PriorityHealth

2017 PCP Incentive Program

An integrated program focused on patient-centered care

Jan. 12, 2017

Contents

2017 Program updates....3
Partners in Performance....4
How our attribution model works....5
Supplemental data....6
Glossary....7
Administrative details....9
Prevention:
- Cervical cancer screenings....13
- Childhood immunizations....14
- Adolescent immunizations....16
- Well-Child visits in the first 15 months of life....18
- Well-Child visits 3-6 years....19
- Chlamydia screening....20
- Lead screening in children....21
- Recorded BMI (pediatric and adult patients)....22
- Colorectal cancer screening....23

Chronic disease
- Diabetes care: Controlled HbA1c less than 7.0%....24
- Diabetes care: Controlled HbA1c less than 8.0%....26
- Diabetes care: Controlled HbA1c less than or equal to 9.0%....27
- Diabetes care: Annual retinal eye exam....28
- Diabetes care: Monitoring for nephropathy....29
- Optimal diabetes care....31
- Hypertension: Controlled blood pressure....32
- Medicare 5-star optimal measure....34
- Depression screening and follow-up....35
- Senior care education....38

Transformation of care
- Medication Therapy Management (MTM)....39
- Care management....40
- Patient-centered medical home (PCMH) recognition....43
- CG CAHPS....44
- Healthy Michigan Plan: HRA completion and open access....45
- All-cause readmissions....47
- ED visits: PCP treatable care....49

Measure code sets....50

2017 Program updates

The PCP Incentive Program is updated annually to reflect current health care trends. The 2017 program aligns with our mission and goals for transformation of models of care and financing of care delivery.

For complete details on these measure changes, refer to the individual measure specification pages.

Administrative changes

2017 PIP categories

- Prevention
- Chronic disease
- Transformation of care

2017 New measures

- All-cause readmissions
- Medicare 5-Star – Tiered payment
- Medication Therapy Management (MTM)
- Recorded BMI (pediatric and adult)

2017 Revised measures

- Adolescent immunization: Added combination 2 - Meningoccal, Tdap and HPV
- Care management – revised criteria and payout
- Chlamydia screening – product change removed commercial
- Colorectal cancer screening – expanded screenings to include CT colonography and FIT-DNA
- Depression screening and follow-up – revised criteria
- ED visits: PCP treatable care – product change added Medicaid
- Optimal diabetes care – product change removed Medicare
- Patient-centered medical home (PCMH) recognition - product change removed commercial and Medicare
- Senior care education – focus includes the addition of proper coding for risk adjustment

2016 Retired measures

- Diabetes care: Hypertension medication therapy
- Pediatric obesity
- Tobacco cessation counseling

Partners in Performance

Helping you thrive in a changing world

For 20 years, we've partnered with PCPs to improve the quality, access and affordability of care for our members. Our goal is to:

- **Optimize health.** We provide tools, programs and information that make it easier for you to improve the health outcomes of your Priority Health patients with integrated, patient-centered care.

- **Ensure the best care experience.** We engage your Priority Health patients and hold them accountable for their health.

- **Eliminate avoidable costs.** We hold you accountable for using evidence-based medicine to reduce costs, and we reward you for achieving the best outcomes.

We will achieve our commitment by focusing—with you, our partner providers—on five foundational elements:

- **Clinical collaboration.** *We work with you*: Building from our combined clinical resources, we'll work together with you to implement transformative programs that meet the needs of your patient population.

- **Access and experience.** *We're committed:* We work with you to ensure that patients have access to exceptional care, in all settings—primary care, specialty care and facility services. In addition, we're committed to assisting you in improving the patient experience by providing actionable information and program support.

- **Fair and transparent cost.** *We're transparent:* We work with you to collect performance data on fair cost of services, usage, quality and experience. We then share this data with Priority Health patients and employers so they can make informed health care decisions.

- **Continuous quality improvement.** *We evaluate and innovate*. Continuous improvement is the hallmark of great organizations and great partnerships. Through our unique tool set, we collect, monitor and share with you opportunities to improve the cost, quality and/or experience of care (Triple Aim). More importantly, we'll work with you to determine which opportunities are achievable and align with our mutual priorities and available resources.

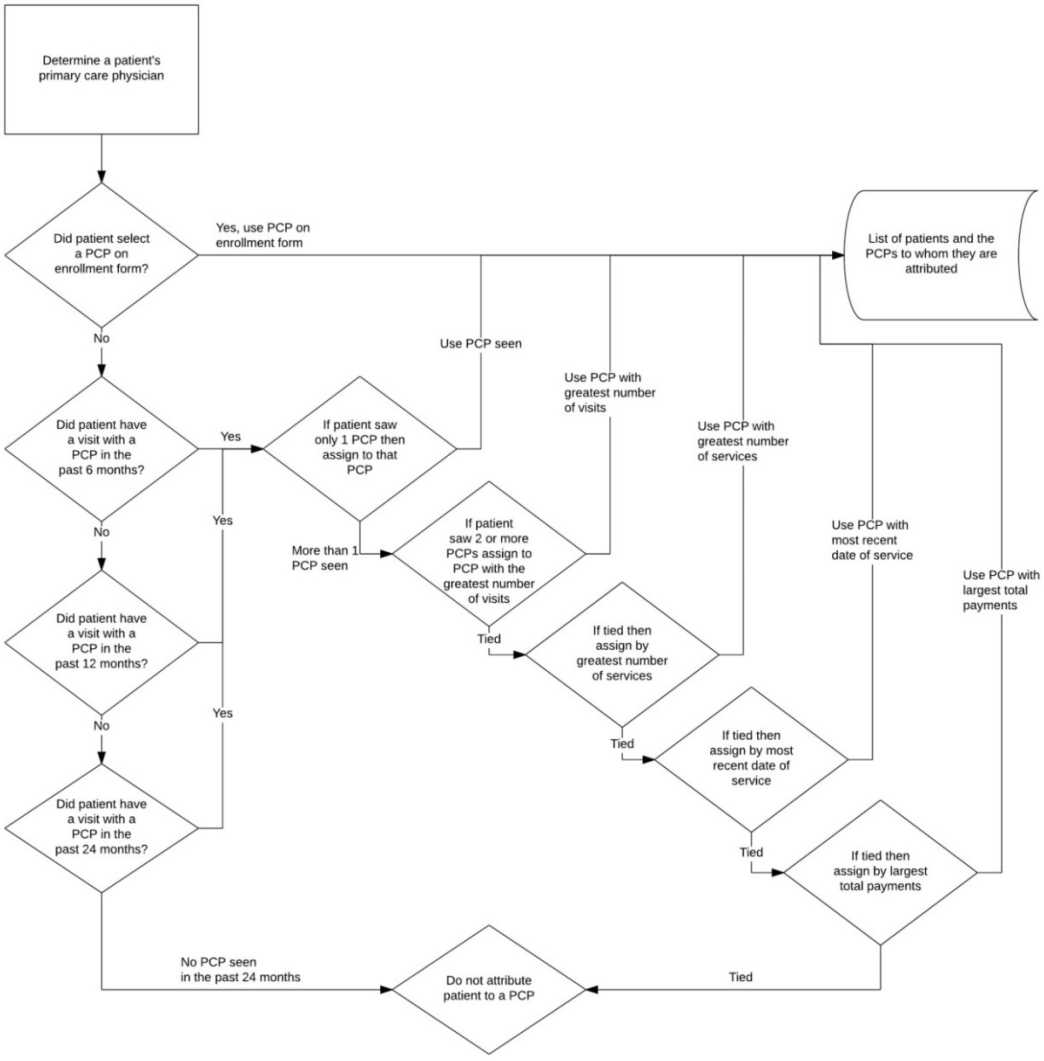
- **Economic alignment.** *We pay for value over volume.* We work with you to transform the way health care is delivered. By collaborating on reimbursement strategies, we can help you successfully transition from a pay-for-volume business model to a pay-for-value one, minimizing economic impact.

Working together, Priority Health and our primary care physician partners have produced outstanding results for Michigan communities year after year. We're here to help your practice maximize its 2017 PCP incentives. Contact your Provider Performance Specialist for practice resources and programs to support your efforts.

How our attribution model works

We're committed to providing a medical home for all Priority Health members.

We use an attribution model to ensure that members enrolled in health plans with no PCP assignment are included in the PCP Incentive Program. This includes members in self-funded and fully funded PPO plans as well as in Medicare PPO plans.



Visits are determined using claims information. Valid E&M codes: 99201-99205, 99212-99215, 99241-99245, 99381-99387, 99391-99397. Valid place of service locations: school, homeless shelter, Indian Health Service free-standing facility, Indian Health Service provider-based facility, Tribal 638 free-standing facility, Tribal 638 provider-based facility, office, patient's home, outpatient hospital, federally qualified health center. state or local public health clinic and rural health clinic.

Supplemental data

Priority Health defines supplemental data as anything that is submitted to Priority Health beyond what is included on a claim form. There are three approved methods of submitting supplemental data:

- HL7
- Patient profile
- Report #70

How we audit supplemental data

Random audits ensure the accuracy of our PCP Incentive Program payouts.

Priority Health audits the supplemental data provided by practices for the PCP Incentive Program measure requirements. This annual audit randomly selects practices throughout the network.

At year end, each audited practice is given a partial list of supplemental data provided to Priority Health. Practices are required to return a copy of the medical record that documents the supplemental data piece. Example: If lab value data was supplied the practice would submit a printed copy of office visit notes with the lab value.

Audit process procedure:

- Audit notices are emailed to the practice group and PHO/PO if applicable.
- Providers are required to respond to the audit within two weeks of the delivery date. Failure to return results by the deadline will result in ineligibility for the 2017 payout.
- If a medical record is unavailable, audit results will be recalculated to determine a compliance score with the audit. An audit result of less than 95% accuracy will require an additional audit of 50 medical records.
- Failure to reach a score of 95% or higher on the second set of 50 records will result in ineligibility for the 2017 payout.
- Revised PCP Incentive Program scores will also be used to determine apple quality ratings as displayed within the Priority Health Find a Doctor tool.
- Additional sanctions against the practice may also be considered based upon audit results.

Glossary

Accountable Care Network (ACN)
Accountable Care Networks are contracted physician organizations/physician hospital organizations (PO/PHOs) or professional groups defined as one entity for reporting and performance measurement purposes. The pay for performance (PFP) group serves as the system template or creation of ACN groups and ACN reporting.

Attribution model
Our attribution model matches a primary care physician with a patient enrolled in a Priority Health plan that does not require an assigned2 PCP. See our attribution model on page 5.

Facility site ID
The administrative number Priority Health assigns to your practice for purposes of identification and payment. The facility site ID is a four to five digit number included on each PIP report.

FileMart
A Priority Health application within our website's Provider Center. FileMart is the available mechanism to receive standard incentive program and membership reports.

Health plan inclusion
All Priority Health plans, except our Medigap and short term individual plans, are included in the PCP Incentive Program.

HEDIS
The Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely-used set of performance measures in the health care industry. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting and improving the quality of care provided by organized delivery systems. If HEDIS definitions are revised throughout 2017, Priority Health will update measures based on those revisions. If a HEDIS revision impacts our PCP Incentive Program, we will provide written notification to the network and update the manual online as appropriate.

MCIR
The Michigan Care Improvement Registry (MCIR) is an electronic immunization registry and is available to private and public providers for maintenance of immunization records for all citizens in the State of Michigan.

MCIR calculates a patient's age, provides an immunization history and determines which immunizations may be due. Priority Health receives monthly data downloads from the Michigan Department of Community Health (MDCH) and displays this data within monthly reports and in Patient Profile.

Non-adherence
Non-adherence is defined as "Members refusing to follow provider recommendations for care".

- Providers can request that non-adherent members be excluded from PIP measure denominators.
- It is the intent of the Non-adherent Member Exclusion Procedure to identify members who have been counseled at least three times on recommended care and who have made the personal choice not to seek care, for any reason. The three outreach attempts must be a minimum of one week apart and must take place in 2017.
- Non-adherence requests will only be accepted using the Patient Profile tool. A provider may request exclusion of a member at any point prior to Nov. 10, 2017 for the 2017 program year. Each request for exclusion will be granted for the current program year only.

- Manual processing of non-adherence member exclusions take place during the 2017 settlement process in the first quarter of 2018. Find additional information about the non-adherent process at *priorityhealth.com/provider/manual/performance/pip/nonadherent-members*

Patient Profile
Patient Profile is an online resource designed to assist PCPs with patient management. Data is based on information gathered through medical claims, lab files submitted by hospitals and independent laboratories, pharmacy claims, HL7 files and physician-supplied data.

Patient Profile features include:
- Patient search: Practices can conduct a search for individual patients and review reports for individualized care needs.
- Health condition search: Searches are available for an entire patient population. Variables may be selected to tailor the search to your practice's specific interests.
- Resource list: Clinical practice guidelines and printable patient education tools.

Patient Profile data updates:
- Patient demographic information is updated nightly.
- Supplemental data provided by primary care practices and network providers is scheduled for a weekly update administered each weekend.
- PCP Incentive Program indicator icons are updated with the monthly PIP report refresh.
- MCIR data is received once monthly, usually between the 23rd and 25th of the month.

Pay for Performance (PFP) group
A Pay for Performance group is a contracted PO, PHO or large medical group.

PMPM
Per member per month (PMPM) identifies one member enrolled in the health plan for one month.

Priority Health Standard of Excellence
Is defined as 75th percentile practice group performance or 90% adherence for patient care processes measured at the point of care.

Administrative details

Understanding the details is key to successful participation in our PCP Incentive Program.

Demographic changes
Centers for Medicare and Medicaid Services (CMS) has issued requirements for 2017 regarding online directories to ensure that members have true availability of contracted providers and specifically whether they are accepting new patients. Under the requirement CMS is requiring the following:

- Require contracted providers to inform the plan of any changes to street address, phone number and office hours or other changes that affect availability.

To become fully compliant with this requirement, Priority Health will make the PIP_099 Physician Audit and PIP_007 Open/Closed and Peak Membership report available to all providers. We expect providers to review these reports regularly and contact Priority Health immediately if their open/closed status has changed. Providers are contractually obligated to provide 60 days prior written notice of closing to new members. Providers, who need to make changes, including location, contact information, office hours, etc., can communicate to Priority Health using the provider change form located on our website at *priorityhealth.com/provider/forms*. Correct physician alignment and demographic information facilitates accurate PIP settlement.

If a PCP has demographic changes they should submit a participating provider change notification form to *PH-PELC@priorityhealth.com*.

Earned members
Earned members are based on assignments to a practice on the 15th of each month, considering retroactivity.

Manual revisions
If revisions are made to the technical manual throughout the calendar year, the updated online version will be considered the official version. The online version will be dated to identify the most current version. We'll alert you of manual revisions via news articles.

Medicaid
Includes members under Children's Special Health Care Services, Healthy Michigan Plan and MIChild.

Member assignment
For most measures, member assignment for program settlement aligns with the participating PCP assigned or attributed on Dec. 31, 2017. Measure case definitions provide a few exceptions to this rule. Official member counts include 90 days of retroactivity. Employers have 30 days to request retroactive member enrollment or termination. However, 90-day retroactivity may be requested by an employer for review.

Member discharge
Discharging members for the sole purpose of reaching PCP Incentive Program measure targets is not allowed. Member discharges are reviewed by Priority Health and must meet the following criteria as listed in the online Provider Manual at *priorityhealth.com/provider/manual/office-mgmt/provider-patient-relationship/discharge.*

Minimum settlement check amount
Practices earning less than $50 will not receive a PCP Incentive Program settlement payout.

Outcomes MTM
OutcomesMTM® is a Cardinal Health company and vendor Priority Health leverages for the delivery and administration of Medication Therapy Management programs.

PCP Incentive Program eligibility
It is easy to participate in our PCP Incentive Program. You're eligible if you:

- Participate with Priority Health as a PCP on Dec. 31, 2017
- Submit claims within 45 days of service
- Participate with Priority Health's Clinical Quality Improvement Programs

The ED visits: PCP Treatable measure includes all data and experience for terminated physicians, PCPs that become specialists, and terminated members throughout the calendar year 2017.

PHO/PO pay-to rules
Contracted PHO/POs will receive program settlement for all member providers in one check at year end settlement (April 2018). These PHO/POs will be responsible for distributing settlement funds to providers at their discretion.

Post-settlement review
Requests for review of final 2017 settlement performance and financial payouts must be submitted in writing by May 12, 2018. Each post-settlement review request must meet or exceed a minimum $1,000 dollar of the total earned PCP incentive program settlement reward by practice group. In addition, the post-settlement review must be considered a health plan error or omission to meet review criteria. For details and submission criteria for post-settlement review request requirements contact your practice's Provider Performance Specialist.

Priority Health apples designation
Apples are awarded annually to PCPs whose performance meets or exceeds threshold targets for preventive care and treatment of chronic illnesses. These quality ratings, illustrated by red apple icons, are published on the PCP's page in our "Find a Doctor" tool at *priorityhealth.com*. An overall rating is awarded based on the average for all applicable measures and are based on HMO/POS Quality Index. The practice must qualify for 3 or more measure and meet a minimum patient threshold to receive apple designation.

PCPs earning a score of:

Four apples:	meet or exceed the target
Three apples:	are in the top third of the target
Two apples:	are in the middle third of the target
One apple:	are in the bottom third of the target

Priority Health Quality Awards
The physicians and groups selected for annual Priority Health Quality Awards have achieved the highest overall scores for ensuring patients receive preventive care, control chronic disease and have a good patient experience. Quality award results are based on performance of a combined quality index score of 1.0 and greater, plus minimum membership of 100 Priority Health members. The quality index (QI) is the sum of the numerators, divided by the sum of the denominators, of each PCP Incentive Program Clinical Outcomes measures. The result is then divided by the weighted average of the targets to determine the recipients.

Program deadlines

All-cause readmission attestation survey	March 1, 2017
Care management attestation survey	June 1, 2017
Senior care education – attestation survey and webcast	June 1, 2017
PCMH recognition – Medicaid only	Aug. 15, 2017
Discharge/Transfers – to be completed for 2017	Oct. 31, 2017
Non-adherence	Nov. 10, 2017
CG CAHPS practice-level performance data for 2017 program year	Jan. 31, 2018
Special exceptions	Jan. 31, 2018
Supplemental data	Jan. 31, 2018
Claims submission	Feb. 28, 2018
Post settlement review 2017	May 12, 2018

Program funding
The PCP Incentive Program is funded with a per member per month (PMPM) accrual for HMO/POS, ASO/PPO, Medicare and Medicaid. The PMPM funding amount varies by each of these business categories. Forecasting is used to determine measure payout and measure availability by business category. Forecasting includes analysis of expected business category performance and measure member populations in 2017. Although the ASO and PPO products will be settled based upon combined performance, the PMPM funding amount for each product will vary and a total combined amount will be used to determine a maximum budget amount for this business category. Program funding is subject to change and updating at any time during the program year.

