Healthy happens together

Aetna Better Health® of New Jersey

2019 Value Based Programs
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Dear Aetna Better Health of New Jersey Provider,

At Aetna Better Health of 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 2019 Value Based Programs to you.

Among the best in the New Jersey market, our 2019 Value Based Programs not only pay higher incentives for many measures, but also makes it easier to qualify for incentives.

It does not end there. Along with top-paying comprehensive programs come 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 Value Based Programs work. Additionally, it presents the Aetna Better Health of New Jersey team members who are available to support you and help you maximize the Programs’ incentive opportunities. I invite you to share your thoughts with me about our Programs 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
Cell: 609-613-0432
About Us

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 attention to the social determinants of health. 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 are a state-contracted Medicaid managed care health plan that offers Medicaid services, Children’s Health Insurance Programs (CHIP) and Managed Long Term Care Services and Support (MLTSS) to NJ FamilyCare members in all 21 counties.

Our 2019 goals:
• Receive NCQA Comendable Accreditation, demonstrating our ongoing commitment to providing quality care (we received health plan accreditation status in 2018)
• Continued focus on improvement in quality
• Continued network improvement and expansion
• Alignment to our Primary Care Strategy to provide value based solutions to our providers
• Optimized and supportive partnerships with our network physicians to ensure our members are receiving high-quality health care
• Getting every member to a primary care visit yearly or more often
• Improving ER and inpatient utilization
Always Here to Help – Contact Us

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 dedicated staff are fully committed to supporting our network of providers in achieving the level of quality. 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
  - Enhanced data and analytics
  - Access to a population health specialist
If you have questions or concerns, contact one of our dedicated staff:

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2019 Value Based Programs

Purpose
At Aetna Better Health of New Jersey, we understand that a key component of achieving superior health care and satisfaction for members is the doctor-patient relationship. Members who have a positive relationship with their health provider are more likely to seek appropriate care. Our primary care Programs seek to enhance this relationship and support our members toward the highest quality healthcare as measured by national benchmarks.

All of our Value Based Programs are based on quality parameters we collect in our data processes. There are multiple programs that reward providers for meeting or exceeding quality goals. By meeting or exceeding the quality goals, providers are eligible to earn incentive payments, while delivering the highest-quality health care to our members.

Our Value Based Programs support 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

We have Value Based Programs for every kind of primary care setting. Some programs apply to small practices and others to large practices and now feature the ability for providers limited to adults or pediatrics to have access to a full range of incentives.

Aetna Better Health's Value Based Programs are based only on HEDIS administrative data.
What is HEDIS?

HEDIS is a registered trademark of the National Quality Committee for Quality Assurance (NCQA).

Healthcare Effectiveness Data and Information Set (HEDIS)

NCQA defines HEDIS as “a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of health care plans.”

- HEDIS is a registered trademark of the National Committee for Quality Assurance
- HEDIS is a performance measurement tool that is coordinated and administered by NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations
- Results from HEDIS data collection serve as measurements for quality improvement processes, educational initiatives, and preventive care programs
- All managed care companies who are NCQA accredited perform HEDIS reviews the same time each year
- HEDIS 2019 consists of 92 measures across six domains of care that address important health issues
- HEDIS is a retrospective review of services and performance of care from the prior calendar year

There are two types of HEDIS data collected:

- Administrative data – comes from submitted claims and encounters (claim-like records of services)
- Hybrid data – comes from chart collection/review
About Our Programs

The program measurement year is the calendar year, covering dates of service January 1 to December 31, 2019.

Based upon your population of Aetna members, a program is available for you to earn incentives while providing quality care for your patients, our members. There are three Value Based Programs as follows:

1. Quality Incentive Program

For all providers with a population of more than 50 Aetna Better Health members

The Quality Incentive Program is an annual program based on quality metrics for providers who do not immediately qualify for our other Value Based Solutions (VBS) and Programs; the program rewards providers for achieving better performance on a broad spectrum of HEDIS and utilization metrics for the practice's Aetna Better Health member panel.

