AETNA BETTER HEALTH® OF NEW JERSEY
2017 Quality Incentive Program

www.aetnabetterhealth.com/newjersey
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A letter from our CEO

Dear Aetna Better Health of New Jersey Provider,

At Aetna Better Health New Jersey, we value the role you play in providing the highest quality care to your patients – our members. We also understand that improving the health outcomes of our members necessitates a level of collaboration between us – you as the professional who provides the care, and ourselves, as the health plan that covers the care. To show you how deeply we are committed to working with you, we are proud to introduce our Quality Incentive Program to you.

One of the best in our market, our 2017 Quality Incentive Program not only pays higher incentives for many measures, but also makes it easier to qualify for incentives.

It does not end there. Along with a top-paying comprehensive program, comes the expertise and support of our Quality Management and Network Management teams. We will work with you and your staff to regularly track your progress and suggest opportunities to increase member engagement, which should translate into higher incentive potential for your practice.

This manual contains everything you need to know about how our program works. Additionally, it presents the Aetna Better Health of New Jersey team members who are available to support you and help you maximize the program’s incentive opportunities. I invite you to share your thoughts with me about our program by writing to: MacFarlaneG1@aetna.com.

Thank you again for your continued participation in our provider network and helping us improve the quality of care our members receive.

Sincerely,

Glenn A. MacFarlane
Chief Executive Officer
Aetna Better Health of New Jersey
Aetna Better Health of New Jersey

Nationally recognized – locally focused

For more than 160 years, our success has been built on serving our members at the local, community-based level with a fully integrated care model that includes physical health, behavioral health and social economic supports. Our history and experience demonstrate our total commitment to achieving a healthier population in the communities we serve.

Your partner in providing quality health care

We take great pride in our network of physicians and related professionals. We want to assist those who serve our members with the highest level of quality care and service. We are committed to making sure our providers receive the best possible information, and the latest technology and tools available. This helps ensure their success in providing for our members. Our focus is on operational excellence. We strive to eliminate redundancy and streamline processes for the benefit and value of all our partners.
Who we serve

We proudly serve New Jerseyans of all ages who qualify for NJ FamilyCare and Managed Long-Term Services and Supports (MLTSS).

We currently serve New Jerseyans in the following 13 counties:

- Passaic
- Morris
- Union
- Somerset
- Mercer
- Camden
- Atlantic
- Bergen
- Essex
- Hudson
- Middlesex
- Burlington
- Gloucester

By early 2017 we will provide health care for New Jerseyans statewide.

Our 2017 goals:

- Renewed focus on improvement in quality
- Continued network improvement and expansion
- Alignment to our primary care strategy to provide value-based solutions to our members
- Optimized partnerships with our network physicians to ensure our members are receiving high-quality health care
Always here to help

Contact information

We want to assist those who serve our members with the highest level of quality care and service. That’s why we are always here to help support you. Our Quality Management Team is fully dedicated to supporting our network of providers. Our staff works directly with you to:

• Host face-to-face provider office site meetings
• Provide onsite training and support
• Conduct face-to-face quarterly report and progress reviews
• Assist with plan-based interventions to help you increase your scores, such as:
  ° Member outreach: telephone calls, member mailers or information included in member newsletters and member website
  ° Onsite or webinar-based meetings for you and your staff to refresh your knowledge of HEDIS measures and how to maximize results
  ° Specific measure-based focused activities
  ° Member incentive initiatives

If you have questions or concerns, contact one of our dedicated staff:

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Health Care Quality HEDIS Manager  
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Widdis@aetna.com
Additional resources

Member Services and Provider Relations
1-855-232-3596

Aetna Medicaid Web Portal Information
1-855-232-3596
2017 Quality Incentive Program

Purpose
At Aetna Better Health of New Jersey, we understand that a key component of achieving superior health care and satisfaction for our members is the member-provider relationship. We recognize the importance of this partnership and base our Quality Incentive Program on key goals in primary care. By meeting or exceeding quality goals, providers are eligible to earn incentive payments, while delivering the highest quality health care to our members.

Our Quality Incentive Program supports your patients and our quality care initiatives by:
- Promoting care that results in a healthier population by improving quality and outcomes
- Enriching care delivery consistency and adherence to evidence-based standards of care
- Promoting a continuous quality improvement orientation
- Promoting care coordination between providers and the health plan, resulting in greater alignment of goals for our members’ health

Overview
The program measurement year is the calendar year for dates of service January 1 – December 31, 2017.