Reporting
No custom reports will be built or provided to PO/PHOs or practices for the 2017 PCP Incentive Program.

Report #70
Report #70 is an Excel file made available by Priority Health for PCP practices to compile and provide data to Priority Health. Practices enter member-specific data into the file and return the file electronically to their Provider Performance Specialist who routes it to the correct department within Priority Health for data downloading.

Secondary cardholders
Members with primary insurance coverage through another health insurer are included in the PCP Incentive Program.

Settlement
For traditional (practice sites not approved in a CPC+ track), settlement for the PCP Incentive Program occurs at year end. No prospective payments will be distributed. For practice sites approved in a CPC+ track, prospective payments will be distributed.

Comprehensive Primary Care Plus (CPC+)
CMS model that impacts the delivery of primary care services. Priority Health considers CPC+ a program under Partners in Performance. Partners in Performance includes, but is not limited to our standard PCP Incentive Program and CPC+. Practices may not participate in both the standard PCP Incentive Program and CPC+.

Participation in CPC+ is determined by CMS and is only available to practices that met the eligibility requirements to participate in the model. CPC+ payers expect that practices participating in CPC+ will do so for the full five years of the model. However, participation in CPC+ is voluntary and practices may withdraw from the model without penalty any time during the 5-year program period. Practices are required to notify CMS (and cc: Priority Health), at least 90 calendar days before the planned day of withdrawal. Departing the program before completion of a performance year (PY) puts a practice at risk for recoupment of the prospectively paid performance based incentive payment.

Upon termination of CPC+ participation, practices would be eligible for Priority Health's standard PCP Incentive Program (standard PIP).

Settlement entities
Settlement will be attributed to the participating primary care provider (PCP) assigned as of Dec. 31, 2017 unless otherwise specified, and paid to the physicians' primary contracted physician hospital organization (PHO) or physician organization (PO). Physicians participating in multiple PHO/POs will be asked to select a primary affiliation for purposes of the PCP Incentive Program. PHO/POs will only receive incentive payment for contracted product lines. If physicians have a contract for any product directly with Priority Health outside of the PHO/PO contract, Priority Health will distribute those non-contracted funds directly to the same entity his/her claims are paid to for primary care services.

Special exceptions
Special exceptions are only accepted for measures with performance targets. They must be entered in the patient profile tool and must be submitted online by the Jan. 31, 2018 deadline. No other reasons for

exclusion or method of submitting your request will be accepted. Manual processing of special exceptions will take place with the 2017 settlement process in the first quarter of 2018. To learn more about special exceptions go to *priorityhealth.com/provider/manual/performance/pip/special-exceptions.*

Supplemental data
Supplemental data may be submitted to Priority Health through these methods:

- Patient Profile using the "Update Data" function
- PIP Report #70, Supplemental Data Extract available via FileMart.
  To learn more, contact your Provider Performance Specialist
- EMR or Patient Registry data exchange (e.g. HL7 file format)
- Michigan Care Improvement Registry (MCIR)

Supplemental data must provide the date on which the service is performed rather than the date a test or result was reviewed with the patient. All supplemental (provider-reported) data is subject to audit.

Supplemental data upload schedule – HL7 data, Patient Profile, and Report #70

- Demographic data: Data transactions including address and benefits are updated nightly.
- Supplemental data: The bulk of Patient Profile data comes from supplemental data elements from claims, HL7 files and provider updates: This update is administered each weekend.
- Release of PIP FileMart reports: Reports are released approximately by the 15th of each month and include data received through the end of the previous month. If the 15th falls on a weekend, reports are released the following Monday. The release of reports corresponds with the "Opportunity" indicators in Patient Profile.
- Opportunity indicators: These update the Monday following the release of the reports. If the 15th falls on a weekend or a Monday, opportunity indicator updates will display the following Monday.
- MCIR data is received from the state typically between the 23rd and 25th of the month. Immunization values, dates or counts are updated Monday following the receipt of the MCIR file.

Note: These timelines assume all systems are refreshing properly and in a timely manner. Technical issues may result in delays.

Prevention
Cervical cancer screenings

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of women 21–64 years of age with a cervical cancer screening according to the following schedule: • 30–64 who had cervical cancer screen and human papillomavirus (HPV) co-testing performed every 5 years. With service dates four or less days apart during 2013, 2014, 2015, 2016 or 2017 and who were 30 years or older on the date of both tests. For example, if the service date for cervical cancer screen was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year. or • 21-64 years of age: cervical cancer screen in 2015, 2016 or 2017
Case definition	Women must be continuously enrolled with Priority Health in 2015, 2016 and 2017 with no more than a 45-day gap in coverage each year. Women must be members of Priority Health on Dec. 31, 2017.
Age criteria	24–64 years of age as of Dec. 31, 2017. The measured age range for women with a cervical cancer screen and human papillomavirus (HPV) co-testing is 30-64.
Exclusionary criteria	Women who have had a complete, total or radical abdominal or vaginal hysterectomy on or before Dec. 31, 2017. If Priority Health has not received claims data regarding this history, providers may supply through supplemental data options. Member in hospice or using hospice services any time during 2017.
Numerator	The number of women who received cervical cancer screening as defined above.
Denominator	The number of women who reached the age of 24-64 years as of Dec. 31, 2017.
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018, and provider supplemental data by Jan. 31, 2018.
Provider data input	Supplemental data for hysterectomy history may be provided until Jan. 31, 2018. Supplemental data for non-billed cervical cancer screenings and/or HPV co-testing may be provided until Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data for non-billed HPV screenings Report #70 an patient profile Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	84%%
Target: Medicaid	73%%
Payout	$10 per measured member

Prevention
Childhood immunizations

Source	HEDIS Combination 3
Target source	2016 HEDIS 90th percentile
Identified measure	Immunization set combination 3: • **Four DTaP/DTP**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **Three Hepatitis B**: On or before the second birthday, with different dates of service • **Three H Influenza Type B (HIB)**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One MMR**: On or before the second birthday. MMR the "14-day rule" does not apply • **Three IPV**: All at least 42 days after birth, with different dates of service, and on or before the second birthday • **One Varicella**: On or before second birthday, or history of disease on or before the second birthday • **Four Pneumococcal Conjugate**: All at least 42 days after birth, with different dates of service, and on or before the second birthday
Case definition	Children continuously enrolled with Priority Health for a 12-month period preceding their second birthday, with no more than a 45-day gap in coverage. Children must have active enrollment and be assigned to a participating PCP on their second birthday. Member/PCP assignment: PCP assigned on the member's second birthday. All events except for MMR must be at least 14 days apart. Following HEDIS criteria, numerator events such as influenza vaccines must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two influenza vaccines) happen within 14 days of each other we will credit only the first one. For example, if the service date was February 1, then the service date for the second visit must be on or after February 15.
Age criteria	2 years of age as of Dec. 31, 2017
Exclusionary criteria	Children who are documented in MCIR as having certain health conditions for which vaccines are contraindicated. Members in hospice or using hospice services any time during 2017.
Immunization waivers	The PCP Incentive Program also allows members to be excluded from this measure when parents choose not to vaccinate their child. An immunization waiver form is required as documentation for these cases. The parent or guardian must sign the immunization waiver form yearly and a copy must be saved in the patient's medical record. History of a member's immunization waiver needs to be submitted through the Update Data function in Patient Profile. These members are removed from the measure denominator. Priority Health requires the use of one of the following immunization waiver templates: • Michigan Department of Community Health • American Academy of Pediatrics • Alliance for Immunization in Michigan

Numerator	The number of children with completed vaccinations as defined above
Denominator	The number of children 2 years of age as of Dec. 31, 2017
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. MCIR data is downloaded from the State of Michigan monthly. MCIR immunization history must be entered by Jan. 31, 2018. MCIR and Priority Health match member records using a point system. We aren't always able to make a perfect match. Check monthly reporting for non-matches and provide the member's MCIR number to Priority Health through Patient Profile or Report #70.
Provider data input	For the varicella vaccine, history of illness or seropositive test should be entered in MCIR as a "documented immunity" (e.g., a child with chicken pox history would be noted as having a documented immunity to the varicella vaccine).
Target: HMO/POS, ASO/PPO	87%
Target: Medicaid	81%
Payout	$170 per measured member

Prevention
Adolescent immunizations

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	Percentage of adolescents 13 years of age who had the following vaccines: • **Meningococcal**: One meningococcal conjugate between the 11th and 13th birthdays • **Tdap**: One between the 10th and 13th birthdays • **HPV**: Two human papilloma virus vaccine between 9th and 13th birthdays at least 146 days apart
Case definition	Adolescents must be continuously enrolled with Priority Health for a 12-month period preceding their 13th birthday with no more than a 45-day gap in coverage. Adolescents must have active enrollment and be assigned to a participating PCP on their 13th birthday. Member/PCP assignment: PCP assigned on the member's 13th birthday Following HEDIS criteria, numerator events such as influenza vaccines must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two influenza vaccines) happen within 14 days of each other we will credit only the first one. For example, if the service date was February 1, then the service date for the second visit must be on or after February 15.
Age criteria	13 years of age as of Dec. 31, 2017
Exclusionary criteria	Refer to the CDC guidelines regarding health history, which may result in contraindication for a vaccine. The health history must be noted in MCIR. Members in hospice or using hospice services any time during 2017
Immunization waivers	The PCP Incentive Program also allows members to be excluded from this measure when parents choose not to vaccinate their child. An immunization waiver form is required as documentation for these cases. The parent or guardian must sign the immunization waiver form yearly and a copy must be saved in the patient's medical record. History of a member's immunization waiver needs to be submitted through the Update Data function in Patient Profile. These members are removed from the measure denominator. Priority Health requires the use of one of the following immunization waiver templates: • Michigan Department of Community Health • American Academy of Pediatrics • Alliance for Immunization in Michigan
Numerator	The number of adolescents with completed immunizations as defined above
Denominator	The number of adolescents 13 years of age as of Dec. 31, 2017
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, and Medicaid

Method of measurement	Claims data processed by Feb. 28, 2018. MCIR data is downloaded from the State of Michigan monthly. MCIR immunization history must be entered by Jan. 31, 2018. MCIR and Priority Health match member records using a point system. We aren't always able to make a perfect match. Check monthly reporting for non-matches and provide the member's MCIR number to Priority Health through Patient Profile or Report #70.
Provider data input	All immunization data must be updated in MCIR by Jan. 31, 2018.
Target: HMO/POS, ASO/PPO	26%
Target: Medicaid	32%
Payout	$50 per measured member

Prevention
Well-Child visits in the first 15 months of life

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	Infants turning 15 months of age in 2017 who had at least six well-child visits by 15 months of age
Case definition	Continuously enrolled with Priority Health from 31 days of age to 15 months of age with no more than a 45-day gap in coverage. The infant must be enrolled and assigned to a PCP on the day of their 15th month of age. Fifteen months of age is defined as the 90th day following the infant's first birthday. Member/PCP assignment: PCP assigned to the infant on the date the infant reaches 15 months of age. Following HEDIS criteria, numerator events such as a well-child visit must be at least 14 days apart to count as two separate events. If two of the same numerator events (i.e. two well-child visits) happen within 14 days of each other we will credit only the first one. For example, if the service date was February 1, then the service date for the second visit must be on or after February 15.
Age criteria	15 months of age during 2017
Exclusionary criteria	Members in hospice or using hospice services any time during 2017
Numerator	Infants with at least six well-child visits before turning 15 months of age
Denominator	Infants turning 15 months of age during 2017
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018
Provider data input	Supplemental data includes: • HL7 • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	90%
Target: Medicaid	74%
Payout	$75 per measured member

Physical exams (well-child visits)

Here's how often children should have complete physicals (well-child exams):

Age	Recommendation
Newborn	1 visit 3-5 days after discharge
0-2 years	1 visit at 2, 4, 6, 9, 12, 15, 18 and 24 months
3-6 years	1 visit at 30 months and 1 visit every year for ages 3-6
7-10 years	1 visit every 1-2 years
11-18 years	1 visit every year

Prevention
Well-Child visits 3–6 years

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	Children 3–6 years of age who received one or more well-child visits with a PCP in 2017
Case definition	Children must be continuously enrolled with Priority Health during 2017 with no more than a 45-day gap in coverage. Children must be members of Priority Health and assigned to a participating PCP on Dec. 31, 2017.
Age criteria	3-6 years of age as of Dec. 31, 2017
Exclusionary criteria	Members in hospice or using hospice services any time during 2017
Numerator	The number of children with at least one well-child visit in 2017
Denominator	The number of children 3-6 years of age as of Dec. 31, 2017
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018
Provider data input	Supplemental data includes: • HL7 • Report #70 Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	88%
Target: Medicaid	84%
Payout	$60 per measured member

Physical exams (well-child visits)

Here's how often children should have complete physicals (well-child exams):

Age	Recommendation
Newborn	1 visit 3-5 days after discharge
0-2 years	1 visit at 2, 4, 6, 9, 12, 15, 18 and 24 months
3-6 years	1 visit at 30 months and 1 visit every year for ages 3-6
7-10 years	1 visit every 1-2 years
11-18 years	1 visit every year

Prevention
Chlamydia screening

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of women 16–24 years of age who were identified as sexually active with one or more chlamydia screenings during 2017.
Case definition	Women must be continuously enrolled with Priority Health in 2017 with no more than a 45-day gap in coverage. Women must be enrolled with Priority Health and assigned to a participating PCP on Dec. 31, 2017.
Age criteria	16–24 years of age as of Dec. 31, 2017
Exclusionary criteria	A billed pregnancy test during 2017 and a filled prescription for isotretinoin (Accutane) or an X-ray on the same day as the pregnancy test or six days after the pregnancy test. Submit a special exception in Patient Profile for women with a pregnancy test conducted pre-surgery. Members in hospice or using hospice services any time during 2017
Numerator	Women with at least one or more chlamydia tests during 2017.
Denominator	Sexually active women 16-24 years old.
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	Medicaid
Method of measurement	Pharmacy and medical claims processed by Feb. 28, 2018. Physician reported data submitted by Jan. 31, 2018. Sexual activity is identified through billed diagnosis codes, procedure codes and pharmacy claims.
Provider data input	Documented chlamydia screening may be supplied as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target: Medicaid	70%
Payout	$15 per measured member

Prevention
Lead screening in children

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of children two years of age who had one or more capillary or venous blood screenings for lead poisoning on or before their second birthday
Case definition	Children must be continuously enrolled for 12 months prior to their second birthday with no more than a 45-day gap in coverage. Children must have active coverage and be assigned to a participating PCP on their second birthday. Member/PCP assignment: PCP assigned to the child on their second birthday
Age criteria	2 years of age as of Dec. 31, 2017
Exclusionary criteria	Members in hospice or using hospice services any time during 2017
Numerator	One or more capillary or venous blood tests to screen for lead poisoning on or before the child's second birthday.
Denominator	All children turning age two in 2017
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. Physician reported data submitted by Jan. 31, 2018. Lead screenings noted within MCIR will also be downloaded to supplement claims data. The MCIR lead file from the State of Michigan does not include MIChild or Healthy Michigan Plan members, or Children's Special Health Care. Therefore, some practices may notice members not meeting the lead screening measure even though the member may have had the service completed. Providers should enter these screenings as supplemental data.
Provider data input	Documented lead screenings may be supplied as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target	86%
Payout	$15 per measured member

Prevention
Recorded BMI (pediatric and adult patients)

Source	Priority Health standard of excellence derived from HEDIS and 5-Star Guidelines
Identified measure	The percentage of patients with a billed PCP E&M claim between Jan. 1, 2017 and Dec. 31, 2017 that had a BMI or BMI percentile documented in the chart and submitted to Priority Health through supplemental data.
Case definition	Member must be continuously enrolled with Priority Health medical coverage in 2017 with no more than one 45 day gap in coverage. Member must have active Priority Health medical coverage on Dec. 31, 2017. Only the first PCP E&M visit during the measurement year will be evaluated. E&M visits tied to members PCP on date of the earliest PCP E&M visit.
Age criteria	Medicaid members 3-74 years of age on Dec. 31, 2017. For Medicare members 18-74 years of age on Dec. 31, 2017.
Exclusionary criteria	None
Numerator	Count of unique members identified in the denominator with a BMI or BMI percentile submitted to Priority Health through supplemental data between Jan. 1, 2017 and Dec. 31, 2017.
Denominator	The percentage of patients with a billed PCP E&M claim between Jan. 1, 2017 and Dec. 31, 2017 that had a BMI or BMI percentile documented in the chart and submitted to Priority Health through supplemental data.
Level of measurement	Practice group
Minimum members	1 per practice group
Applicable product lines	Medicaid and Medicare
Method of measurement	Claims data processed by Feb. 28, 2018 and supplemental data entered on or before Jan. 31, 2018.
Provider data input	Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Target: Medicare	Medicare: 96%
Target: Medicaid	Medicaid: 90%
Payout	$0.10 per member per month for members 3-74 years of age on Dec. 31, 2017. Payout will be for the full 12 months of 2017.
Notes	Providers are encouraged to bill BMI or BMI percentile ICD-10 diagnosis code on any PCP E&M claim. (ICD-10 diagnosis code of Z68.51-Z68.54 for members younger than 20 and Z68.1-Z68.45, E66.01 & E66.2 for members 20-74)

Prevention
Colorectal cancer screening

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer
Case definition	Members continuously enrolled in 2016 and 2017, with no more than a 45-day gap in coverage. Members 51-75 years of age as of Dec. 31, 2017.
Age criteria	51-75 years
Exclusionary criteria	Members with a diagnosis of colorectal cancer or total colectomy on or before Dec. 31, 2017 Members in hospice or using hospice services any time during 2017.
Numerator	One or more screenings for colorectal cancer: • Fecal occult blood test (FOBT) during 2017 • Flexible sigmoidoscopy anytime during 2013 – 2017 • Colonoscopy anytime during 2008 – 2017 • FIT-DNA (Cologuard) anytime during 2015 – 2017 • CT colonography anytime during 2015 – 2017
Denominator	Eligible members between 50-75 years of age
Level of measurement	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. Physician reported data submitted by Jan. 31, 2018.
Provider data input	Supplemental data may be provided until Jan. 31, 2018 Supplemental data includes: • HL7 • Patient Profile • Report #70 If member had any of these services defined below completed prior to enrollment with Priority Health, enter that date of service and result in Patient Profile or Report #70 • Fecal occult blood test (FOBT) • Flexible sigmoidoscopy • Colonoscopy Enter the date and result of these services in Report #70 • CT colonography • FIT-DNA (Cologuard) Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	76%
Target: Medicare	81%
Target: Medicaid	56%
Payout:	$10 per measured member

Chronic disease

Diabetes care: Controlled HbA1c less than 7.0%

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes with an HbA1c <7.0%. This measure considers the most recent lab conducted in 2017. If no HbA1c was conducted during 2017, the level is considered to be greater than or equal to 7.0%

Case definition	A member with diabetes is defined by:
	• Two face-to-face encounters with a diagnosis of diabetes:
	  o On different dates of service
	  o In an outpatient setting, observation visit, ED visit or non-acute inpatient encounter
	  o In 2016 or 2017, or
	• One face-to-face encounter with a diagnosis of diabetes:
	  o In an acute inpatient encounter
	  o In 2015 or 2016, or
	• Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2016 or 2017.
	
	Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2017.

Age criteria	18–64 years of age as of Dec. 31, 2017

Exclusionary criteria	• Coronary artery bypass graft (CABG): Members who had a CABG in any setting in 2016 or 2017
	• Percutaneous Coronary Intervention (PCI): Members who had at least one encounter, in any setting, with any code to identify PCI in 2016 or 2017
	• Ischemic vascular disease (IVD): Members with either of the following in 2016 or 2017:
	  o At least one outpatient visit with an IVD diagnosis, or
	  o At least one acute inpatient visit
	• Chronic heart failure (CHF): Members who had at least one encounter, in any setting, with any code to identify CHF
	• Thoracic aortic aneurysm: Members who had at least one outpatient visit or one acute inpatient visit with any code to identify thoracic aortic aneurysm in 2016 or 2017
	• Prior myocardial infarction (MI): Members who had at least one encounter, in any setting, with any code to identify MI
	• Chronic kidney disease end-stage renal disease (ESRD): Members who had at least one encounter in any setting with any code to identify ESRD
	• Dementia: Members who had at least one encounter, in any setting, with any code to identify dementia
	• Blindness: Members who had at least one encounter, in any setting, with any code to identify blindness
	• Amputation: Members who had at least one encounter, in any setting, with any code to identify lower extremity amputation
	• Gestational or steroid induced diabetes: Members with gestational or steroid induced diabetes who did not have any face to face encounters with diagnosis of diabetes, in 2016 or 2017.
	• Members in hospice or using hospice services any time during 2017.

Numerator	The number of members with diabetes with an HbA1c <7.0%. This measure considers the most recent lab conducted in 2017. If no HbA1c was conducted during 2017, the level is considered to be greater than or equal to 7.0%.
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, and Medicaid
Method of measurement	HbA1c values are sent electronically to Priority Health by many network hospitals and independent labs. Supplemental data submitted by Jan. 31, 2018.
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function in Patient Profile. The deadline for data submission is Jan. 31, 2018. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	46%
Target: Medicaid	42%
Payout:	$25 per measured member

Chronic disease

Diabetes care: Controlled HbA1c less than 8.0%

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes with an HbA1c <8.0%. This measure considers the most recent lab conducted in 2017. If no HbA1c was conducted during 2017, the level is considered to be greater than or equal to 8.0%.
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting, observation visit, ED visit or non-acute inpatient encounter o In 2016 or 2017, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient encounter o In 2016 or 2017, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2016 or 2017. Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2017.
Age criteria	18–75 years of age as of Dec. 31, 2017
Exclusionary criteria	• Gestational or steroid induced diabetes: Members with gestational or steroid induced diabetes who did not have any face to face encounters with diagnosis of diabetes, in 2016 or 2017. • Members in hospice or using hospice services any time during 2017.
Numerator	The number of members with diabetes with an HbA1c <8.0%. This measure considers the most recent lab conducted in 2017. If no HbA1c was conducted during 2017, the level is considered to be greater than or equal to 8.0%
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	HbA1c values are sent electronically to Priority Health by many network hospitals and independent labs. Supplemental data submitted by Jan. 31, 2018.
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function in Patient Profile. The deadline for data submission is Jan. 31, 2018. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	70%
Target: Medicare	78%
Target: Medicaid	59%
Payout:	$30 per measured member

Chronic disease

Diabetes care: Controlled HbA1c less than or equal to 9.0%

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes with an HbA1c ≤9.0%. This measure considers the most recent lab conducted in 2017. If no HbA1c was conducted during 2017, the level is considered to be greater than 9.0%.
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting, observation visit, ED visit or non-acute inpatient encounter o In 2016 or 2017, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient encounter o In 2016 or 2017, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2016 or 2017. Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2017.
Age criteria	18–75 years of age as of Dec. 31, 2017
Exclusionary criteria	• Gestational or steroid induced diabetes: Members with gestational or steroid induced diabetes who did not have any face to face encounters with diagnosis of diabetes, in 2016 or 2017. • Members in hospice or using hospice services any time during 2017.
Numerator	The number of members with diabetes with an HbA1c ≤ 9.0%. This measure considers the most recent lab conducted in 2017. If no HbA1c was conducted during 2017, the level is considered to be greater than 9.0%.
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO and Medicaid
Method of measurement	HbA1c values are sent electronically to Priority Health by many network hospitals and independent labs. Supplemental data submitted by Jan. 31, 2018.
Provider data input	Documented lab values may be provided as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function in Patient Profile. The deadline for data submission is Jan. 31, 2018. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	81%
Target: Medicare	88%
Target: Medicaid	71%
Payout	$25 per measured member

Chronic disease

Diabetes care: Annual retinal eye exam

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes and a retinal eye exam in 2017
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting, observation visit, ED visit or non-acute inpatient encounter o In 2016 or 2017, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient encounter o In 2016 or 2017, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2016 or 2017. Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2017.
Age criteria	18–75 years of age as of Dec. 31, 2017
Exclusionary criteria	• Gestational or steroid induced diabetes: Members with gestational or steroid induced diabetes who did not have any face to face encounters with diagnosis of diabetes, in 2016 or 2017. • Members in hospice or using hospice services any time during 2017.
Numerator	The number of members with diabetes with a retinal eye exam performed in 2017 or a negative retinal eye exam in 2016.
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. Supplemental data submitted by Jan. 31, 2018
Provider data input	Documented retinal eye exams may be provided as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function in Patient Profile. The deadline for data submission is Jan. 31, 2018. Supplemental data is subject to audit.
Target: HMO/POS, ASO/PPO	74%
Target: Medicare	83%
Target: Medicaid	68%
Payout	$15 per measured member

Chronic disease

Diabetes care: Monitoring for nephropathy

Source	HEDIS
Target source	2016 HEDIS 90th percentile
Identified measure	The percentage of members with diabetes who have had one of the following: • A microalbuminuria lab during 2017 • Diagnosis of or treatment for nephropathy in 2017 • Pharmacy claim for ACE/ARB therapy during 2017 • Visit with a nephrologist in 2017 • Evidence of kidney transplant • Evidence of ESRD • Evidence of stage 4 chronic kidney disease
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting, observation visit, ED visit or non-acute inpatient encounter In 2016 or 2017, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient encounter In 2016 or 2017, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2016 or 2017. Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage. Members must be active with Priority Health and assigned to a participating PCP on Dec. 31, 2017.
Age criteria	18–75 years of age as of Dec. 31, 2017
Exclusionary criteria	• Gestational or steroid induced diabetes: Members with gestational or steroid induced diabetes who did not have any face to face encounters with diagnosis of diabetes, in 2016 or 2017. • Members in hospice or using hospice services any time during 2017.
Numerator	Members with diabetes who have had one of the following: • A microalbuminuria lab during 2017 • Diagnosis of or treatment for nephropathy in 2017 • Pharmacy claim for ACE/ARB therapy during 2017 • Visit with a nephrologist in 2017 • Evidence of ESRD • Evidence of stage 4 chronic kidney disease • Evidence of kidney transplant
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. Supplemental data submitted by Jan. 31, 2018.
Provider data input	Documented microalbuminuria labs may be provided as supplemental data through Jan. 31, 2018. Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as diabetic by submitting data through the Update Data function in Patient Profile. The deadline for data submission is Jan. 31, 2018. Supplemental data is subject to audit.

Target: HMO/POS, ASO/PPO	94%
Target: Medicare	98%
Target: Medicaid	94%
Payout	$10 per measured member

Chronic disease
Optimal diabetes care

Source	Extrapolated from HEDIS Diabetes Care measures
Identified measure	The percentage of patients with diabetes who have met all standards defined in each of the following measures: • Diabetes care: Controlled HbA1c Less Than 7.0% (if applicable, based on co-morbidities and age) • Diabetes care: Controlled HbA1c Less Than 8.0% • Diabetes care: Annual retinal eye exam • Diabetes care: Monitoring for nephropathy • Diabetes care: Controlled blood pressure
Case definition	A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2016 or 2017, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2016 or 2017, or • Insulin or oral hypoglycemic/anti-hyperglycemic filled script with diagnosis of diabetes during 2016 or 2017. Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage, and active with Priority Health on Dec. 31, 2017.
Age criteria	18–75 years of age as of Dec. 31, 2017 (Exception: Diabetes Care: Controlled HbA1c Less than 7.0% measure age range is 65 years)
Exclusionary criteria	• Gestational or steroid induced diabetes: Members with gestational or steroid induced diabetes who did not have any face to face encounters with diagnosis of diabetes, in 2016 or 2017. • Members in hospice or using hospice services any time during 2017.
Numerator	The number of members with diabetes that met each of the standards in the following diabetes measures: • Diabetes care: Controlled HbA1c Less Than 7% (if applicable, based on co-morbidities and age) • Diabetes care: Controlled HbA1c Less Than 8% • Diabetes care: Annual retinal eye exam • Diabetes care: Monitoring for nephropathy • Diabetes care: Controlled blood pressure
Denominator	All members with diabetes as defined above
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. Supplemental data submitted by Jan. 31, 2018.
Provider data input	None
Targets: HMO/POS, ASO/PPO and Medicaid	20-29%, 30-34%, 35% and above
Payout: HMO/POS, ASO/PPO and Medicaid	$ 75 per member measured for performance of 20-29%, $125 per member measured for performance of 30-34% $200 per member measured for performance of and above 35% and above

Chronic disease
Hypertension: Controlled blood pressure

Source	Priority Health Standard of Excellence
Identified measure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. Hypertension diagnosis can come from any physician (PCPs and specialists) within the first 6 months of the year. We accept blood pressure data through supplemental data sources as specified below. We use the BP value submitted on or after the date of the most recent billed PCP visit to determine if blood pressure is controlled. If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. The systolic and diastolic results do not need to be from the same reading. If no BP is recorded during the measurement year assume that the member is "not controlled." If a member does not have a PCP office visit during 2017 and is failing to meet the measure, the member will be removed from the measure denominator at year-end.
Case definition	A member with hypertension is defined by: • One outpatient encounter between Jan. 1 and June 30, 2017, and • Billed diagnosis of 401.x during the outpatient encounter A member with diabetes is defined by: • Two face-to-face encounters with a diagnosis of diabetes: o On different dates of service o In an outpatient setting o In 2016 or 2017, or • One face-to-face encounter with a diagnosis of diabetes: o In an acute inpatient or emergency department setting o In 2016 or 2017, or • Insulin or oral hypoglycemic/antihyperglycemic filled script with diagnosis of diabetes during 2016 or 2017. The following members in the eligible population should not be considered to have diabetes: Gestational or steroid-induced diabetes: Members with gestational or steroid-induced diabetes who did not have any face-to-face encounters with diagnosis of diabetes, in any setting, in 2016 or 2017. Members must be continuously enrolled with Priority Health in 2017 with no more than a 45 day gap in coverage. Members must be active with Priority Health on Dec. 31, 2017.
Age criteria	18–85 years of age as of Dec. 31, 2017
Exclusionary criteria	Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) or kidney transplant on or prior to Dec. 31, 2017, all members with a diagnosis of pregnancy during 2017, all members who had a non-acute inpatient admission during 2017, and all members in hospice or using hospice services.

Numerator	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg • Members 60–85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg • Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg
Denominator	Hypertensive patients as defined above
Level of measure	Practice group
Minimum members	1 per practice
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Physician reported data submitted by Jan. 31, 2018
Provider data input	Documented blood pressure may be provided as supplemental data through Jan. 31, 2018 Supplemental data includes: • HL7 • Patient Profile • Report #70 Providers may exclude any member they determine to be incorrectly defined as hypertensive by submitting data through the Update Data function in Patient Profile by Jan. 31, 2018. Supplemental data is subject to audit. BPs must be documented by a health care provider and saved within the member's medical record.
Special note for members with no PCP visit in 2017	Monthly 2017 reporting includes members who have a billed diagnosis of hypertension by any physician. If a member does not have a PCP office visit during 2017, the member will be removed from the measure denominator at year-end. As an option to keep these members in your measure denominator—and potentially the measure numerator—practices may obtain medical records of a blood pressure recorded during a specialist office visit. With this documentation, practices may submit the blood pressure and apply it as supplemental data. We do not apply claims that contain an afterhours CPT code. Within reporting, you may see BP history unfamiliar to your practice. Health systems using a shared patient registry submit BP data from all visits, including specialists.
Target: HMO/POS, ASO/PPO	76%
Target: Medicare	84%
Target: Medicaid	71%
Payout:	$50 per measured member

Chronic disease
Medicare 5-star optimal measure

<table>
<tr><td>Source</td><td>Extrapolated from HEDIS Diabetes Care, Hypertension: Controlled blood pressure and colorectal cancer screening measures</td></tr>
<tr><td>Target source</td><td>The higher of 2016 CMS 5-Star Threshold and Medicare HEDIS 90th percentile</td></tr>
<tr><td>Identified measure</td><td>The number of the following measures the practice score is at or above the target:

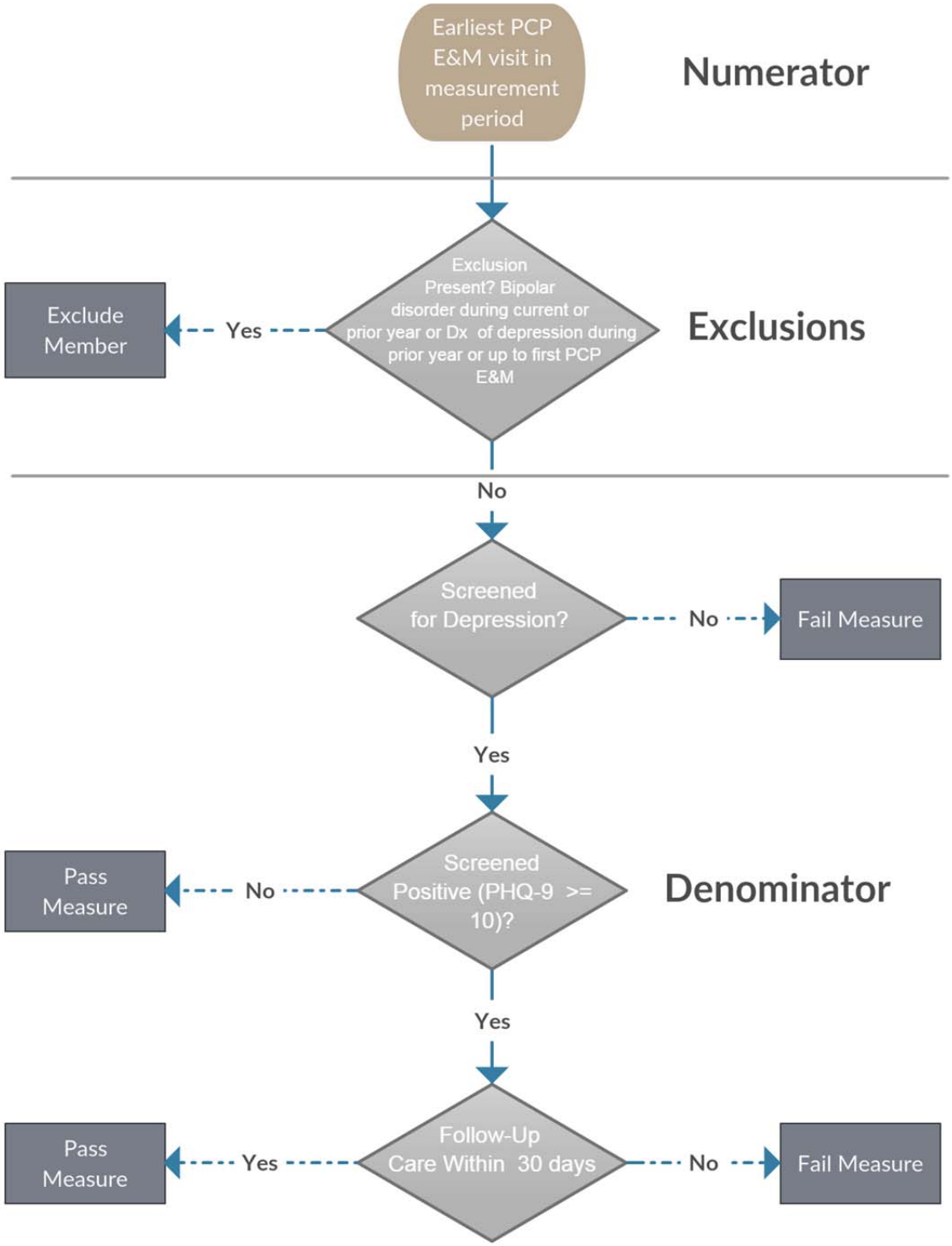
<table><tr><th>Measure</th><th>Target</th></tr><tr><td>Colorectal cancer screening</td><td>81%</td></tr><tr><td>Diabetes care: Controlled HbA1c ≤ 9.0%</td><td>88%</td></tr><tr><td>Diabetes care: Eye exam</td><td>83%</td></tr><tr><td>Diabetes care: Monitoring for Nephropathy</td><td>98%</td></tr><tr><td>Hypertension: Controlled blood pressure</td><td>84%</td></tr></table>
A minimum of one member must be in the measure for the practice group to be eligible for meeting a measure.</td></tr>
<tr><td>Case definition</td><td>See individual measures for measure case definitions</td></tr>
<tr><td>Age criteria</td><td>Defined by measure</td></tr>
<tr><td>Exclusionary criteria</td><td>Defined by measure</td></tr>
<tr><td>Numerator</td><td>Defined by measure</td></tr>
<tr><td>Denominator</td><td>Defined by measure</td></tr>
<tr><td>Level of measure</td><td>Practice group</td></tr>
<tr><td>Minimum members</td><td>1 per practice group</td></tr>
<tr><td>Applicable product lines</td><td>Medicare</td></tr>
<tr><td>Method of measurement</td><td>Defined by measure</td></tr>
<tr><td>Provider data input</td><td>Defined by measure</td></tr>
<tr><td>Targets: Medicare</td><td>3, 4 or 5 measures met</td></tr>
<tr><td>Payout: Medicare</td><td><table><tr><th>Measures met</th><th>Payout</th></tr><tr><td>3</td><td>$0.25 per member per month</td></tr><tr><td>4</td><td>$0.75 per member per month</td></tr><tr><td>5</td><td>$1.50 per member per month</td></tr></table></td></tr>
</table>

