633	Hepatitis A vaccine (HepA), pediatric/adolescent dosage-2 dose schedule, for intramuscular use	Hep A, ped/adol, 2 dose	83
		Hepatitis A vaccine, pediatric dosage, unspecified formulation; Do NOT use this code. If formulation is unknown, use CVX 85. There is only one formulation of Hep A, peds.	Hep A, pediatric, unspecified formulation	31
Varicella (1 dose)	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use	MMRV	94
	90716	Varicella virus vaccine (VAR), live, for subcutaneous use	varicella	21

Immunizations for adolescents

Vaccine Type	CPT_Code	CPT_description	CVX Short Description	CVX Code
Meningococcal	90734	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, diphtheria toxoid carrier (MenACWY-D) or CRM197 carrier (MenACWY-CRM), for intramuscular use	Meningococcal MCV4, unspecified formulation	147
		This CVX is intended for use when one of the meningococcal vaccines containing serogroups A, C, W and Y (conjugate or polysaccaride) was given and the exact formulation was not recorded. It should not be used to record newly administered immunizations. It is not to be used when one of the meningococcal vaccines containing other serogroups was administered.	Meningococcal ACWY vaccine, unspecified formulation	108
		Meningococcal polysaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4P)	Meningococcal MCV4P	114
		Meningococcal oligosaccharide (groups A, C, Y and W-135) diphtheria toxoid conjugate vaccine (MCV4O)	Meningococcal MCV4O	136
		This CVX is intended for use when any one of the meningococcal vaccines is recorded and there is no information about which serogroups are protected against. This code should not be used when a newly administered immunization is recorded.	Meningococcal, unknown serogroups	167
Tdap	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals age 7 or older, for intramuscular use	Tdap	115
HPV	90649	Human Papillomavirus vaccine, types 6, 11, 16, 18, quadrivalent (4vHPV), 3 dose schedule, for intramuscular use	HPV, quadrivalent	62
	90650	Human Papillomavirus vaccine, types 16, 18, bivalent (2vHPV), 3 dose schedule, for intramuscular use	HPV, bivalent	118
	90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use	HPV9	165
		This CVX code allows reporting of a vaccination when formulation is unknown (for example, when recording a HPV vaccination when noted on a vaccination card)	HPV, unspecified formulation	137

Women's health measures

Breast Cancer Screening (BCS)	**Exclusions:** **ICD-10** Z90.13, Bilateral mastectomy (history of); ICD-PCS: 0HTV0ZZ Z90.12, Absence of left breast Z90.11, Absence of right breast **Unilateral Mastectomy:** **CPT:** 19180, 19200, 19220, 19240, 19303–19307 with LT (left) or RT (right) modifier **ICD-10CM Codes:** 0HTU0ZZ (left) 0HTT0ZZ (right)
Cervical Cancer Screening (CCS)	**Cervical Cytology Lab Test:** **PAP CPT:** 88141 - 88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175 **HPV Test:** **CPT:** 87620–87622, 87624, 87625 **Exclusions:** **Absence of cervix** Q51.5, Z90.710 **Absence of cervix with remaining uterus** Z90.712
Prenatal (PPC)	**Prenatal Visits CPT:** **New patient visits** 99201–99205 **Evaluation and Management** 99211–99215 **Consultation New or established patient** 99241–99245, **With Cognitive impairment** 99483 **CPT-CAT-II:** **Hospital Outpatient Visit:** G0463 **Community Clinic or FQHC:** T1015 **CPT:** 99500 **CPT-CAT-II:** 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004 **Stand Alone Prenatal Visits** **CPT:** 99500 **CPT-CAT-II:** 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Postpartum Care (PPC)	**Postpartum Visit:** **CPT:** 99501, 58300, 59430 **CPT-CAT-II:** 0503F **HCPCS:** G0101 **ICD-10:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
Chlamydia Screening (CHL)	**CPT:** 87110, 87270, 87320, 87490–87492, 87810