- The program is an all “upside” program. Credit is given for any service related to a metric, which has been provided any time in 2017 and can be included in the financial payout calculations.
- Seven HEDIS metrics were selected; each measure, a performance target reflective of the 2016 National Medicaid HEDIS 50th percentile was defined.
  - Providers are given credit toward incentives for any metric that meets or exceeds the 50th percentile.
- Each metric is calculated and rewarded individually based on claims data, which has a 90-day lag after submission of a claim. At the end of the performance year (2017), the cumulative annual performance is calculated for each measure, for each eligible provider in a practice. Providers are rewarded for each metric-related service for which they meet or exceed the established target. Financial incentive payments are expected to be paid during summer 2018.
- High performers in this program may be eligible for additional incentive opportunities.

Eligibility
All participating network providers (defined at the organizational TIN level) with a panel size of at least 25 members are eligible to participate as long as they maintain an open panel (they accept new Aetna Better Health New Jersey members) during 2017. All eligible providers will be able to earn financial incentives in this program.
2017 timeline

• January, 2017 – Send Quality Incentive Program introductory letters to participating providers

• January, 2017 – Mail Quality Incentive Program manuals to participating providers

• February, 2017 – Host Quality Incentive Program seminars

Save the dates:

Tuesday, February 7, 2017
Renaissance Newark Airport Hotel by Marriott
1000 Spring Street
Elizabeth, NJ 07201
5:30 p.m. – Dinner
6 to 7 p.m. – Seminar

Tuesday, February 21, 2017
Marriott Forrestal
100 College Rd E
Princeton, NJ 08540
5:30 p.m. – Dinner
6 to 7 p.m. – Seminar

*Inclement weather alternate dates
(check our website to confirm):

Thursday, February 9, 2017
Thursday, February 23, 2017

• June, 2017 – Submit final HEDIS data to NCQA and the state of New Jersey

• Summer, 2018 – Distribute incentive rewards for 2017 Quality Incentive Program

• Ongoing – Conduct provider visits to discuss current rates, best practices, and process to maximize results
Key terms

- **The Quality Incentive Program** is a claims-based incentive program in which information on the services provided to members is cumulated to indicate provider performance against established benchmarks of quality primary care. Providers who meet or exceed criteria receive financial incentives.

- **Metric or measure** describes a particular evidence-based health care service that is used to assess the percentage of members in a given population (by age, gender, diagnosis, membership category, etc.) who have received recommended care.

- **HEDIS (Healthcare Effectiveness Data and Information Set)** is a standardized set of evidence-based measures used by health plans and other entities to measure quality of care; examples of HEDIS measures include well-child visits and retinal exams for members with diabetes; the Quality Incentive Program uses selected HEDIS measures; each HEDIS measure has percentiles for various covered populations, including the Medicaid population.

How do I calculate my payment?

The table and data below are for illustrative purposes only. Total award pool dollars for this example is $5,000.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Target</th>
<th>Provider Annual Performance Rate</th>
<th>Points Earned</th>
<th>Measure Denominator Count</th>
<th>Total Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>ADD</td>
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<td>AMBED</td>
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<tr>
<td>AWC</td>
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<td>25</td>
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<tr>
<td>URI</td>
<td>92.51</td>
<td>62.62</td>
<td>0</td>
<td>15</td>
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</tr>
<tr>
<td>W34</td>
<td>78.46</td>
<td>80.8</td>
<td>1</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

- Inverse measure; lower is better
- Uses panel count, not denominator
- Meets target, earns point
- Did not meet target, no point awarded

<table>
<thead>
<tr>
<th>Measure</th>
<th>Points Earned</th>
<th>Measure Denominator Count</th>
<th>Total Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>ADD</td>
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<td>AMBED</td>
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<td>URI</td>
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<td>0</td>
</tr>
<tr>
<td>W34</td>
<td>1</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

**TOTAL POINTS EARNED**

- ADD: 40
- AMBED: 25
- AWC: 25
- URI: 0
- W34: 10

**DOLLARS PER POINT**

- $16.50

**TOTAL DOLLARS EARNED**

- $123.75
- $376.20
Financial award calculation process

1. Calculate provider annual performance rates
   a. Identify assigned members who met the inclusion criteria established for each quality measure included in the program (measure denominator).
   b. Identify assigned members who met the inclusion criteria established for each quality measure and also received qualifying services (measure numerator).
   c. Determine provider annual performance rate for each quality measure (numerator/denominator)

2. Calculate total points earned
   a. Compare provider annual performance rate against designated performance target(s) for each quality measure included in the program.
   b. For each quality measure where provider successfully met or exceeded the performance target, provider receives 1 point.
   c. Multiply points earned by the number of members who met the inclusion criteria (measure denominator)
      Example: Provider A, ADD measure, 1 x 40 = 40
   d. Sum total points for all providers and measures
      Example: TOTAL POINTS EARNED (all providers): 75 + 228 = 303