Chronic disease
Depression screening and follow-up

Source	Future HEDIS
Target source	Priority Health Standard of Excellence
Identified measure	The percentage of patients 12 years of age or older as of Dec. 31, 2017 who had a billed preventive evaluation and management (E&M) visit with a participating PCP and were screened for clinical depression using the standardized tool (PHQ-2, PHQ-4 or PHQ-9) AND If screened positive, received appropriate follow-up care. A PHQ-2, PHQ-4 or PHQ-9 value must be provided via supplemental data and must be conducted on the same date as the E&M visit completed by the PCP.
Case definition	Members who had a PCP E&M visit and screened for clinical depression and if screened positive for clinical depression with a PHQ-9 score ≥ 10 on that visit date received appropriate follow-up care. Only the first billed preventative E&M visit with a participating PCP during the measurement year will be evaluated. Members must be continuously enrolled in 2016 and 2017 with no more than a 45-day gap in coverage in each year and active with Priority health on Dec. 31, 2016 and Dec. 31, 2017.
Age criteria	12 years and older as of Dec. 31, 2017
Exclusionary criteria	An active diagnosis of bipolar disorder during 2016 or 2017. An active diagnosis of depression in 2016 and up to the day before the preventive E&M visit in 2017. An active diagnosis of depression in 2016 and 2017.
Numerator	Patients 12 years and older as of the last day of the measurement year who had an outpatient visit during 2017 and were screened for depression and for those who were screened positive for clinical depression, were provided follow-up care within 30 calendar days of the positive result with one or more of the following: • Dispensed an antidepressant medication (Table AMM-C) – see manual code set • A follow-up encounter in behavioral health, including assessment, therapy, medication management, acute care. • A follow-up outpatient visit with a diagnosis of depression. • Follow-up with a care manager with documented assessment of depression symptoms assessment (any encounter that addresses depression symptoms). Care management encounters on the same day as the positive screen do not count as follow-up care. See care management code set. • Assessment on the same day as the positive screen which includes documentation of additional depression assessment indicating no depression.
Denominator	Patients 12 years and older as of the last day of the measurement year who had a billed preventive evaluation and management (E&M) visit with a participating PCP on or before Nov. 30, 2017.
Level of measure	Practice group
Minimum members	1 per practice group

Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018. Supplemental data submitted by Jan. 31, 2018.
HCPCS billing codes	G8431-Positive screen for clinical depression, follow-up plan documented (requires evidence of follow-up) G8510-Negative screen for clinical depression documented, follow-up plan not required (numerator compliant) G8511-Positive screen of clinical depression using an age appropriate standardized tool documented, follow-up plan not documented, reason not specified (requires evidence of follow-up)
Provider data input	Supplemental data includes: • HL7 • Patient Profile • Report #70 Supplemental data is subject to audit.
Targets: HMO/POS, ASO/PPO, Medicare and Medicaid	80%
Payout:	$0.20 per member per month
Notes:	Behavioral health encounters on the same day as the positive screen count as follow-up care. Outpatient encounters outside behavioral health on the same day as the positive screen do not count as follow-up care. For example, a visit with a primary care provider with a diagnosis of depression or dysthymia on the same day as the positive screen does not meet the criteria for follow-up care.

Depression flow chart



Chronic disease
Senior care education

Source	Priority Health Standard of Excellence
Identified measure	An incentive is provided for practices that have implemented routine discussions/counseling during annual wellness visits or a comprehensive physical exam to cover the following topics with Medicare members: • Fall prevention: Ways to prevent falls and problems with balance and walking • Proper coding for risk adjustment: Documentation of the members full burden of illness and coding to specificity to ensure the capture of a full diagnosis on a claim • Bladder control: How to improve bladder control • Mental health: What they can do if they have feelings of sadness, confusion, forgetfulness or loneliness • Physical health: How to stay physically active and the importance of exercise To receive credit for this incentive, providers must complete a pre-recorded educational webcast and complete the attestation survey (questionnaire). The 2017 webcast and attestation is posted on *priorityhealth.com/provider/manual/performance/pip/senior-care-education* (login required).
Age criteria	64 years of age and older
Exclusionary criteria	None
Level of measure	Practice group
Minimum members	1 Medicare member per practice group
Applicable product line	Medicare
Method of measurement	Implementation of routine discussions/counseling during annual wellness visits or a comprehensive physical exam to cover the topics outlined above in measure specifications by May 31, 2017. Completion of the Priority Health provider webcast and attestation survey by June 1, 2017.
Payout	$0.25 per member per month

Transformation of care
Medication Therapy Management (MTM)

Source	CMS 5-Star Measure
Target source	Priority Health Standard of Excellence
Identified measure	The percentage of patients identified by OutcomesMTM that received a comprehensive medication review.
Case definition	Members who meet eligibility criteria for medication therapy management (MTM) services as defined by OutcomesMTM. Members must be continuously enrolled in 2017 with no more than a 45-day gap in coverage and active with Priority health on Dec. 31, 2017. Members must be eligible for the MTM services as defined by OutcomesMTM greater than 60 days before Dec. 31, 2017.
Age criteria	18 years and older as of Dec. 31, 2017
Exclusionary criteria	None
Numerator	The number of patients in the denominator that have received one or more comprehensive medication reviews (CMRs)* during the measurement year.
Denominator	Patients 18 years and older as of the last day of the measurement year who met eligibility criteria for medication therapy management (MTM) services by Nov. 1, 2017 OR Received a comprehensive medication review (CMR) during the measurement year.
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	CMR billed by OutcomesMTM processed by Feb. 28, 2018.
Provider data input	None
Targets: HMO/POS, ASO/PPO, Medicare and Medicaid	TBD
Payout:	$TBD per measured member
Note	Practice groups receiving direct funding for pharmacists may be ineligible for this measure.

Transformation of care
Care management

<table>
<tr>
<td>Identified measure</td>
<td>
An incentive is available for primary care practices that have implemented a care management program which includes Priority Health members. Care management programs must include a minimum of one part- or full-time care manager assigned to the practice and actively working with Priority Health members.

To receive the care management incentive, practices must meet/provide the following in 2017:

Billed claims for care management services
Attestation form
Continuing education documentation

Claims
Practices must meet or exceed a 3% target of unique Priority Health members receiving care management services. This is a combined target for all active members assigned or attributed to the practice. Member continuous enrollment criteria does not apply. Members need only be active on the date care management services were provided.

The measure denominator is defined as the practice’s assigned/attributed 2017 member months divided by 12.

Claims with the following HCPCS and CPT codes will serve to identify members that have received care management services and will count toward the 3% care management billing threshold for PIP/CPC+:

<table>
<tr><th>CPT</th></tr>
<tr><td>G9001-G9002</td></tr>
<tr><td>G9007-G9008</td></tr>
<tr><td>98966-98968</td></tr>
<tr><td>99487</td></tr>
<tr><td>99490</td></tr>
</table>

Additional billing information can be found at: priorityhealth.com/provider/manual/billing-and-payment/services/caremanagement-codes.

Filemart report PIP_013 Care Management is available in Excel and PDF format and provides detail on care management claims practice-level performance. For information on this report or to be set up to receive it electronically, contact your Provider Performance Specialist.

Attestation
Practices will also be required to attest to care management program details. The following details will be addressed in an attestation survey. Each of these items is required to receive the incentive.

Care management program requirements:
</td>
</tr>
</table>

	• Full- or part-time equivalent care manager(s) in the practice • Care managers must have the licensure of a qualified health professional. This requirement aligns with licensure required to bill care management codes (RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP) • Care management staff trained under program models consistent with nationally recognized programs. Examples include: o Care Management Society of America o Geisinger o Health Services Institute o Learning Action Network o Michigan Center for Clinical System Improvement (MICCSI) o Michigan Primary Care Transformation (MiPCT) o Practice Transformation Institute o State Innovation Model (SIM) Priority Health requires all qualified health professionals working as a care manager to complete care management training under a nationally recognized program. Beyond the initial training requirement for first year care managers, each care manager must be able to document at least 8 hours of continuing education during 2017 to qualify for this incentive. • The practice's care management program is built on the team-based model • Provider registry or EMR use for risk stratification, or Priority Health population segmentation reports to identify patients for care management • The practice supports integration with the Priority Health care management team. Integration is defined as communication, as needed, between Priority Health and practice care managers to coordinate care. The frequency of communication will vary based on the membership size within the practice. • Practice written protocol or policy regarding patient populations selected for care management. • Practice or PHO/PO must have a physician champion for their care management program. If the practice is a member of a PO/PHO and the physician champion for care management covers all practice sites, this meets criteria. Independent practices must designate a physician lead for care management. • For information on the survey attestation survey requirements go to *priorityhealth.com/provider/manual/performance/pip/care-management* (login required). Practices may be audited to confirm compliance with measure criteria. Priority Health recommends the Michigan Primary Care Transformation (MiPCT) Demonstration, Agency for Healthcare Research and Quality (AHRQ) and Care Management Society of America (CMSA) as resources to learn more about care management.
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid

Method of measurement	Claims activity to measure 3% unique member target. Two billed care management claims in 2017 per unique member. Attestation via a completed survey due by June 1, 2017.
Targets:	Of all active members attributed or assigned to the practice, 3% or greater of unique members must have two billed care management claims for 2017 date of services.
Payout:	$2.75 per member per month for HMO/POS, ASO/PPO and Medicare. $1.25 per member per month for Medicaid
Notes	Practices contracted with Medicaid product line are eligible for both the care management measure and the PCMH incentive

Transformation of care
Patient-centered medical home (PCMH) recognition

Identified measure	Priority Health provides an incentive for all practices with active patient-centered medical home recognition. Priority Health is honoring three recognition programs: BCBS of Michigan, NCQA and URAC. **BCBS PGIP PCMH recognition** Practices are required to resubmit proof of PCMH renewal through BCBS by Aug. 15, 2017. This process aligns with BCBS' annual announcement of PGIP PCMH recognized practices. Practices that lose BCBS PCMH recognition July 2017 will have monthly pro-rated recognition end September 2017. Practices that are newly recognized by BCBS in July 2017 will have recognition begin October 2017. Failure to submit proof of recognition by Aug. 15, 2017 will stop existing PCMH recognition in September 2017. **NCQA recognition** Practices with existing NCQA recognition are requested to submit proof of recognition status during the fourth quarter of 2017. Practices that are newly recognized should submit proof of recognition as soon as it is granted. **URAC** Practices with existing URAC recognition are requested to submit proof of recognition status during fourth quarter 2016. Practices that are newly recognized should submit proof of recognition as soon as it is granted.
Level of measure	Practice group
Minimum members	1 per practice group
Applicable product line	Medicaid
Method of measurement	Practices must have active patient-centered medical home recognition. Priority Health is honoring three recognition programs: BCBS of Michigan, NCQA and URAC. **BCBS of Michigan** The BCBS PHO/PO notification Excel spreadsheet is required as proof of recognition status. Priority Health facility site IDs are required for those practice groups that received BCBS PGIP PCMH designation. Priority Health will require practices to submit the Priority Health facility site ID with the BCBS documentation. **NCQA** Newly-recognized practices must provide documentation of recognition status. A letter from NCQA or certificate is appropriate documentation. Priority Health will require practices to submit the Priority Health facility site ID with the NCQA documentation. **URAC** Practices must provide documentation of recognition status. A letter or certificate from URAC is appropriate documentation. Priority Health will require practices to submit the Priority Health facility site ID with the URAC documentation.
Payout	$1.00 per member per month
Note:	Practices contracted with Medicaid product line are eligible for both the care management measure and the PCMH incentive.

Transformation of care
CG CAHPS

<table>
<tr><td>Identified measure</td><td>An incentive is available to practices that have conducted the CG Consumer Assessment Healthcare Providers and Systems (CAHPS) patient experience survey.

CG CAHPS is promoted by the Michigan Patient Experience of Care (MIPEC) initiative. However, practices do not need to participate with the MIPEC initiative to receive an incentive.

Practices eligible for this incentive must conduct a minimum number of surveys as identified in the chart below. The chart was developed by the Agency for Healthcare Research and Quality (AHRQ). Practices are identified by Priority Health facility site ID. The minimum survey count applies to any patient, not just Priority Health members.

<table>
<tr><td># of Providers per practice site</td><td>Required # of completed surveys</td></tr>
<tr><td>1</td><td>50</td></tr>
<tr><td>2</td><td>100</td></tr>
<tr><td>3</td><td>150</td></tr>
<tr><td>4-9</td><td>175</td></tr>
<tr><td>10-13</td><td>200</td></tr>
<tr><td>14+</td><td>250</td></tr>
</table>

Based on the need for comparable, reliable and bias-free survey methodology and results, Priority Health reserves the right to require use of a certified vendor to conduct the CG-CAHPS survey.</td></tr>
<tr><td>Level of measurement</td><td>Practice group</td></tr>
<tr><td>Minimum members</td><td>No minimum member requirement</td></tr>
<tr><td>Applicable product lines</td><td>HMO/POS, ASO/PPO, Medicare and Medicaid</td></tr>
<tr><td>Method of measurement</td><td>Initiate CG CAHPS survey processes by May 1, 2017.

Submit practice-level performance data for each GC CAHPS survey question via flat ASC II or excel to Priority Health by Jan. 31, 2018.

For additional CG-CAHPS measure information and to download the practice-level performance data excel spreadsheets visit priorityhealth.com/provider/manual/performance/pip/cg-cahps (login required)</td></tr>
<tr><td>Payout</td><td>$0.10 per member per month</td></tr>
</table>

Transformation of care
Healthy Michigan Plan: HRA completion and open access

Identified measure	For calendar year 2017, primary care providers are eligible for a $25 incentive for proper completion of a health risk assessment (HRA) and billing of code of 99610 and an additional $25 if they are open to new Medicaid members on the date of service. **$25 incentive for HRA completion** Priority Health will pay a $25 incentive to participating PCPs only when the PCP (physician or mid-level primary care provider) completes the HRA form properly and timely. To receive the incentive, the PCP must: • Conduct an initial visit with the Healthy Michigan Plan member within 150 days of the member's original enrollment date • Bill an E&M code for the initial visit. Use code 96160 to indicate that the form was completed during the initial visit; bill with zero dollar charges as payment will occur with all other measures at settlement in April 2017 • Use age-appropriate preventive health V-code as the diagnosis with 99610 • Within 30 days of the initial visit OR the patient's effective date with Priority Health, whichever is later, fax the entire completed HRA to Priority Health at 616.942.0616. Incomplete forms will be returned to you for completion. Complete and fax back to Priority Health within 10 days. Failure to complete the form properly will result in ineligibility for the incentive. To be considered, HRA must be signed and include results of all questions and the provider attestation information. Handwritten forms must be legible. **$25 additional incentive for PCPs open to new Medicaid members** PCPs open to new Medicaid members can earn an additional $25 per completed HRA form. To receive the additional incentive, PCPs must meet the criteria above for earning the $25 HRA incentive and be open to new Medicaid members on the date of service on which the visit occurred. If a practice is currently closed to new Medicaid members, use the Participating Provider Change Form to inform Priority Health that you will open your practice to new members. Priority Health will use the date the form is received as the effective date of open status. Both incentive payments will be processed annually. Federally qualified health clinics and rural health clinics are eligible. Note: This incentive is paid once per member to the PCP who conducts the visit. Only those members with greater than a two month gap in coverage who re-enroll are eligible for the incentive again. The member's anchor date is the visit date with 99490 code. Members will show on the assigned PCP's report until such time as they have a qualifying visit with another PCP. From then on, the member will appear on the treating PCP's report.
Case definition	Members with coverage under the Healthy Michigan Plan. PCPs must be open to new members under their Priority Health Medicaid contract to receive the additional $25 payout.
Age criteria	19-64 years of age
Exclusionary criteria	None
Level of measure	Practice level. Open status is based on the individual practitioner.

Minimum members	1 per practice
Applicable product line	Healthy Michigan Plan
Method of measurement	Billed claims with CPT 96160 for dates of service in 2017, received and processed by Feb. 28, 2018 and completed HRA faxed.
Provider data input	Complete and faxed HRA within 30 days of the initial visit date of service and bill code 96160 for the initial visit.
Payout	$25 per measured member for faxing of completed HRA and billing of CPT 96160 within criteria $25 per measured member for Open Access on date of service.
Notes	Payment award will be paid with all other settlement payments (April 2018)

Transformation of care
All-cause readmissions

Source	Priority Health standard of excellence derived from HEDIS.
Identified measure	The percentage of acute inpatient stays discharged on or between December 1, 2016 and November 30, 2017 that were followed by an unplanned acute readmission for any diagnosis within 30 days. **Attestation** In an effort to assess your organization's current initiatives around preventing readmission rates ACNs will also be required to complete a survey attestation. The attestation survey will be available in January and will be emailed to ACNs that meet the minimum membership requirement. The deadline to complete the attestation survey is March 1, 2017.
Case definition	For each eligible acute inpatient stay the member must be continuously enrolled 365 days prior to discharge with no more than one 45 day gap in medical coverage and also be continuously enrolled 30 days post discharge with no gaps in medical coverage. In the event of an acute-to-acute direct transfer, the discharge date from the direct transfer is used for measurement. A direct transfer is when the discharge date from one acute inpatient stay is one calendar day apart or less from the next. All eligible inpatient stays are assigned to the members PCP on the date of discharge. A lower rate is better
Age criteria	18 years and older on the date of discharge
Exclusionary criteria	An acute inpatient stay is excluded from measurement if the first readmission within 30 days of discharge meets any of the following criteria: • A primary diagnosis of maintenance chemotherapy • A primary diagnosis of rehabilitation • An organ transplant (kidney, bone marrow, etc.)• A potentially planned procedure without a primary acute diagnosis Acute inpatient stays where the admission date is the same as the discharge date are excluded. An acute inpatient stay is also excluded for any of the following reasons: • The member died during stay • The acute inpatient stay has a primary diagnosis of pregnancy • The acute inpatient stay has a primary diagnosis of a condition originating in the perinatal period
Numerator	Count of unique acute inpatient stays from the denominator with an unplanned acute readmission for any diagnosis within 30 days of a discharge.
Denominator	Count of unique acute inpatient stays with a discharge date on or between Dec. 1, 2016 and Nov. 30, 2017.
Level of measure	Contracted Accountable Care Network (ACN)

Minimum members	ACNs with 10,000 or more unique members defined by product line as of Jan. 31, 2017 are eligible for this measure.
Applicable product lines	HMO/POS, ASO/PPO, Medicare and Medicaid
Method of measurement	Claims data processed by Feb. 28, 2018.
Provider data input	None
Targets: HMO/POS, ASO/PPO, Medicare and Medicaid	TBD
Payout:	TBD

Transformation of care
ED visits: PCP treatable care

<table>
<tr><td>MiPCT</td><td>Aligned with MiPCT</td></tr>
<tr><td>Case definition</td><td>Emergency department utilization of PCP treatable care as identified through ICD-10 coding. PCP treatable care is based on the NYU code set.