Adult/Chronic conditions measures

Controlling Blood Pressure (CBP)	**Systolic Blood Pressure CPT II:** 3074F, BP less than 130, 3075F, BP 130–139 3077F, BP greater than 140	**Diastolic Blood Pressure CPT II:** 3078F, BP less than 80 3079F, BP 80–89 3080F, BP greater than 90
	Online Assessment Telehealth: **98970** Qualified non-physician health care professional online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes **98971** Qualified non-physician health care professional online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes **98972** Qualified non-physician health care professional online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes **99421** Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 5–10 minutes **99422** Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes	**99423** Online digital E/M service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes **G2010** Virtual communication, remote evaluation of record video or images submitted by an established patient **G2012** Virtual communication (phone included) 5–10 minute discussion **G2061** Qualified non-physician healthcare professional online assessment and management services for an established patient for up to seven days, cumulative time during the seven days, 5–10 minutes **G2062** Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11–20 minutes **G2063** Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes
	Phone Visit codes: **98966** Phone discussion 5–10 minutes **98967** Phone discussion 11–20 minutes **98968** Phone discussion 21–30 minutes minutes	**99441** Phone evaluation and management 5–10 minutes **99442** Phone evaluation and management 11–20 minutes **99443** Phone evaluation and management 21–30 minutes
	Remote blood pressure monitoring CPT codes: **93784,** ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report **93788,** ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; scanning analysis with report **93790,** ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; review with interpretation and report **99091,** collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days **99453,** (onboarding new patient onto RPM) Remote monitoring of physiologic parameter(s) (e.g, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment **99454,** device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	**99457,** remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month **99458** Online Monitoring, online assessment, 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; additional 20 minutes **99473,** may be submitted when the physician practice staff provide training, device setup and calibration of the SMBP validated for clinical accuracy. This code can only be submitted once. Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration **99474,** may be submitted once a month for ongoing treatment decisions. This code can be used when patients and /or caregivers report their BP readings back to the practice. Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

Adult/Chronic conditions measures (cont.)

Comprehensive Diabetes Care (CDC)	**A1c testing:** **CPT:** 83036, 83037 **A1c test results:** **CPT II codes:** 3044F, A1c less than 7.0 3051F, A1c = 7.0 and less than 8.0 3052F, A1c = 8.0 and less than 9.0 3046F, A1c greater than 9.0 **Retinal Eye Exam:** **CPT II Codes:** 3072F, Diabetic retinal eye negative 2022F, Diabetic retinal screening with eye care professional 2024F, Diabetic retinal screening with eye care professional 2025F, Diabetic retinal screening with eye care professional 2026F, Diabetic retinal screening with eye care professional **Blood pressure:** Refer to Controlling Blood Pressure (CBP) above for CPT codes.
Kidney Health Evaluation for Patients with Diabetes (KED)	**Urine Albumin to Creatinine Ratio:** **CPT** 82570, random urine **CPT** 82043, random urine or 24-hour urine **Glomerular Filtration Rate:** **CPT** 80047, 80048, 80050, 80053, 80069, 82565

Behavioral health measures

Metabolic Monitoring for Children and Adolescents on Antipsychotics	**HbA1C Lab Tests:** **CPT:** 83036, 83037 **HbA1c Lab Test Result:** 3044F, A1c less than 7.0 3051F, A1c =7.0 and less than 8.0 3052F, A1c = 8.0 and less than 9.0 3046F, A1c greater than 9.0 **Glucose Lab Test:** **CPT:** 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 **LDL-C Lab Test:** **CPT:** 80061, 83700, 83701, 83704, 83721 **LDL-C Lab Test Result:** 3048F, LDL-C less than 100 mg/dl 3049F, LDL-C 100–129 mg/dl 3050F, LDL-C 130 mg/dl or greater **Cholesterol Lab Test** 82465 Cholesterol serum, total 83718 Lipoprotein, direct measurement high density cholesterol (HDL cholesterol) 83722 Sd-LDL (CHL) 84478 Triglycerides
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are using Antipsychotic Medications (SSD)	**A1c Lab Test:** **CPT:** 83036, 83037 **A1c Test Result:** **CPT-CAT-II:** 3044F, A1c less than 7.0 3051F, A1c =7.0 and less than 8.0 3052F, A1c = 8.0 and less than 9.0 3046F, A1c greater than 9.0 **Glucose Test** **CPT:** 82947, 82950, 82951, 80047, 80048, 80050, 80053, 80069

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