3. Calculate dollars per point
   a. Determine funds available for distribution (total award pool)
   b. Divide total funds by total points earned
      Example: $5,000 / 303 = $16.50 dollars per point

4. Calculate total dollars earned
   a. Multiply total points earned for all quality measures by dollars per point
      Example: 75 x $16.50 = $1,237.50

NOTE: If two-tiered program, provider receives additional points for successfully achieving second target. Some quality measures are inverse measures, where success is measured by provider performance rate being below performance target. The performance of all individual practitioners is aggregated at the provider tax ID (TIN) level for the purpose of performance analysis and payment. Incentive payment amounts are calculated by the VBS team and will be reviewed with the health plans for approval. Health plans complete a check request to the Aetna Better Health Treasury Department. Checks will be mailed or personally delivered by an Aetna Better Health of New Jersey staff member.
**Award determination process**

- **Award opportunity**
  - Providers will receive credit for any metric-related service for those members identified as part of their panel as of December 31, 2017 (even when care was rendered by another Aetna Better Health of New Jersey practitioner).
  - *For example:* Mary Jane’s PCP is Dr. Smith. Member obtains an AWC visit from Dr. Jones in March, but switches to Dr. Smith as PCP in October. Dr. Smith will be given the credit for fulfillment of the AWC visit for that member since he is the PCP of record as of December 31. Conversely, Jane Miller is a patient of Dr. Smith until November 2017 and never had her AWC visit. In November, Jane becomes the patient of Dr. Jones. Dr. Jones is held accountable for Jane’s care for all of 2017.
  - Any eligible provider who meets the performance target for at least one metric will be eligible for a proportionate share of the total incentive amount.
  - Performance for each metric is compared against the target; incentive dollars are awarded based on a provider’s performance against the targets and the total number of measures achieved.

- **Reconciliation**
  - The reconciliation process will begin once the end of year reports are available (Q2 2018).
  - Aetna Better Health of New Jersey will conduct an initial program reconciliation based on the services rendered to each provider’s members relevant to the metrics for Aetna Better Health of New Jersey and reviewed with our finance team.
  - Reconciliation is completed at the TIN level.
  - Upon approval from the Aetna Better Health of New Jersey finance team, the Aetna VBS team will complete the process to request checks for providers eligible for incentives.

**When will I be paid?**

- At the end of the calendar year, 90 days is allowed for a claims lag period.
- After the 90-day claims lag period, each measure will be calculated individually.
- If an amount of reward is due, a check will be mailed to your office to the address on file; in some cases the check will be personally delivered by an Aetna Better Health of New Jersey staff member.
Provider incentive payments

• Incentive payments for the 2017 Quality Incentive Program are generated at the TIN level and distributed to providers in the summer 2018.

• Detailed reports will be provided to Aetna Better of Health of New Jersey as supplemental information to the incentive checks.

• Providers will have an opportunity to review and question the incentive award calculation within 30 days of receipt of their check.

• Final reconciliation will be completed by summer 2018.

Reports and performance monitoring

Our program contains two types of reports:

1. A VBS quality report includes individual and provider group performance against the quality measures and targets. The report highlights gaps in care (services that members should have received) and the actions required to successfully achieve the program targets. An itemized list of all members for whom the quality measures applies is also included to assist with outreach efforts.

   The report is generated by tax ID number (TIN) and data displayed for a TIN will include data for all associated provider IDs. Providers will have access to view performance for all providers associated with their TIN. Program performance is measured at the TIN level.

   VBS quality reports are available monthly on the Aetna Medicaid provider web portal to help providers track progress of members and toward meeting HEDIS measure goals. We encourage you to log on frequently to review your performance and identify opportunities for achieving quality care initiatives for your patients.

• A cumulative year-end report calculates financial rewards distributed at the conclusion of the 2017 performance year. The report highlights performance within the entire program. The report allows for a 90 day claims run out (January through March 2018). The year-end report will highlight performance for the entire program and will be used to calculate financial rewards.
Accessing reports

Step 1: Log on to the Aetna Medicaid web portal
https://medicaid.aetna.com/MWP/selectPlan/showPlans

If you don’t have access to the web portal, please complete the online form at https://www.aetnabetterhealth.com/newjersey/assets/pdf/providers/WebPortalRegistrationForm-NJ.pdf.

If you have questions, call Provider Relations at 1-855-232-3596.