Performance is measured in a PCP treatable ED rate per 1,000 members.

A shared savings incentive will be provided to primary care practices that:
Exceed (lower than) a target of 64 ED PCP treatable visits per thousand, or
Experience improvement from year-end 2016 to year-end 2017 and have a year-end 2017 rate between 64 and 88 ED PCP treatable visits per thousand.</td></tr>
<tr><td>Age criteria</td><td>All ages</td></tr>
<tr><td>Exclusionary criteria</td><td>ED visits resulting in an inpatient admission</td></tr>
<tr><td>Numerator</td><td>Number of PCP treatable ED visits with a PCP treatable defined primary diagnosis.</td></tr>
<tr><td>Denominator</td><td>Member months affiliated with an ACN</td></tr>
<tr><td>Level of measure</td><td>Accountable Care Network (ACN)</td></tr>
<tr><td>Minimum members</td><td>A minimum of 12,000 annual member months at the ACN level in 2017.

ACNs with fewer than 12,000 annual member months in 2016 who reach more than 12,000 annual member months in 2017, will only be eligible for the target measurement. No improvement criteria will apply.</td></tr>
<tr><td>Applicable product lines</td><td>HMO/POS, Medicaid</td></tr>
<tr><td>Method of measurement</td><td>Claims data submitted by Feb. 28, 2018</td></tr>
<tr><td>Calculation</td><td>PCP treatable ED visits x 12,000
Total member months</td></tr>
<tr><td>Target, improvement and shared savings</td><td>Each ED PCP treatable visits is valued at TBD for each per thousand increment.

<table>
<tr><td>Target/Improvement</td><td>Share of savings</td></tr>
<tr><td>Rate that exceeds (lower than) 64</td><td>50% savings share for each ED PCP treatable unit below 64</td></tr>
<tr><td>Experience improvement from 2016 to 2017 and have a rate between 64 and 88</td><td>25% savings share for each ED PCP treatable unit between 64 and 88</td></tr>
</table>
</td></tr>
</table>

Measure code sets

Cervical cancer screenings

CPT			HCPCS	
88141	88150	88165	G0123	G0145
88142	88152	88166	G0124	G0147
88143	88153	88167	G0141	G0148
88147	88154	88174	G0143	P3000
88148	88164	88175	G0144	P3001
				Q0091

HPV screening

CPT	HCPCS
87620	G0476
87621	
87622	
87624	
87625	

Hysterectomy exclusion

CPT			ICD10CM
51925	58267	58570	Q51.5
56308	58270	58571	Z90.710
57540	58275	58572	Z90.712
57545	58280	58573	0UTC0ZZ
57550	58285	58951	0UTC4ZZ
57555	58290	58953	0UTC7ZZ
57556	58291	58954	0UTC8ZZ
58150	58292	58956	
58152	58293	59135	
58200	58294		
58210	58548		
58240	58550		
58260	58552		
58262	58553		
58263	58554		

Measures codes for childhood immunizations

DTaP		IPV		MMR		
CPT	CVX	CPT	CVX	CPT	CVX	ICD10CM
90698	20	90698	10	90705	05	B26.0
90700	50	90713	110	90707	03	B26.1
90721	106	90723	120	90710	94	B26.2
90723	110			90708	04	B26.3
	120			90704	07	B26.81
				90706	06	B26.82
						B26.83
						B26.84
						B26.85
						B26.89
						B26.9
						B06.00
						B06.01
						B06.02
						B06.09
						B06.81
						B06.82
						B06.89
						B06.9

HIB		HepB				
CPT	CVX	CPT	CVX	HCPCS	ICD10PCS	ICD10CM
90644	46	90723	08	G0010	3E0234Z	B16.0
90645	47	90740	44	3E0234Z		B16.1
90646	48	90744	51			B16.2
90647	49	90747	110			B16.9
90648	50	90748				B17.0
90698	51					B18.0
90721	120					B18.1
90748	148					B19.10
						B19.11
						Z22.51

Varicella						
CPT	CVX	ICD10CM				
90710	21	B01.0	B01.89	B02.22	B02.31	B02.7
90716	94	B01.11	B01.9	B02.23	B02.32	B02.8
		B01.12	B02.0	B02.24	B02.33	B02.9
		B01.2	B02.1	B02.29	B02.34	
		B01.81	B02.21	B02.30	B02.39	

Pneumoncocal Conjugate		
CPT	CVX	HCPCS
90669	100	G0009
90670	133	

HIV

ICD10CM
B20
Z21

HIV type 2

ICD10CM
B97.35

Severe combined immunodeficiency

ICD10CM
D81.0
D81.1
D81.2
D81.9

Measure codes for adolescent immunizations

Meningoccal		Tdap		HPV	
CPT	CVX	CPT	CVX	CPT	CVX
90644	136	90715	115	90649	62
90734	148			90650	118
				90651	165

Measure codes for well-child visits 3-6 years

CPT	HCPCS	ICD10CM	
99381	G0438	Z00.00	Z02.3
99382	G0439	Z00.01	Z02.4
99383		Z00.110	Z02.5
99384		Z00.111	Z02.6
99385		Z00.121	Z02.71
99391		Z00.129	Z02.79
99392		Z00.5	Z02.81
99393		Z00.8	Z02.82
99394		Z02.0	Z02.83
99395		Z02.1	Z02.89
99461		Z02.2	Z02.9

Measure codes for chlamydia screening

CPT	
87110	87491
87270	87492
87320	87810
87490	

Sexually active women

CPT					HCPCS	UBREV
11976	59150	59841	80055	87624	G0101	0112
57022	59151	59850	80081	87625	G0123	0122
57170	59160	59851	82105	87660	G0124	0132
58300	59200	59852	82106	87661	G0141	0142
58301	59300	59855	82143	87808	G0143	0152
58600	59320	59856	82731	87810	G0144	0720
58605	59325	59857	83632	87850	G0145	0721
58615	59350	59866	83661	88141	G0147	0722
58970	59400	59870	83662	88142	G0148	0724
58974	59409	59871	83663	88143	G0475	0729
58976	59410	59897	83664	88147	G0476	0923
59000	59412	59898	84163	88148	H1000	
59001	59414	59899	84704	88150	H1001	
59012	59425	76801	86592	88152	H1003	
59015	59426	76805	86593	88153	H1004	
59020	59430	76811	86631	88154	H1005	

Sexually active women

CPT					HCPCS
59025	59510	76813	86632	88164	P3000
59030	59514	76815	87110	88165	P3001
59050	59515	76816	87164	88166	Q0091
59051	59525	76817	87166	88167	S0199
59070	59610	76818	87270	88174	S4981
59072	59612	76819	87320	88175	S8055
59074	59614	76820	87490	88235	
59076	59618	76821	87491	88267	
59100	59620	76825	87492	88269	
59120	59622	76826	87590		
59121	59812	76827	87591		
59130	59820	76828	87592		
59135	59821	76941	87620		
59136	59830	76945	87621		
59140	59840	76946	87622		

Sexually active women

ICD10CM						
A34	A52.77	A56.11	N71.1	Z30.011	Z32.2	Z3A.08
A51.0	A52.78	A56.19	N71.9	Z30.012	Z32.3	Z3A.09
A51.1	A52.79	A56.2	N93.0	Z30.013	Z33.1	Z3A.10
A51.2	A52.8	A56.3	N94.1	Z30.014	Z33.2	Z3A.11
A51.31	A52.9	A56.4	N96	Z30.018	Z34.00	Z3A.12
A51.32	A53.0	A56.8	N97.0	Z30.019	Z34.01	Z3A.13
A51.39	A53.9	A57	N97.1	Z30.02	Z34.02	Z3A.14
A51.41	A54.00	A58	N97.2	Z30.09	Z34.03	Z3A.15
A51.42	A54.01	A59.00	N97.8	Z30.2	Z34.80	Z3A.16
A51.43	A54.02	A59.01	N97.9	Z30.40	Z34.81	Z3A.17
A51.44	A54.03	A59.03	O94	Z30.41	Z34.82	Z3A.18
A51.45	A54.09	A59.09	T38.4X1A	Z30.42	Z34.83	Z3A.19
A51.46	A54.1	A59.8	T38.4X1D	Z30.430	Z34.90	Z3A.20
A51.49	A54.21	A59.9	T38.4X1S	Z30.431	Z34.91	Z3A.21
A51.5	A54.24	A60.00	T38.4X2A	Z30.432	Z34.92	Z3A.22
A51.9	A54.29	A60.03	T38.4X2D	Z30.433	Z34.93	Z3A.23
A52.00	A54.30	A60.04	T38.4X2S	Z30.49	Z36	Z3A.24
A52.01	A54.31	A60.09	T38.4X3A	Z30.8	Z37.0	Z3A.25
A52.02	A54.32	A60.1	T38.4X3D	Z30.9	Z37.1	Z3A.26

Sexually active women

ICD10CM						
A52.03	A54.33	A60.9	T38.4X3S	Z31.0	Z37.2	Z3A.27
A52.04	A54.39	A63.0	T38.4X4A	Z31.41	Z37.3	Z3A.28
A52.05	A54.40	A63.8	T38.4X4D	Z31.42	Z37.4	Z3A.29
A52.06	A54.41	A64	T38.4X4S	Z31.430	Z37.50	Z3A.30
A52.09	A54.42	B20	T38.4X5A	Z31.438	Z37.51	Z3A.31
A52.10	A54.43	B97.33	T38.4X5D	Z31.440	Z37.52	Z3A.32
A52.11	A54.49	B97.34	T38.4X5S	Z31.441	Z37.53	Z3A.33
A52.12	A54.5	B97.35	T38.4X6A	Z31.448	Z37.54	Z3A.34
A52.13	A54.6	B97.7	T38.4X6D	Z31.49	Z37.59	Z3A.35
A52.14	A54.81	F52.6	T38.4X6S	Z31.5	Z37.60	Z3A.36
A52.15	A54.82	F53	T83.31XA	Z31.61	Z37.61	Z3A.37
A52.16	A54.83	G44.82	T83.31XD	Z31.62	Z37.62	Z3A.38
A52.17	A54.84	N70.01	T83.31XS	Z31.69	Z37.63	Z3A.39
A52.19	A54.85	N70.02	T83.32XA	Z31.81	Z37.64	Z3A.40
A52.2	A54.86	N70.03	T83.32XD	Z31.82	Z37.69	Z3A.41
A52.3	A54.89	N70.11	T83.32XS	Z31.83	Z37.7	Z3A.42
A52.71	A54.9	N70.12	T83.39XA	Z31.84	Z37.9	Z3A.49
A52.72	A55	N70.13	T83.39XD	Z31.89	Z39.0	Z64.0
A52.73	A56.00	N70.91	T83.39XS	Z31.9	Z39.1	Z64.1
A52.74	A56.01	N70.92	Z20.2	Z32.00	Z39.2	Z72.51
A52.75	A56.02	N70.93	Z21	Z32.01	Z3A.00	Z72.52
A52.76	A56.09	N71.0	Z22.4	Z32.02	Z3A.01	Z72.53
Z79.3						
Z92.0						
Z97.5						
Z98.51						

Pregnancy test (when billed with diagnostic radiology)

CPT	UBREV
81025	0925
84702	
84703	

Diagnostic radiology

CPT	UBREV		
70010-76499	0320	0322	0324
	0321	0323	0329

Exclusion for prescription retinoid (lostretinoin) identified by National Drug Code

Oral contraceptive prescriptions to determine sexual activity identified by National Drug Code

Measure code for lead screening in children

Lead test

CPT
83655

Measure codes for adult BMI

Z68.51 - Z68.54 - members younger than 20
Z68.1 – Z68.45 for members 20-74

Measure codes for colorectal cancer screening

Colonoscopy

CPT				HCPCS
44388	44403	45381	45391	G0105
44389	44404	45382	45392	G0121
44390	44405	45383	45393	
44391	44406	45384	45398	
44392	44407	45385		
44393	44408	45386		
44394	45355	45387		
44397	45378	45388		
44401	45379	45389		
44402	45380	45390		

Fecal occult blood test (FOBT)

CPT	HCPCS
82270	G0328
82274	

Flexible sigmoidoscopy

CPT				HCPCS
45330	45334	45339	45345	G0104
45331	45335	45340	45346	
45332	45337	45341	45347	
45333	45338	45342	45349	
			45350	

Colorectal cancer

HCPCS	ICD10CM		
G0213	C18.0	C18.7	C78.5
G0214	C18.1	C18.8	Z85.038
G0215	C18.2	C18.9	Z85.048
G0231	C18.3	C19	
	C18.4	C20	
	C18.5	C21.2	
	C18.6	C21.8	

Total colectomy

CPT	ICD10PCS
44150	0DTE0ZZ
44151	0DTE4ZZ
44152	0DTE7ZZ
44153	0DTE8ZZ
44155	
44156	
44157	
44158	
44210	
44211	
44212	

CT colonography

CPT
74263

FIT-DNA (Cologuard)

CPT	HCPCS
81528	G0464

Measure codes for diabetes care measures

Diabetes

ICD-10CM					
E10.10	E10.59	E11.339	E11.649	E13.41	O24.019
E10.11	E10.610	E11.341	E11.65	E13.42	O24.02
E10.21	E10.618	E11.349	E11.69	E13.43	O24.03
E10.22	E10.620	E11.351	E11.8	E13.44	O24.111
E10.29	E10.621	E11.359	E11.9	E13.49	O24.112
E10.311	E10.622	E11.36	E13.00	E13.51	O24.113
E10.319	E10.628	E11.39	E13.01	E13.52	O24.119
E10.321	E10.630	E11.40	E13.10	E13.59	O24.12

Diabetes

ICD-10CM					
E10.329	E10.638	E11.41	E13.11	E13.610	O24.13
E10.331	E10.641	E11.42	E13.21	E13.618	O24.311
E10.339	E10.649	E11.43	E13.22	E13.620	O24.312
E10.341	E10.65	E11.44	E13.29	E13.621	O24.313
E10.349	E10.69	E11.49	E13.311	E13.622	O24.319
E10.351	E10.8	E11.51	E13.319	E13.628	O24.32
E10.359	E10.9	E11.52	E13.321	E13.630	O24.33
E10.36	E11.00	E11.59	E13.329	E13.638	O24.811
E10.39	E11.01	E11.610	E13.331	E13.641	O24.812
E10.40	E11.21	E11.618	E13.339	E13.649	O24.813
E10.41	E11.22	E11.620	E13.341	E13.65	O24.819
E10.42	E11.29	E11.621	E13.349	E13.69	O24.82
E10.43	E11.311	E11.622	E13.351	E13.8	O24.83
E10.44	E11.319	E11.628	E13.359	E13.9	
E10.49	E11.321	E11.630	E13.36	O24.011	
E10.51	E11.329	E11.638	E13.39	O24.012	
E10.52	E11.331	E11.641	E13.40	O24.013	

HbA1C lab codes

CPT	
83036	3044F
83037	3045F
	3046F

Diabetes care: HbA1c less than 7.0% - CABG exclusion

CPT	HCPCS	ICD10PCS			
33510	S2205	0210093	02100Z8	02120A8	02130JC
33511	S2206	0210098	02100Z9	02120A9	02130JF
33512	S2207	0210099	02100ZC	02120AC	02130JW
33513	S2208	0211093	02100ZF	02120AF	02130K3
33514	S2209	0211098	021109C	02120AW	02130K8
33516		0211099	021109F	02120J3	02130K9
33517		0212093	021109W	02120J8	02130KC
33518		0212098	02110A3	02120J9	02130KF
33519		0212099	02110A8	02120JC	02130KW
33521		0213093	02110A9	02120JF	02130Z3
33522		0213098	02110AC	02120JW	02130Z8
33523		0213099	02110AF	02120K3	02130Z9
33533		021009C	02110AW	02120K8	02130ZC
33534		021009F	02110J3	02120K9	02130ZF
33535		021009W	02110J8	02120KC	
33536		02100A3	02110J9	02120KF	
		02100A8	02110JC	02120KW	
		02100A9	02110JF	02120Z3	
		02100AC	02110JW	02120Z8	
		02100AF	02110K3	02120Z9	
		02100AW	02110K8	02120ZC	
		02100J3	02110K9	02120ZF	
		02100J8	02110KC	021309C	
		02100J9	02110KF	021309F	
		02100JC	02110KW	021309W	
		02100JF	02110Z3	02130A3	
		02100JW	02110Z8	02130A8	
		02100K3	02110Z9	02130A9	
		02100K8	02110ZC	02130AC	
		02100K9	02110ZF	02130AF	
		02100KC	021209C	02130AW	
		02100KF	021209F	02130J3	
		02100KW	021209W	02130J8	
		02100Z3	02120A3	02130J9	

Diabetes care: HbA1c less than 7.0% - PCI exclusion

CPT	HCPCS	ICD10PCS				
92920	C9600	0270346	02703Z6	02713TZ	02723T6	02733DZ
92924	C9602	0270446	02703ZZ	02713Z6	02723TZ	02733T6
92928	C9604	0271346	027044Z	02713ZZ	02723Z6	02733TZ
92933	C9606	0271446	02704D6	027144Z	02723ZZ	02733Z6
92937	C9607	0272346	02704DZ	02714D6	027244Z	02733ZZ
92941		0272446	02704T6	02714DZ	02724D6	027344Z
92943		0273346	02704TZ	02714T6	02724DZ	02734D6
92980		0273446	02704Z6	02714TZ	02724T6	02734DZ
92982		027034Z	02704ZZ	02714Z6	02724TZ	02734T6
92995		02703D6	027134Z	02714ZZ	02724Z6	02734TZ
		02703DZ	02713D6	027234Z	02724ZZ	02734Z6
		02703T6	02713DZ	02723D6	027334Z	02734ZZ
		02703TZ	02713T6	02723DZ	02733D6	

Diabetes care: Controlled HbA1c less than 7.0% - IVD exclusion

ICD10CM						
I20.0	I63.20	I66.09	I70.328	I70.502	I70.65	I75.013
I20.8	I63.211	I66.11	I70.329	I70.503	I70.661	I75.019
I20.9	I63.212	I66.12	I70.331	I70.508	I70.662	I75.021
I24.0	I63.219	I66.13	I70.332	I70.509	I70.663	I75.022
I24.1	I63.22	I66.19	I70.333	I70.511	I70.668	I75.023
I24.8	I63.231	I66.21	I70.334	I70.512	I70.669	I75.029
I24.9	I63.232	I66.22	I70.335	I70.513	I70.691	I75.81
I25.10	I63.239	I66.23	I70.338	I70.518	I70.692	I75.89
I25.110	I63.29	I66.29	I70.339	I70.519	I70.693	
I25.111	I63.30	I66.3	I70.341	I70.521	I70.698	
I25.118	I63.311	I66.8	I70.342	I70.522	I70.699	
I25.119	I63.312	I66.9	I70.343	I70.523	I70.701	
I25.5	I63.319	I67.2	I70.344	I70.528	I70.702	
I25.6	I63.321	I70.0	I70.345	I70.529	I70.703	
I25.700	I63.322	I70.1	I70.348	I70.531	I70.708	
I25.701	I63.329	I70.201	I70.349	I70.532	I70.709	
I25.708	I63.331	I70.202	I70.35	I70.533	I70.711	
I25.709	I63.332	I70.203	I70.361	I70.534	I70.712	
I25.710	I63.339	I70.208	I70.362	I70.535	I70.713	
I25.711	I63.341	I70.209	I70.363	I70.538	I70.718	
I25.718	I63.342	I70.211	I70.368	I70.539	I70.719	
I25.719	I63.349	I70.212	I70.369	I70.541	I70.721	
I25.720	I63.39	I70.213	I70.391	I70.542	I70.722	

Diabetes care: Controlled HbA1c less than 7.0% - IVD exclusion

ICD10CM					
I25.721	I63.40	I70.218	I70.392	I70.543	I70.723
I25.728	I63.411	I70.219	I70.393	I70.544	I70.728
I25.729	I63.412	I70.221	I70.398	I70.545	I70.729
I25.730	I63.419	I70.222	I70.399	I70.548	I70.731
I25.731	I63.421	I70.223	I70.401	I70.549	I70.732
I25.738	I63.422	I70.228	I70.402	I70.55	I70.733
I25.739	I63.429	I70.229	I70.403	I70.561	I70.734
I25.750	I63.431	I70.231	I70.408	I70.562	I70.735
I25.751	I63.432	I70.232	I70.409	I70.563	I70.738
I25.758	I63.439	I70.233	I70.411	I70.568	I70.739
I25.759	I63.441	I70.234	I70.412	I70.569	I70.741
I25.760	I63.442	I70.235	I70.413	I70.591	I70.742
I25.761	I63.449	I70.238	I70.418	I70.592	I70.743
I25.768	I63.49	I70.239	I70.419	I70.593	I70.744
I25.769	I63.50	I70.241	I70.421	I70.598	I70.745
I25.790	I63.511	I70.242	I70.422	I70.599	I70.748
I25.791	I63.512	I70.243	I70.423	I70.601	I70.749
I25.798	I63.519	I70.244	I70.428	I70.602	I70.75
I25.799	I63.521	I70.245	I70.429	I70.603	I70.761
I25.810	I63.522	I70.248	I70.431	I70.608	I70.762
I25.811	I63.529	I70.249	I70.432	I70.609	I70.763
I25.812	I63.531	I70.25	I70.433	I70.611	I70.768
I25.82	I63.532	I70.261	I70.434	I70.612	I70.769
I25.83	I63.539	I70.262	I70.435	I70.613	I70.791
I25.84	I63.541	I70.263	I70.438	I70.618	I70.792
I25.89	I63.542	I70.268	I70.439	I70.619	I70.793
I25.9	I63.549	I70.269	I70.441	I70.621	I70.798
I63.00	I63.59	I70.291	I70.442	I70.622	I70.799
I63.011	I63.6	I70.292	I70.443	I70.623	I70.8
I63.012	I63.8	I70.293	I70.444	I70.628	I70.90
I63.019	I63.9	I70.298	I70.445	I70.629	I70.91
I63.02	I65.01	I70.299	I70.448	I70.631	I70.92
I63.031	I65.02	I70.301	I70.449	I70.632	I74.01
I63.032	I65.03	I70.302	I70.45	I70.633	I74.09
I63.039	I65.09	I70.303	I70.461	I70.634	I74.10
I63.09	I65.1	I70.308	I70.462	I70.635	I74.11
I63.10	I65.21	I70.309	I70.463	I70.638	I74.19
I63.111	I65.22	I70.311	I70.468	I70.639	I74.2

Diabetes care: Controlled HbA1c less than 7.0% - IVD exclusion

ICD10CM					
I63.112	I65.23	I70.312	I70.469	I70.641	I74.3
I63.119	I65.29	I70.313	I70.491	I70.642	I74.4
I63.12	I65.8	I70.318	I70.492	I70.643	I74.5
I63.131	I65.9	I70.319	I70.493	I70.644	I74.8
I63.132	I66.01	I70.321	I70.498	I70.645	I74.9
I63.139	I66.02	I70.322	I70.499	I70.648	I75.011
I63.19	I66.03	I70.323	I70.501	I70.649	I75.012

Diabetes care: Controlled HbA1c less than 7.0% - thoracic aortic aneurysm exclusion

ICD10CM
I71.01
I71.03
I71.1
I71.2
I71.5
I71.6

Diabetes care: Controlled HbA1c less than 7.0% - CHF exclusion

ICD10CM			
I42.0	I42.8	I50.30	I50.9
I42.1	I42.9	I50.31	
I42.2	I43	I50.32	
I42.3	I50.1	I50.33	
I42.4	I50.20	I50.40	
I42.5	I50.21	I50.41	
I42.6	I50.22	I50.42	
I42.7	I50.23	I50.43	

Diabetes care: Controlled HbA1c less than 7.0% - Prior myocardial infarction exclusion

ICD-10CM		
I21.01	I21.4	I23.2
I21.02	I22.0	I23.3
I21.09	I22.1	I23.4
I21.11	I22.2	I23.5
I21.19	I22.8	I23.6
I21.21	I22.9	I23.7
I21.29	I23.0	I23.8
I21.3	I23.1	I25.2

Diabetes care: Controlled HbA1c less than 7.0% - blindness exclusion

ICD10CM	
H54.0	H54.41
H54.10	H54.42
H54.11	H54.50
H54.12	H54.51
H54.2	H54.52
H54.40	H54.8

Diabetes care: Controlled HbA1c less than 7.0% - lower extremity amputation exclusion

CPT	ICD10CM	ICD10PCS			
27290	Z89.411	0Y620ZZ	0Y6M0Z8	0Y6Q0Z3	0Y6W0Z3
27295	Z89.412	0Y630ZZ	0Y6M0Z9	0Y6R0Z0	0Y6X0Z0
27590	Z89.419	0Y640ZZ	0Y6M0ZB	0Y6R0Z1	0Y6X0Z1
27591	Z89.421	0Y670ZZ	0Y6M0ZC	0Y6R0Z2	0Y6X0Z2
27592	Z89.422	0Y680ZZ	0Y6M0ZD	0Y6R0Z3	0Y6X0Z3
27594	Z89.429	0Y6C0Z1	0Y6M0ZF	0Y6S0Z0	0Y6Y0Z0
27596	Z89.431	0Y6C0Z2	0Y6N0Z0	0Y6S0Z1	0Y6Y0Z1
27598	Z89.432	0Y6C0Z3	0Y6N0Z4	0Y6S0Z2	0Y6Y0Z2
27880	Z89.439	0Y6D0Z1	0Y6N0Z5	0Y6S0Z3	0Y6Y0Z3
27881	Z89.441	0Y6D0Z2	0Y6N0Z6	0Y6T0Z0	
27882	Z89.442	0Y6D0Z3	0Y6N0Z7	0Y6T0Z1	
27884	Z89.449	0Y6F0ZZ	0Y6N0Z8	0Y6T0Z2	
27886	Z89.511	0Y6G0ZZ	0Y6N0Z9	0Y6T0Z3	
27888	Z89.512	0Y6H0Z1	0Y6N0ZB	0Y6U0Z0	
27889	Z89.519	0Y6H0Z2	0Y6N0ZC	0Y6U0Z1	
28800	Z89.521	0Y6H0Z3	0Y6N0ZD	0Y6U0Z2	
28805	Z89.522	0Y6J0Z1	0Y6N0ZF	0Y6U0Z3	
28810	Z89.529	0Y6J0Z2	0Y6P0Z0	0Y6V0Z0	
28820	Z89.611	0Y6J0Z3	0Y6P0Z1	0Y6V0Z1	
28825	Z89.612	0Y6M0Z0	0Y6P0Z2	0Y6V0Z2	
	Z89.619	0Y6M0Z4	0Y6P0Z3	0Y6V0Z3	
	Z89.621	0Y6M0Z5	0Y6Q0Z0	0Y6W0Z0	
	Z89.622	0Y6M0Z6	0Y6Q0Z1	0Y6W0Z1	
	Z89.629	0Y6M0Z7	0Y6Q0Z2	0Y6W0Z2	

Diabetes care: Controlled HbA1c less than 7.0% - dementia exclusion

ICD10CM					
F01.50	F03.91	F13.97	F19.27	G30.9	G31.09
F01.51	F04	F18.17	F19.97	G31.83	
F02.80	F10.27	F18.27	G30.0	G31.01	
F02.81	F10.97	F18.97	G30.1	G31.09	
F03.90	F13.27	F19.17	G30.8	G31.01	

Measure codes for Diabetes care: Annual retinal eye exam

Retinal eye exam

CPT					HCPCS	CPT II
67028	67108	67227	92228	99242	S0620	2022F
67030	67110	67228	92230	99243	S0621	2024F
67031	67112	92002	92235	99244	S3000	2026F
67036	67113	92004	92240	99245		3072F
67039	67121	92012	92250			
67040	67141	92014	92260			
67041	67145	92018	99203			
67042	67208	92019	99204			
67043	67210	92134	99205			
67101	67218	92225	99213			
67105	67220	92226	99214			
67107	67221	92227	99215			

Diabetes mellitus without complications

ICD10CM
E10.9
E11.9
E13.9

Measure codes for Diabetes care: Monitoring for nephropathy

Microalbuminuria and treatment

CPT	CPT II	ICD10CM				
81000	3060F	E08.21	N01.0	N04.3	N07.6	Q60.2
81001	3061F	E08.22	N01.1	N04.4	N07.7	Q60.3
81002	3062F	E08.29	N01.2	N04.5	N07.8	Q60.4
81003	3066F	E09.21	N01.3	N04.6	N07.9	Q60.5
81005	4010F	E09.22	N01.4	N04.7	N08	Q60.6
82042		E09.29	N01.5	N04.8	N14.0	Q61.00
82043		E10.21	N01.6	N04.9	N14.1	Q61.01
82044		E10.22	N01.7	N05.0	N14.2	Q61.02
84156		E10.29	N01.8	N05.1	N14.3	Q61.11
		E11.21	N01.9	N05.2	N14.4	Q61.19
		E11.22	N02.0	N05.3	N17.0	Q61.2
		E11.29	N02.1	N05.4	N17.1	Q61.3
		E13.21	N02.2	N05.5	N17.2	Q61.4
		E13.22	N02.3	N05.6	N17.8	Q61.5
		E13.29	N02.4	N05.7	N17.9	Q61.8
		I12.0	N02.5	N05.8	N18.1	Q61.9
		I12.9	N02.6	N05.9	N18.2	R80.0
		I13.0	N02.7	N06.0	N18.3	R80.1
		I13.10	N02.8	N06.1	N18.4	R80.2
		I13.11	N02.9	N06.2	N18.5	R80.3
		I13.2	N03.0	N06.3	N18.6	R80.8
		I15.0	N03.1	N06.4	N18.9	R80.9
		I15.1	N03.2	N06.5	N19	
		N00.0	N03.3	N06.6	N25.0	
		N00.1	N03.4	N06.7	N25.1	
		N00.2	N03.5	N06.8	N25.81	
		N00.3	N03.6	N06.9	N25.89	
		N00.4	N03.7	N07.0	N25.9	
		N00.5	N03.8	N07.1	N26.1	
		N00.6	N03.9	N07.2	N26.2	
		N00.7	N04.0	N07.3	N26.9	
		N00.8	N04.1	N07.4	Q60.0	
		N00.9	N04.2	N07.5	Q60.1	

Stage 4 Chronic kidney disease

CPT
N18.4

End stage renal disease (ESRD)

CPT		HCPCS	ICD10CM	ICD10PCS	UBREV	
36147	90958	G0257	N18.5	3E1M39Z	0800	0839
36800	90959	S9339	N18.6	5A1D00Z	0801	0840
36810	90960		Z91.15	5A1D60Z	0802	0841
36815	90961		Z99.2		0803	0842
36818	90962				0804	0843
36819	90965				0809	0844
36820	90966				0820	0845
36821	90969				0821	0849
36831	90970				0822	0850
36832	90989				0823	0851
36833	90993				0824	0852
90935	90997				0825	0853
90937	90999				0829	0854
90940	99512				0830	0855
90945					0831	0859
90947					0832	0880
90957					0833	0881
					0834	0882
					0835	0889

Kidney transplant

CPT	HCPCS	ICD10CM	ICD10PCS	UBREV
50300	S2065	Z94.0	0TY00Z0	367
50320			0TY00Z1	
50340			0TY00Z2	
50360			0TY10Z0	
50365			0TY10Z1	
50370			0TY10Z2	
50380				

Measure codes for hypertension: Controlled blood pressure

Blood pressure

CPT II
Systolic
2074F - Most recent systolic blood pressure < 130 mm Hg
3075F - Most recent systolic blood pressure 130 -139 mm Hg
3077F - Most recent systolic blood pressure greater than or equal to 140 mm Hg
Diastolic
3078F - Most recent diastolic blood pressure less than 80 mm Hg
3079F - Most recent diastolic blood pressure 80-89 mm Hg
3080F - Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Pregnancy exclusions

ICD10CM						
O00.0	O03.5	O07.0	O09.00	O09.519	O09.893	O10.319
O00.1	O03.6	O07.1	O09.01	O09.521	O09.899	O10.32
O00.2	O03.7	O07.2	O09.02	O09.522	O09.90	O10.33
O00.8	O03.80	O07.30	O09.03	O09.523	O09.91	O10.411
O00.9	O03.81	O07.31	O09.10	O09.529	O09.92	O10.412
O01.0	O03.82	O07.32	O09.11	O09.611	O09.93	O10.413
O01.1	O03.83	O07.33	O09.12	O09.612	O10.011	O10.419
O01.9	O03.84	O07.34	O09.13	O09.613	O10.012	O10.42
O02.0	O03.85	O07.35	O09.211	O09.619	O10.013	O10.43
O02.1	O03.86	O07.36	O09.212	O09.621	O10.019	O10.911
O02.81	O03.87	O07.37	O09.213	O09.622	O10.02	O10.912
O02.89	O03.88	O07.38	O09.219	O09.623	O10.03	O10.913
O02.9	O03.89	O07.39	O09.291	O09.629	O10.111	O10.919
O03.0	O03.9	O07.4	O09.292	O09.70	O10.112	O10.92
O03.1	O04.5	O08.0	O09.293	O09.71	O10.113	O10.93
O03.2	O04.6	O08.1	O09.299	O09.72	O10.119	O11.1
O03.30	O04.7	O08.2	O09.30	O09.73	O10.12	O11.2
O03.31	O04.80	O08.3	O09.31	O09.811	O10.13	O11.3
O03.32	O04.81	O08.4	O09.32	O09.812	O10.211	O11.9
O03.33	O04.82	O08.5	O09.33	O09.813	O10.212	O12.00
O03.34	O04.83	O08.6	O09.40	O09.819	O10.213	O12.01
O03.35	O04.84	O08.7	O09.41	O09.821	O10.219	O12.02
O03.36	O04.85	O08.81	O09.42	O09.822	O10.22	O12.03
O03.37	O04.86	O08.82	O09.43	O09.823	O10.23	O12.10
O03.38	O04.87	O08.83	O09.511	O09.829	O10.311	O12.11

Pregnancy exclusions

ICD10CM						
O03.39	O04.88	O08.89	O09.512	O09.891	O10.312	O12.12
O03.4	O04.89	O08.9	O09.513	O09.892	O10.313	O12.13
O12.20	O22.10	O23.32	O24.419	O26.41	O26.879	O29.212
O12.21	O22.11	O23.33	O24.420	O26.42	O26.891	O29.213
O12.22	O22.12	O23.40	O24.424	O26.43	O26.892	O29.219
O12.23	O22.13	O23.41	O24.429	O26.50	O26.893	O29.291
O13.1	O22.20	O23.42	O24.430	O26.51	O26.899	O29.292
O13.2	O22.21	O23.43	O24.434	O26.52	O26.90	O29.293
O13.3	O22.22	O23.511	O24.439	O26.53	O26.91	O29.299
O13.9	O22.23	O23.512	O24.811	O26.611	O26.92	O29.3X1
O14.00	O22.30	O23.513	O24.812	O26.612	O26.93	O29.3X2
O14.02	O22.31	O23.519	O24.813	O26.613	O28.0	O29.3X3
O14.03	O22.32	O23.521	O24.819	O26.619	O28.1	O29.3X9
O14.10	O22.33	O23.522	O24.82	O26.62	O28.2	O29.40
O14.12	O22.40	O23.523	O24.83	O26.63	O28.3	O29.41
O14.13	O22.41	O23.529	O24.911	O26.711	O28.4	O29.42
O14.20	O22.42	O23.591	O24.912	O26.712	O28.5	O29.43
O14.22	O22.43	O23.592	O24.913	O26.713	O28.8	O29.5X1
O14.23	O22.50	O23.593	O24.919	O26.719	O28.9	O29.5X2
O14.90	O22.51	O23.599	O24.92	O26.72	O29.011	O29.5X3
O14.92	O22.52	O23.90	O24.93	O26.73	O29.012	O29.5X9
O14.93	O22.53	O23.91	O25.10	O26.811	O29.013	O29.60
O15.00	O22.8X1	O23.92	O25.11	O26.812	O29.019	O29.61
O15.02	O22.8X2	O23.93	O25.12	O26.813	O29.021	O29.62
O15.03	O22.8X3	O24.011	O25.13	O26.819	O29.022	O29.63
O15.1	O22.8X9	O24.012	O25.2	O26.821	O29.023	O29.8X1
O15.2	O22.90	O24.013	O25.3	O26.822	O29.029	O29.8X2
O15.9	O22.91	O24.019	O26.00	O26.823	O29.091	O29.8X3
O16.1	O22.92	O24.02	O26.01	O26.829	O29.092	O29.8X9
O16.2	O22.93	O24.03	O26.02	O26.831	O29.093	O29.90
O16.3	O23.00	O24.111	O26.03	O26.832	O29.099	O29.91
O16.9	O23.01	O24.112	O26.10	O26.833	O29.111	O29.92
O20.0	O23.02	O24.113	O26.11	O26.839	O29.112	O29.93
O20.8	O23.03	O24.119	O26.12	O26.841	O29.113	O30.001
O20.9	O23.10	O24.12	O26.13	O26.842	O29.119	O30.002
O21.0	O23.11	O24.13	O26.20	O26.843	O29.121	O30.003
O21.1	O23.12	O24.311	O26.21	O26.849	O29.122	O30.009
O21.2	O23.13	O24.312	O26.22	O26.851	O29.123	O30.011