Step 2: Enter your plan code and group provider ID
The health plan is pre-selected upon login

Step 3: Select your group to display performance data

Additional details on accessing reports and reviewing program data will be provided during our February 2017 seminars. See page 7 for seminar details.

Measures of focus and targets

The HEDIS measures of focus and performance targets for Aetna Better Health of New Jersey are noted below:

<table>
<thead>
<tr>
<th>Measure</th>
<th>HEDIS 2016 National Medicaid 50th Percentile Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCS – breast cancer screening</td>
<td>58.34</td>
</tr>
<tr>
<td>CCS – cervical cancer screening</td>
<td>61.06</td>
</tr>
<tr>
<td>CDC – comprehensive diabetes care – monitoring for nephropathy</td>
<td>81.75</td>
</tr>
<tr>
<td>LSC – lead screening in children</td>
<td>71.93</td>
</tr>
<tr>
<td>W15 – well-child in the first 15 months of life (6 or more visits)</td>
<td>59.76</td>
</tr>
<tr>
<td>W34 – well-child visit in the 3rd, 4th, 5th and 6th year of life</td>
<td>72.02</td>
</tr>
<tr>
<td>IMA – immunizations in adolescence</td>
<td>35.88</td>
</tr>
</tbody>
</table>

Please note the documentation and coding guide on pages 14-21 are for the diagnostic and procedural codes that must be present on a claim for you to receive credit for rendered services.
Measures

Our Quality Incentive Program is comprised of seven measures.
1. BCS – breast cancer screening, page 14
2. CCS – cervical cancer screening, page 15
3. CDC – comprehensive diabetes care – monitoring for nephropathy, page 16
4. LSC – lead screening in children, page 18
5. W15 – well-child in the first 15 months of life (6 or more visits), page 19
6. W34 – well-child visit in the 3rd, 4th, 5th and 6th year of life, page 20
7. IMA – immunizations in adolescence, page 21
1. Breast cancer screening (BCS)
Female members 52 to 74 years of age, with one or more mammograms within the last two years starting at age 50.

Measure target: 58.34
A submitted claim must include:
• This is an administrative measure and captured through claims data.
• Women who have had a bilateral mastectomy, which may occur on the same or separate dates, are excluded from this measure. Please be sure to code for a bilateral mastectomy.

Tips for success
• Educate women regarding the benefits of early detection of breast cancer and encourage testing.
• Encourage mammography to all women who are within risk group.
• Submit appropriate mastectomy code to exclude the woman from this measure if it is part of the woman’s history.
• Order routine breast cancer screening every one to two years and confirm that the test was completed by requesting a copy of the report for your office records.
• If patients did not follow through with getting a mammogram:
  ◦ Schedule a mammogram for the patient, and
  ◦ Send the patient a referral to avoid an additional office visit.

Codes
• CPT codes: 77055-77057
• HCPCS: G0202, G0204, G0206
• UB rev codes: 0403, 0401
• Mastectomy codes
  ◦ ICD-10CM Code: Z90.13 or Z90.12 and Z90.11
  ◦ ICD-10PCS Code: 0HTV0ZZ or 0HTU0ZZ and 0HTT0ZZ
  ◦ CPT codes: 19180, 19200, 19220, 19240, 19303-19307 with bilateral modifier CPT codes: 50, 09950 or LT and RT
2. Cervical cancer screening (CCS)

- Women 21–64 years of age with one or more Pap tests within the last three years
- Women 30–64 years of age, a cervical cytology and human papillomavirus (HPV) co-testing with in the last five years

Measure target: 61.06

A submitted claim must include:
- Women who have had a total hysterectomy with no residual cervix are excluded. This must be documented in history or problem list, and coded as such.
- Cervical cytology and human papillomavirus test must be completed four or less days apart in order to qualify for testing every five years.

Tips for success
- Ensure PCP charts include all specialist reports and test results. Offices should focus on coordination of care. Use the EMR to flag dates and make outreach calls to get the reports if necessary.
- Make sure that all documentation related to the hysterectomy is complete; including date of surgery and presence or absence of the cervix.