Pregnancy exclusions

ICD10CM						
O21.8	O23.20	O24.313	O26.23	O26.852	O29.129	O30.012
O21.9	O23.21	O24.319	O26.30	O26.853	O29.191	O30.013
O22.00	O23.22	O24.32	O26.31	O26.859	O29.192	O30.019
O22.01	O23.23	O24.33	O26.32	O26.86	O29.193	O30.021
O22.02	O23.30	O24.410	O26.33	O26.872	O29.199	O30.022
O22.03	O23.31	O24.414	O26.40	O26.873	O29.211	O30.023
O30.029	O30.292	O31.02X5	O31.20X5	O31.32X5	O32.0XX5	O32.8XX5
O30.031	O30.293	O31.02X9	O31.20X9	O31.32X9	O32.0XX9	O32.8XX9
O30.032	O30.299	O31.03X0	O31.21X0	O31.33X0	O32.1XX0	O32.9XX0
O30.033	O30.801	O31.03X1	O31.21X1	O31.33X1	O32.1XX1	O32.9XX1
O30.039	O30.802	O31.03X2	O31.21X2	O31.33X2	O32.1XX2	O32.9XX2
O30.041	O30.803	O31.03X3	O31.21X3	O31.33X3	O32.1XX3	O32.9XX3
O30.042	O30.809	O31.03X4	O31.21X4	O31.33X4	O32.1XX4	O32.9XX4
O30.043	O30.811	O31.03X5	O31.21X5	O31.33X5	O32.1XX5	O32.9XX5
O30.049	O30.812	O31.03X9	O31.21X9	O31.33X9	O32.1XX9	O32.9XX9
O30.091	O30.813	O31.10X0	O31.22X0	O31.8X10	O32.2XX0	O33.0
O30.092	O30.819	O31.10X1	O31.22X1	O31.8X11	O32.2XX1	O33.1
O30.093	O30.821	O31.10X2	O31.22X2	O31.8X12	O32.2XX2	O33.2
O30.099	O30.822	O31.10X3	O31.22X3	O31.8X13	O32.2XX3	O33.3XX0
O30.101	O30.823	O31.10X4	O31.22X4	O31.8X14	O32.2XX4	O33.3XX1
O30.102	O30.829	O31.10X5	O31.22X5	O31.8X15	O32.2XX5	O33.3XX2
O30.103	O30.891	O31.10X9	O31.22X9	O31.8X19	O32.2XX9	O33.3XX3
O30.109	O30.892	O31.11X0	O31.23X0	O31.8X20	O32.3XX0	O33.3XX4
O30.111	O30.893	O31.11X1	O31.23X1	O31.8X21	O32.3XX1	O33.3XX5
O30.112	O30.899	O31.11X2	O31.23X2	O31.8X22	O32.3XX2	O33.3XX9
O30.113	O30.90	O31.11X3	O31.23X3	O31.8X23	O32.3XX3	O33.4XX0
O30.119	O30.91	O31.11X4	O31.23X4	O31.8X24	O32.3XX4	O33.4XX1
O30.121	O30.92	O31.11X5	O31.23X5	O31.8X25	O32.3XX5	O33.4XX2
O30.122	O30.93	O31.11X9	O31.23X9	O31.8X29	O32.3XX9	O33.4XX3
O30.123	O31.00X0	O31.12X0	O31.30X0	O31.8X30	O32.4XX0	O33.4XX4
O30.129	O31.00X1	O31.12X1	O31.30X1	O31.8X31	O32.4XX1	O33.4XX5
O30.191	O31.00X2	O31.12X2	O31.30X2	O31.8X32	O32.4XX2	O33.4XX9
O30.192	O31.00X3	O31.12X3	O31.30X3	O31.8X33	O32.4XX3	O33.5XX0
O30.193	O31.00X4	O31.12X4	O31.30X4	O31.8X34	O32.4XX4	O33.5XX1
O30.199	O31.00X5	O31.12X5	O31.30X5	O31.8X35	O32.4XX5	O33.5XX2
O30.201	O31.00X9	O31.12X9	O31.30X9	O31.8X39	O32.4XX9	O33.5XX3
O30.202	O31.01X0	O31.13X0	O31.31X0	O31.8X90	O32.6XX0	O33.5XX4
O30.203	O31.01X1	O31.13X1	O31.31X1	O31.8X91	O32.6XX1	O33.5XX5

Pregnancy exclusions

ICD10CM						
O30.209	O31.01X2	O31.13X2	O31.31X2	O31.8X92	O32.6XX2	O33.5XX9
O30.211	O31.01X3	O31.13X3	O31.31X3	O31.8X93	O32.6XX3	O33.6XX0
O30.212	O31.01X4	O31.13X4	O31.31X4	O31.8X94	O32.6XX4	O33.6XX1
O30.213	O31.01X5	O31.13X5	O31.31X5	O31.8X95	O32.6XX5	O33.6XX2
O30.219	O31.01X9	O31.13X9	O31.31X9	O31.8X99	O32.6XX9	O33.6XX3
O30.221	O31.02X0	O31.20X0	O31.32X0	O32.0XX0	O32.8XX0	O33.6XX4
O30.222	O31.02X1	O31.20X1	O31.32X1	O32.0XX1	O32.8XX1	O33.6XX5
O30.223	O31.02X2	O31.20X2	O31.32X2	O32.0XX2	O32.8XX2	O33.6XX9
O30.229	O31.02X3	O31.20X3	O31.32X3	O32.0XX3	O32.8XX3	O33.7
O30.291	O31.02X4	O31.20X4	O31.32X4	O32.0XX4	O32.8XX4	O33.8
O33.9	O34.73	O35.4XX5	O36.0115	O36.0935	O36.1915	O36.22X5
O34.00	O34.80	O35.4XX9	O36.0119	O36.0939	O36.1919	O36.22X9
O34.01	O34.81	O35.5XX0	O36.0120	O36.0990	O36.1920	O36.23X0
O34.02	O34.82	O35.5XX1	O36.0121	O36.0991	O36.1921	O36.23X1
O34.03	O34.83	O35.5XX2	O36.0122	O36.0992	O36.1922	O36.23X2
O34.10	O34.90	O35.5XX3	O36.0123	O36.0993	O36.1923	O36.23X3
O34.11	O34.91	O35.5XX4	O36.0124	O36.0994	O36.1924	O36.23X4
O34.12	O34.92	O35.5XX5	O36.0125	O36.0995	O36.1925	O36.23X5
O34.13	O34.93	O35.5XX9	O36.0129	O36.0999	O36.1929	O36.23X9
O34.21	O35.0XX0	O35.6XX0	O36.0130	O36.1110	O36.1930	O36.4XX0
O34.29	O35.0XX1	O35.6XX1	O36.0131	O36.1111	O36.1931	O36.4XX1
O34.30	O35.0XX2	O35.6XX2	O36.0132	O36.1112	O36.1932	O36.4XX2
O34.31	O35.0XX3	O35.6XX3	O36.0133	O36.1113	O36.1933	O36.4XX3
O34.32	O35.0XX4	O35.6XX4	O36.0134	O36.1114	O36.1934	O36.4XX4
O34.33	O35.0XX5	O35.6XX5	O36.0135	O36.1115	O36.1935	O36.4XX5
O34.40	O35.0XX9	O35.6XX9	O36.0139	O36.1119	O36.1939	O36.4XX9
O34.41	O35.1XX0	O35.7XX0	O36.0190	O36.1120	O36.1990	O36.5110
O34.42	O35.1XX1	O35.7XX1	O36.0191	O36.1121	O36.1991	O36.5111
O34.43	O35.1XX2	O35.7XX2	O36.0192	O36.1122	O36.1992	O36.5112
O34.511	O35.1XX3	O35.7XX3	O36.0193	O36.1123	O36.1993	O36.5113
O34.512	O35.1XX4	O35.7XX4	O36.0194	O36.1124	O36.1994	O36.5114
O34.513	O35.1XX5	O35.7XX5	O36.0195	O36.1125	O36.1995	O36.5115
O34.519	O35.1XX9	O35.7XX9	O36.0199	O36.1129	O36.1999	O36.5119
O34.521	O35.2XX0	O35.8XX0	O36.0910	O36.1130	O36.20X0	O36.5120
O34.522	O35.2XX1	O35.8XX1	O36.0911	O36.1131	O36.20X1	O36.5121
O34.523	O35.2XX2	O35.8XX2	O36.0912	O36.1132	O36.20X2	O36.5122
O34.529	O35.2XX3	O35.8XX3	O36.0913	O36.1133	O36.20X3	O36.5123
O34.531	O35.2XX4	O35.8XX4	O36.0914	O36.1134	O36.20X4	O36.5124

Pregnancy exclusions

ICD10CM						
O34.532	O35.2XX5	O35.8XX5	O36.0915	O36.1135	O36.20X5	O36.5125
O34.533	O35.2XX9	O35.8XX9	O36.0919	O36.1139	O36.20X9	O36.5129
O34.539	O35.3XX0	O35.9XX0	O36.0920	O36.1190	O36.21X0	O36.5130
O34.591	O35.3XX1	O35.9XX1	O36.0921	O36.1191	O36.21X1	O36.5131
O34.592	O35.3XX2	O35.9XX2	O36.0922	O36.1192	O36.21X2	O36.5132
O34.593	O35.3XX3	O35.9XX3	O36.0923	O36.1193	O36.21X3	O36.5133
O34.599	O35.3XX4	O35.9XX4	O36.0924	O36.1194	O36.21X4	O36.5134
O34.60	O35.3XX5	O35.9XX5	O36.0925	O36.1195	O36.21X5	O36.5135
O34.61	O35.3XX9	O35.9XX9	O36.0929	O36.1199	O36.21X9	O36.5139
O34.62	O35.4XX0	O36.0110	O36.0930	O36.1910	O36.22X0	O36.5190
O34.63	O35.4XX1	O36.0111	O36.0931	O36.1911	O36.22X1	O36.5191
O34.70	O35.4XX2	O36.0112	O36.0932	O36.1912	O36.22X2	O36.5192
O34.71	O35.4XX3	O36.0113	O36.0933	O36.1913	O36.22X3	O36.5193
O34.72	O35.4XX4	O36.0114	O36.0934	O36.1914	O36.22X4	O36.5194
O36.5195	O36.61X5	O36.73X5	O36.8225	O36.8995	O40.2XX5	O41.03X5
O36.5199	O36.61X9	O36.73X9	O36.8229	O36.8999	O40.2XX9	O41.03X9
O36.5910	O36.62X0	O36.80X0	O36.8230	O36.90X0	O40.3XX0	O41.1010
O36.5911	O36.62X1	O36.80X1	O36.8231	O36.90X1	O40.3XX1	O41.1011
O36.5912	O36.62X2	O36.80X2	O36.8232	O36.90X2	O40.3XX2	O41.1012
O36.5913	O36.62X3	O36.80X3	O36.8233	O36.90X3	O40.3XX3	O41.1013
O36.5914	O36.62X4	O36.80X4	O36.8234	O36.90X4	O40.3XX4	O41.1014
O36.5915	O36.62X5	O36.80X5	O36.8235	O36.90X5	O40.3XX5	O41.1015
O36.5919	O36.62X9	O36.80X9	O36.8239	O36.90X9	O40.3XX9	O41.1019
O36.5920	O36.63X0	O36.8120	O36.8290	O36.91X0	O40.9XX0	O41.1020
O36.5921	O36.63X1	O36.8121	O36.8291	O36.91X1	O40.9XX1	O41.1021
O36.5922	O36.63X2	O36.8122	O36.8292	O36.91X2	O40.9XX2	O41.1022
O36.5923	O36.63X3	O36.8123	O36.8293	O36.91X3	O40.9XX3	O41.1023
O36.5924	O36.63X4	O36.8124	O36.8294	O36.91X4	O40.9XX4	O41.1024
O36.5925	O36.63X5	O36.8125	O36.8295	O36.91X5	O40.9XX5	O41.1025
O36.5929	O36.63X9	O36.8129	O36.8299	O36.91X9	O40.9XX9	O41.1029
O36.5930	O36.70X0	O36.8130	O36.8910	O36.92X0	O41.00X0	O41.1030
O36.5931	O36.70X1	O36.8131	O36.8911	O36.92X1	O41.00X1	O41.1031
O36.5932	O36.70X2	O36.8132	O36.8912	O36.92X2	O41.00X2	O41.1032
O36.5933	O36.70X3	O36.8133	O36.8913	O36.92X3	O41.00X3	O41.1033
O36.5934	O36.70X4	O36.8134	O36.8914	O36.92X4	O41.00X4	O41.1034
O36.5935	O36.70X5	O36.8135	O36.8915	O36.92X5	O41.00X5	O41.1035
O36.5939	O36.70X9	O36.8139	O36.8919	O36.92X9	O41.00X9	O41.1039
O36.5990	O36.71X0	O36.8190	O36.8920	O36.93X0	O41.01X0	O41.1090

Pregnancy exclusions

ICD10CM						
O36.5991	O36.71X1	O36.8191	O36.8921	O36.93X1	O41.01X1	O41.1091
O36.5992	O36.71X2	O36.8192	O36.8922	O36.93X2	O41.01X2	O41.1092
O36.5993	O36.71X3	O36.8193	O36.8923	O36.93X3	O41.01X3	O41.1093
O36.5994	O36.71X4	O36.8194	O36.8924	O36.93X4	O41.01X4	O41.1094
O36.5995	O36.71X5	O36.8195	O36.8925	O36.93X5	O41.01X5	O41.1095
O36.5999	O36.71X9	O36.8199	O36.8929	O36.93X9	O41.01X9	O41.1099
O36.60X0	O36.72X0	O36.8210	O36.8930	O40.1XX0	O41.02X0	O41.1210
O36.60X1	O36.72X1	O36.8211	O36.8931	O40.1XX1	O41.02X1	O41.1211
O36.60X2	O36.72X2	O36.8212	O36.8932	O40.1XX2	O41.02X2	O41.1212
O36.60X3	O36.72X3	O36.8213	O36.8933	O40.1XX3	O41.02X3	O41.1213
O36.60X4	O36.72X4	O36.8214	O36.8934	O40.1XX4	O41.02X4	O41.1214
O36.60X5	O36.72X5	O36.8215	O36.8935	O40.1XX5	O41.02X5	O41.1215
O36.60X9	O36.72X9	O36.8219	O36.8939	O40.1XX9	O41.02X9	O41.1219
O36.61X0	O36.73X0	O36.8220	O36.8990	O40.2XX0	O41.03X0	O41.1220
O36.61X1	O36.73X1	O36.8221	O36.8991	O40.2XX1	O41.03X1	O41.1221
O36.61X2	O36.73X2	O36.8222	O36.8992	O40.2XX2	O41.03X2	O41.1222
O36.61X3	O36.73X3	O36.8223	O36.8993	O40.2XX3	O41.03X3	O41.1223
O36.61X4	O36.73X4	O36.8224	O36.8994	O40.2XX4	O41.03X4	O41.1224
O41.1225	O41.1495	O41.91X5	O43.101	O44.02	O46.091	O60.13X9
O41.1229	O41.1499	O41.91X9	O43.102	O44.03	O46.092	O60.14X0
O41.1230	O41.8X10	O41.92X0	O43.103	O44.10	O46.093	O60.14X1
O41.1231	O41.8X11	O41.92X1	O43.109	O44.11	O46.099	O60.14X2
O41.1232	O41.8X12	O41.92X2	O43.111	O44.12	O46.8X1	O60.14X3
O41.1233	O41.8X13	O41.92X3	O43.112	O44.13	O46.8X2	O60.14X4
O41.1234	O41.8X14	O41.92X4	O43.113	O45.001	O46.8X3	O60.14X5
O41.1235	O41.8X15	O41.92X5	O43.119	O45.002	O46.8X9	O60.14X9
O41.1239	O41.8X19	O41.92X9	O43.121	O45.003	O46.90	O60.20X0
O41.1290	O41.8X20	O41.93X0	O43.122	O45.009	O46.91	O60.20X1
O41.1291	O41.8X21	O41.93X1	O43.123	O45.011	O46.92	O60.20X2
O41.1292	O41.8X22	O41.93X2	O43.129	O45.012	O46.93	O60.20X3
O41.1293	O41.8X23	O41.93X3	O43.191	O45.013	O47.00	O60.20X4
O41.1294	O41.8X24	O41.93X4	O43.192	O45.019	O47.02	O60.20X5
O41.1295	O41.8X25	O41.93X5	O43.193	O45.021	O47.03	O60.20X9
O41.1299	O41.8X29	O41.93X9	O43.199	O45.022	O47.1	O60.22X0
O41.1410	O41.8X30	O42.00	O43.211	O45.023	O47.9	O60.22X1
O41.1411	O41.8X31	O42.011	O43.212	O45.029	O48.0	O60.22X2
O41.1412	O41.8X32	O42.012	O43.213	O45.091	O48.1	O60.22X3
O41.1413	O41.8X33	O42.013	O43.219	O45.092	O60.00	O60.22X4
O41.1414	O41.8X34	O42.019	O43.221	O45.093	O60.02	O60.22X5
O41.1415	O41.8X35	O42.02	O43.222	O45.099	O60.03	O60.22X9
O41.1419	O41.8X39	O42.10	O43.223	O45.8X1	O60.10X0	O60.23X0
O41.1420	O41.8X90	O42.111	O43.229	O45.8X2	O60.10X1	O60.23X1
O41.1421	O41.8X91	O42.112	O43.231	O45.8X3	O60.10X2	O60.23X2

Pregnancy exclusions

ICD10CM						
O41.1422	O41.8X92	O42.113	O43.232	O45.8X9	O60.10X3	O60.23X3
O41.1423	O41.8X93	O42.119	O43.233	O45.90	O60.10X4	O60.23X4
O41.1424	O41.8X94	O42.12	O43.239	O45.91	O60.10X5	O60.23X5
O41.1425	O41.8X95	O42.90	O43.811	O45.92	O60.10X9	O60.23X9
O41.1429	O41.8X99	O42.911	O43.812	O45.93	O60.12X0	O61.0
O41.1430	O41.90X0	O42.912	O43.813	O46.001	O60.12X1	O61.1
O41.1431	O41.90X1	O42.913	O43.819	O46.002	O60.12X2	O61.8
O41.1432	O41.90X2	O42.919	O43.891	O46.003	O60.12X3	O61.9
O41.1433	O41.90X3	O42.92	O43.892	O46.009	O60.12X4	O62.0
O41.1434	O41.90X4	O43.011	O43.893	O46.011	O60.12X5	O62.1
O41.1435	O41.90X5	O43.012	O43.899	O46.012	O60.12X9	O62.2
O41.1439	O41.90X9	O43.013	O43.90	O46.013	O60.13X0	O62.3
O41.1490	O41.91X0	O43.019	O43.91	O46.019	O60.13X1	O62.4
O41.1491	O41.91X1	O43.021	O43.92	O46.021	O60.13X2	O62.8
O41.1492	O41.91X2	O43.022	O43.93	O46.022	O60.13X3	O62.9
O41.1493	O41.91X3	O43.023	O44.00	O46.023	O60.13X4	O63.0
O41.1494	O41.91X4	O43.029	O44.01	O46.029	O60.13X5	O63.1
O63.2	O64.5XX5	O69.0XX4	O69.81X4	O71.89	O86.21	O88.83
O63.9	O64.5XX9	O69.0XX5	O69.81X5	O71.9	O86.22	O89.01
O64.0XX0	O64.8XX0	O69.0XX9	O69.81X9	O72.0	O86.29	O89.09
O64.0XX1	O64.8XX1	O69.1XX0	O69.82X0	O72.1	O86.4	O89.1
O64.0XX2	O64.8XX2	O69.1XX1	O69.82X1	O72.2	O86.81	O89.2
O64.0XX3	O64.8XX3	O69.1XX2	O69.82X2	O72.3	O86.89	O89.3
O64.0XX4	O64.8XX4	O69.1XX3	O69.82X3	O73.0	O87.0	O89.4
O64.0XX5	O64.8XX5	O69.1XX4	O69.82X4	O73.1	O87.1	O89.5
O64.0XX9	O64.8XX9	O69.1XX5	O69.82X5	O74.0	O87.2	O89.6
O64.1XX0	O64.9XX0	O69.1XX9	O69.82X9	O74.1	O87.3	O89.8
O64.1XX1	O64.9XX1	O69.2XX0	O69.89X0	O74.2	O87.4	O89.9
O64.1XX2	O64.9XX2	O69.2XX1	O69.89X1	O74.3	O87.8	O90.0
O64.1XX3	O64.9XX3	O69.2XX2	O69.89X2	O74.4	O87.9	O90.1
O64.1XX4	O64.9XX4	O69.2XX3	O69.89X3	O74.5	O88.011	O90.2
O64.1XX5	O64.9XX5	O69.2XX4	O69.89X4	O74.6	O88.012	O90.3
O64.1XX9	O64.9XX9	O69.2XX5	O69.89X5	O74.7	O88.013	O90.4
O64.2XX0	O65.0	O69.2XX9	O69.89X9	O74.8	O88.019	O90.5
O64.2XX1	O65.1	O69.3XX0	O69.9XX0	O74.9	O88.02	O90.6
O64.2XX2	O65.2	O69.3XX1	O69.9XX1	O75.0	O88.03	O90.81
O64.2XX3	O65.3	O69.3XX2	O69.9XX2	O75.1	O88.111	O90.89
O64.2XX4	O65.4	O69.3XX3	O69.9XX3	O75.2	O88.112	O90.9
O64.2XX5	O65.5	O69.3XX4	O69.9XX4	O75.3	O88.113	O91.011
O64.2XX9	O65.8	O69.3XX5	O69.9XX5	O75.4	O88.119	O91.012
O64.3XX0	O65.9	O69.3XX9	O69.9XX9	O75.5	O88.12	O91.013

Pregnancy exclusions

ICD10CM						
O64.3XX1	O66.0	O69.4XX0	O70.0	O75.81	O88.13	O91.019
O64.3XX2	O66.1	O69.4XX1	O70.1	O75.82	O88.211	O91.02
O64.3XX3	O66.2	O69.4XX2	O70.2	O75.89	O88.212	O91.03
O64.3XX4	O66.3	O69.4XX3	O70.3	O75.9	O88.213	O91.111
O64.3XX5	O66.40	O69.4XX4	O70.4	O76	O88.219	O91.112
O64.3XX9	O66.41	O69.4XX5	O70.9	O77.0	O88.22	O91.113
O64.4XX0	O66.5	O69.4XX9	O71.00	O77.1	O88.23	O91.119
O64.4XX1	O66.6	O69.5XX0	O71.02	O77.8	O88.311	O91.12
O64.4XX2	O66.8	O69.5XX1	O71.03	O77.9	O88.312	O91.13
O64.4XX3	O66.9	O69.5XX2	O71.1	O80	O88.313	O91.211
O64.4XX4	O67.0	O69.5XX3	O71.2	O82	O88.319	O91.212
O64.4XX5	O67.8	O69.5XX4	O71.3	O85	O88.32	O91.213
O64.4XX9	O67.9	O69.5XX5	O71.4	O86.0	O88.33	O91.219
O64.5XX0	O68	O69.5XX9	O71.5	O86.11	O88.811	O91.22
O64.5XX1	O69.0XX0	O69.81X0	O71.6	O86.12	O88.812	O91.23
O64.5XX2	O69.0XX1	O69.81X1	O71.7	O86.13	O88.813	O92.011
O64.5XX3	O69.0XX2	O69.81X2	O71.81	O86.19	O88.819	O92.012
O64.5XX4	O69.0XX3	O69.81X3	O71.82	O86.20	O88.82	O92.013
O92.019	O98.412	O99.112	O99.351	O99.844	Z34.01	
O92.02	O98.413	O99.113	O99.352	O99.845	Z34.02	
O92.03	O98.419	O99.119	O99.353	O99.89	Z34.03	
O92.111	O98.42	O99.12	O99.354	O9A.111	Z34.80	
O92.112	O98.43	O99.13	O99.355	O9A.112	Z34.81	
O92.113	O98.511	O99.210	O99.411	O9A.113	Z34.82	
O92.119	O98.512	O99.211	O99.412	O9A.119	Z34.83	
O92.12	O98.513	O99.212	O99.413	O9A.12	Z34.90	
O92.13	O98.519	O99.213	O99.419	O9A.13	Z34.91	
O92.20	O98.52	O99.214	O99.42	O9A.211	Z34.92	
O92.29	O98.53	O99.215	O99.43	O9A.212	Z34.93	
O92.3	O98.611	O99.280	O99.511	O9A.213	Z36	
O92.4	O98.612	O99.281	O99.512	O9A.219		
O92.5	O98.613	O99.282	O99.513	O9A.22		
O92.6	O98.619	O99.283	O99.519	O9A.23		
O92.70	O98.62	O99.284	O99.52	O9A.311		
O92.79	O98.63	O99.285	O99.53	O9A.312		
O98.011	O98.711	O99.310	O99.611	O9A.313		
O98.012	O98.712	O99.311	O99.612	O9A.319		
O98.013	O98.713	O99.312	O99.613	O9A.32		

Pregnancy exclusions

ICD10CM				
O98.019	O98.719	O99.313	O99.619	O9A.33
O98.02	O98.72	O99.314	O99.62	O9A.411
O98.03	O98.73	O99.315	O99.63	O9A.412
O98.111	O98.811	O99.320	O99.711	O9A.413
O98.112	O98.812	O99.321	O99.712	O9A.419
O98.113	O98.813	O99.322	O99.713	O9A.42
O98.119	O98.819	O99.323	O99.719	O9A.43
O98.12	O98.82	O99.324	O99.72	O9A.511
O98.13	O98.83	O99.325	O99.73	O9A.512
O98.211	O98.911	O99.330	O99.810	O9A.513
O98.212	O98.912	O99.331	O99.814	O9A.519
O98.213	O98.913	O99.332	O99.815	O9A.52
O98.219	O98.919	O99.333	O99.820	O9A.53
O98.22	O98.92	O99.334	O99.824	Z03.71
O98.23	O98.93	O99.335	O99.825	Z03.72
O98.311	O99.011	O99.340	O99.830	Z03.73
O98.312	O99.012	O99.341	O99.834	Z03.74
O98.313	O99.013	O99.342	O99.835	Z03.75
O98.319	O99.019	O99.343	O99.840	Z03.79
O98.32	O99.02	O99.344	O99.841	Z33.1
O98.33	O99.03	O99.345	O99.842	Z33.2
O98.411	O99.111	O99.350	O99.843	Z34.00

Senior care education
Senior care education measure instructions and access to the webcast and attestation survey
priorityhealth.com/provider/manual/performance/pip/senior-care-education (login required)

Measure codes for care management

Care management

CPT
G9001-G9002
G9007-G9008
98966-98968
99487
99490

Care management measure instructions and access to the attestation survey
priorityhealth.com/provider/manual/performance/pip/care-management (login required)

CG CAHPS
CG CAHPS measure instructions and to access the practice-level performance data spreadsheet
priorityhealth.com/provider/manual/performance/pip/cg-cahps (login required)

All-cause readmissions

Chemotherapy

ICD10CM
Z51.0
Z51.11
Z51.12

Rehabilitation

ICD10CM			
Z44.001	Z44.109	Z44.9	Z45.819
Z44.002	Z44.111	Z45.1	Z46.82
Z44.009	Z44.112	Z45.31	Z46.89
Z44.011	Z44.119	Z45.320	Z46.9
Z44.012	Z44.121	Z45.321	Z51.0
Z44.019	Z44.122	Z45.328	Z51.11
Z44.021	Z44.129	Z45.41	Z51.12
Z44.022	Z44.30	Z45.42	Z51.5
Z44.029	Z44.31	Z45.49	Z51.81
Z44.101	Z44.32	Z45.811	Z51.89
Z44.102	Z44.8	Z45.812	

Kidney transplant

ICD10CM	CPT		HCPCS	UBREV
Z94.0	50300	50365	S2065	367
	50320	50370		
	50340	50380		
	50360			

Bone marrow transplant

ICD10PCS					
30230AZ	30233X0	30240Y1	30250X0	30260G0	30263Y0
30230G0	30233X1	30243AZ	30250X1	30260G1	30263Y1
30230G1	30233Y0	30243G0	30250Y0	30260X0	
30230X0	30233Y1	30243G1	30250Y1	30260X1	
30230X1	30240AZ	30243X0	30253G0	30260Y0	
30230Y0	30240G0	30243X1	30253G1	30260Y1	
30230Y1	30240G1	30243Y0	30253X0	30263G0	
30233AZ	30240X0	30243Y1	30253X1	30263G1	
30233G0	30240X1	30250G0	30253Y0	30263X0	
30233G1	30240Y0	30250G1	30253Y1	30263X1	

Organ transplant other than kidney

CPT		HCPCS	ICD10PCS			UBREV
32850	44720	S2053	02YA0Z0	0BYH0Z1	0DYE0Z2	0362
32851	44721	S2054	02YA0Z1	0BYH0Z2	0FY00Z0	0810
32852	47133	S2055	02YA0Z2	0BYJ0Z0	0FY00Z1	0811
32853	47135	S2060	07YP0Z0	0BYJ0Z1	0FY00Z2	0812
32854	47136	S2061	07YP0Z1	0BYJ0Z2	0FYG0Z0	0813
32855	47140	S2152	07YP0Z2	0BYK0Z0	0FYG0Z1	0819
32856	47141		0BYC0Z0	0BYK0Z1	0FYG0Z2	
33930	47142		0BYC0Z1	0BYK0Z2		
33933	47143		0BYC0Z2	0BYL0Z0		
33935	47144		0BYD0Z0	0BYL0Z1		
33940	47145		0BYD0Z1	0BYL0Z2		
33944	47146		0BYD0Z2	0BYM0Z0		
33945	47147		0BYF0Z0	0BYM0Z1		
44132	48160		0BYF0Z1	0BYM0Z2		
44133	48550		0BYF0Z2	0DY80Z0		
44135	48551		0BYG0Z0	0DY80Z1		
44136	48552		0BYG0Z1	0DY80Z2		
44137	48554		0BYG0Z2	0DYE0Z0		
44715	48556		0BYH0Z0	0DYE0Z1		

Potentially planned procedures

For a list of ICD10PCS codes, contact your Provider Performance Specialist.

Acute condition

For a list of ICD10PCS codes, contact your Provider Performance Specialist.

Perinatal

ICD10CM						
P00.0	P05.10	P13.0	P28.11	P52.22	P71.8	P92.09
P00.1	P05.11	P13.1	P28.19	P52.3	P71.9	P92.1
P00.2	P05.12	P13.2	P28.2	P52.4	P72.0	P92.2
P00.3	P05.13	P13.3	P28.3	P52.5	P72.1	P92.3
P00.4	P05.14	P13.4	P28.4	P52.6	P72.2	P92.4
P00.5	P05.15	P13.8	P28.5	P52.8	P72.8	P92.5
P00.6	P05.16	P13.9	P28.81	P52.9	P72.9	P92.6
P00.7	P05.17	P14.0	P28.89	P53	P74.0	P92.8
P00.81	P05.18	P14.1	P28.9	P54.0	P74.1	P92.9
P00.89	P05.2	P14.2	P29.0	P54.1	P74.2	P93.0
P00.9	P05.9	P14.3	P29.11	P54.2	P74.3	P93.8
P01.0	P07.00	P14.8	P29.12	P54.3	P74.4	P94.0
P01.1	P07.01	P14.9	P29.2	P54.4	P74.5	P94.1
P01.2	P07.02	P15.0	P29.3	P54.5	P74.6	P94.2
P01.3	P07.03	P15.1	P29.4	P54.6	P74.8	P94.8
P01.4	P07.10	P15.2	P29.81	P54.8	P74.9	P94.9
P01.5	P07.14	P15.3	P29.89	P54.9	P76.0	P95
P01.6	P07.15	P15.4	P29.9	P55.0	P76.1	P96.0
P01.7	P07.16	P15.5	P35.0	P55.1	P76.2	P96.1
P01.8	P07.17	P15.6	P35.1	P55.8	P76.8	P96.2
P01.9	P07.18	P15.8	P35.2	P55.9	P76.9	P96.3
P02.0	P07.20	P15.9	P35.3	P56.0	P77.1	P96.5
P02.1	P07.21	P19.0	P35.8	P56.90	P77.2	P96.81
P02.20	P07.22	P19.1	P35.9	P56.99	P77.3	P96.82
P02.29	P07.23	P19.2	P36.0	P57.0	P77.9	P96.83
P02.3	P07.24	P19.9	P36.10	P57.8	P78.0	P96.89
P02.4	P07.25	P22.0	P36.19	P57.9	P78.1	P96.9
P02.5	P07.26	P22.1	P36.2	P58.0	P78.2	Z38.00
P02.60	P07.30	P22.8	P36.30	P58.1	P78.3	Z38.01
P02.69	P07.31	P22.9	P36.39	P58.2	P78.81	Z38.1
P02.7	P07.32	P23.0	P36.4	P58.3	P78.82	Z38.2
P02.8	P07.33	P23.1	P36.5	P58.41	P78.83	Z38.30
P02.9	P07.34	P23.2	P36.8	P58.42	P78.89	Z38.31
P03.0	P07.35	P23.3	P36.9	P58.5	P78.9	Z38.4
P03.1	P07.36	P23.4	P37.0	P58.8	P80.0	Z38.5
P03.2	P07.37	P23.5	P37.1	P58.9	P80.8	Z38.61
P03.3	P07.38	P23.6	P37.2	P59.0	P80.9	Z38.62
P03.4	P07.39	P23.8	P37.3	P59.1	P81.0	Z38.63
P03.5	P08.0	P23.9	P37.4	P59.20	P81.8	Z38.64

P03.6	P08.1	P24.00	P37.5	P59.29	P81.9	Z38.65
P03.810	P08.21	P24.01	P37.8	P59.3	P83.0	Z38.66
P03.811	P08.22	P24.10	P37.9	P59.8	P83.1	Z38.68
P03.819	P09	P24.11	P38.1	P59.9	P83.2	Z38.69
P03.82	P10.0	P24.20	P38.9	P60	P83.30	Z38.7
P03.89	P10.1	P24.21	P39.0	P61.0	P83.39	Z38.8
P03.9	P10.2	P24.30	P39.1	P61.1	P83.4	
P04.0	P10.3	P24.31	P39.2	P61.2	P83.5	
P04.1	P10.4	P24.80	P39.3	P61.3	P83.6	
P04.2	P10.8	P24.81	P39.4	P61.4	P83.8	
P04.3	P10.9	P24.9	P39.8	P61.5	P83.9	
P04.41	P11.0	P25.0	P39.9	P61.6	P84	
P04.49	P11.1	P25.1	P50.0	P61.8	P90	
P04.5	P11.2	P25.2	P50.1	P61.9	P91.0	
P04.6	P11.3	P25.3	P50.2	P70.0	P91.1	
P04.8	P11.4	P25.8	P50.3	P70.1	P91.2	
P04.9	P11.5	P26.0	P50.4	P70.2	P91.3	
P05.00	P11.9	P26.1	P50.5	P70.3	P91.4	
P05.01	P12.0	P26.8	P50.8	P70.4	P91.5	
P05.02	P12.1	P26.9	P50.9	P70.8	P91.60	
P05.03	P12.2	P27.0	P51.0	P70.9	P91.61	
P05.04	P12.3	P27.1	P51.8	P71.0	P91.62	
P05.05	P12.4	P27.8	P51.9	P71.1	P91.63	
P05.06	P12.81	P27.9	P52.0	P71.2	P91.8	
P05.07	P12.89	P28.0	P52.1	P71.3	P91.9	
P05.08	P12.9	P28.10	P52.21	P71.4	P92.01	

ED visits: PCP Treatable Care
wagner.nyu.edu/faculty/billings/nyued-background

Measure codes for depression screening

Dispensed an antidepressant medication

Table AMM-C: Antidepressant medications

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

Depression encounter

CPT			HCPCS		UBREV	
90791	99218	99384	G0155	H2012	0510	0911
90792	99219	99385	G0176	H2013	0513	0912
90832	99220	99386	G0177	H2014	0516	0913
90834	99241	99387	G0409	H2015	0517	0914
90837	99242	99391	G0410	H2016	0519	0915
98960	99243	99392	G0411	H2017	0520	0916
98961	99244	99393	G0463	H2018	0521	0917
98962	99245	99394	H0002	H2019	0522	0919
99078	99341	99395	H0004	H2020	0523	0982
99201	99342	99396	H0031	M0064	0526	0983
99202	99343	99397	H0034	S0201	0527	
99203	99344	99401	H0035	S9480	0528	
99204	99345	99402	H0036	S9484	0529	
99205	99347	99403	H0037	S9485	0900	
99211	99348	99404	H0039	T1015	0901	
99212	99349	99411	H0040		0902	
99213	99350	99412	H2000		0903	
99214	99381	99510	H2001		0904	
99215	99382		H2010		0905	
99217	99383		H2011		0907	

Depression reportable codes

HCPCS
G8431
G8510
G8511

FUH
For a list of codes, contact your Provider Performance Specialist