Codes
- Cervical cytology
  - CPT codes: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
  - HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
- UB rev codes: 0923
- LOINC codes: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
- HPV
  - CPT codes: 87620-87622, 87624-87625
  - HCPCS: G0476
  - LOINC codes: 21440-3, 30167-1, 38372-9, 49896-4, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75406-9, 75694-0, 77379-6, 77399-4, 77400-0
3. Comprehensive diabetes care (CDC) – monitoring for nephropathy

Members 18–75 with diabetes (type 1 and type 2) who had one of the following during the measurement year:

• Medical attention for nephropathy (nephropathy test, evidence nephropathy)
• Urine microalbumin screen
• At least one angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) dispensing event

Measure target: 81.75

A submitted claim must include:

• Coding that indicates evidence of nephropathy (e.g. renal transplant, end-stage renal disease (ESRD), or microalbumin test)

Any of the following meet criteria for a nephropathy screening or monitoring test:

• 24-hour urine for albumin or protein
• Timed urine for albumin or protein
• Spot urine for albumin or protein
• Urine for albumin/creatinine ratio
• 24-hour total protein
• Random urine for protein/creatinine ratio
• Nephrology consult

Tips for success

• Bring the member in for testing
• Communicate the importance of nephropathy screening and help coordinate the scheduling if indicated
• Consider starting patient on an ACE-I or ARB medication to avoid nephropathy
• Document date of nephrology consult, and obtain results of visit
Codes

- CPT codes: 82042, 82043, 82044, 84156
- CPT category II
  - 3060F: Positive microalbuminuria test result documented and reviewed
  - 3061F: Negative microalbuminuria test result documented and reviewed
  - 4010F: ACE Inhibitor or ARB therapy prescribed or currently being taken
- LOINC: 1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13705-9, 13801-6, 14585-4, 14956-7, 14957-5, 14958-3, 14959-1, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8, 56553-1, 57369-1, 58448-2, 58992-9, 59159-4, 60678-0, 63474-1
4. Lead screening in children (LSC)

The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning on or before their second birthday.

Measure target: 71.93

A submitted claim must include:
• A note indicating the date the test was performed, and
• The result or finding.

Tips for success:
• Verbal lead risk assessments do not meet the measure criteria for screening.
• Educate parents on the need and importance to screen their child/children for lead poisoning via a blood test, not a verbal lead risk assessment.
• Help coordinate and schedule the blood test.

Codes
• CPT: 83655
• LOINC: 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7
5. Well-child 15 months (W15)
Members 0–15 months of age with six comprehensive well-child visits. A minimum of six well-visits required before 15 months old.

Measure target: 59.76

A submitted claim must include:
Coding that identifies the following were performed:
1. Health education/anticipatory guidance;
2. Physical exam; and
3. Health and developmental history (physical and mental).

Anticipatory guidance must be documented.

Tips for success
• Exam requirements can be performed during a sick visit or a well-child exam.
• Educate families on the importance of immunizations and well-visits.
• Give call reminders for follow-up well-visits and vaccines.
• Provide parent/guardian with written anticipatory guidance materials, as available.

Codes
• ICD-10CM codes: Z00.11-Z00.129, Z00.5, Z00.8, Z02.0-Z02.9
• CPT codes: 99381, 99382, 99391, 99392, 99461
• HCPCS: G0438, G0439
6. Well-child 3-6 years (W34)

Members 3-6 years of age with at least one comprehensive well-child visit annually. A minimum of one visit required annually.

Measure target: 72.02

A submitted claim must include:

Coding that identifies the following was performed:

1. Health education/anticipatory guidance;
2. Physical exam; and
3. Health and developmental history (physical and mental).

Anticipatory guidance must be documented.

Tips for success

• Exam requirements can be performed during a sick visit or a well-child exam.
• Educate families on the importance of immunizations and well-visits.
• Give call reminders for follow-up well-visits and vaccines.
• Provide parent/guardian with written anticipatory guidance materials, as available.

Codes

• ICD-10CM Codes: Z00.121-Z00.129, Z00.5, Z00.8, Z02.0-Z02.9
• CPT Codes: 99382, 99383, 99392, 99393
• HCPCS: G0438, G0439
7. Immunizations in adolescents (IMA)

Members age 13 years of age who received:

• One Tdap vaccine between the 10th and 13th birthday;
• One meningococcal conjugate vaccine between the 11th and 13th birthday; and
• Three doses of HPV vaccine between the 9th and 13th birthday.

Individual rates and two combinations are reported:

• Tdap, Meningococcal conjugate
• Tdap, Meningococcal conjugate and HPV

Measure target: 35.88

A submitted claim must include:

• Appropriate coding to indicate immunizations given.

Tips for success:

• Educate staff to schedule PRIOR to 13th birthday.
• Educate families on the importance of immunizations.
• Give call reminders for follow-up vaccines.

Codes

Tdap

• CPT Code: 90715
• CVX Code: 115

Meningococcal

• CPT Codes: 90644 90734
• CVX Codes: 114, 136, 148

HPV

• CPT Codes: 90649, 90650, 90651
• CVX Codes: 62, 118, 165