The program does not require a contract addendum and all providers who meet the 50-member threshold are automatically enrolled.

The program is an all “up-side” program. Credit is given for any claim showing provision of a service related to a metric, provided any time in 2019; all credits may be included in the financial payout calculations. There is no penalty in the program (“down-side”).

Certain HEDIS measures have been specifically selected for this program. Performance targets for all measures are based upon the 2018 National Medicaid HEDIS 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 (2019), the cumulative annual performance is calculated for each measure and 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 2020.
- High performers in this program may be eligible for additional incentive opportunities based on meeting the 75th or 90th percentiles for certain measures.

Summary

- All providers with at least 50 members are automatically enrolled
- Claims data is reviewed for HEDIS measures automatically
- Providers meeting the above criteria are automatically qualified for incentives
2. Patient-Centered Medical Home (PCMH)

A voluntary program for selected providers with 100-999 Aetna Better Health members

Our PCMH program helps address the complex health needs of our members through a coordinated system of care including comprehensive primary care, referral to specialty care, acute care, behavioral health integration, and referral to community resources.

Providers do not need to be NCQA-certified as a PCMH. A contract addendum is required for participation in the Aetna PCMH program. Requirements may be individualized for each participating practice.

Our PCMH program uses the following payment model:

- Fee-for-service payments for services provided with a per-member-per-month (PMPM) care coordination payment and additional incentives based on clinical outcomes measures.
- PCMH agreements are collaborative and outline the expectations of both stakeholders so that all share accountability for outcomes.

The PCMH arrangements are made up of two utilization measures and 3 additional HEDIS quality measures. The provider will have the option to choose from a preselected group of measures specific to the providers practice type (pediatrician, family practice or internal medicine). Descriptions for both the utilization measures and HEDIS quality measures can be found on page 24.
3. Shared Savings/Shared Risk

A voluntary program for selected providers with 1,000 or more Aetna Better Health members.

Our Shared Savings arrangements are built on a fee-for-service architecture and include an opportunity for providers (with 1,000 or more members) to earn incentives based on the costs of the services they provide compared to a benchmark.

Providers must qualify to earn Shared Savings incentives by achieving clinical quality outcomes. These arrangements are for those practices serving a larger portion of our Medicaid members and who possess the skills and infrastructure necessary to manage the population and financial risk.

The Shared Savings/Shared Risk arrangements are made up of two utilization measures and three additional HEDIS quality measures. The provider will have the option to choose from a preselected group of measures specific to the provider’s practice type (pediatrician, family practice or internal medicine. Descriptions for both the utilization measures and HEDIS quality measures can be found on page 24.

All providers participating in the Shared Savings agreement require a signed contract addendum. Any practice with interest in a Shared Savings/Shared Risk agreement can contact CEO Glenn MacFarlane or Ashley Bolduc, Director of Primary Care Services.
2019 Quality Measures

Quality Measures for VBS Programs will include three HEDIS measures plus two Utilization Measures (ED visits/1000 and Inpatient readmissions).

Internal medicine (adults) measures

AAP – Adult Access to Primary Care – The percentage of members 20 years and older who had an ambulatory or preventive care visit.

ABA – Adult BMI Assessment – The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

BCS – Breast Cancer Screening – Percentage of women ages 50-74 years of age screened for breast cancer.

CDC – Comprehensive Diabetic Screening – The percentage of members 18–75 years of age with diabetes (type 1 and type 2) that had evidence of nephropathy screening or monitoring test.

Family medicine measures

AAP – Adult Access to Primary Care – The percentage of members 20 years and older who had an ambulatory or preventive care visit.

AWC – Adolescent Well Care – The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner by December 31st of the measurement year.

CDC – Comprehensive Diabetic Screening – The percentage of members 18–75 years of age with diabetes (type 1 and type 2) that had evidence of an HbA1c adequate result (<9).

LSC – Lead Screening for Children – The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

W34 – Well-Child Visits 3, 4, 5, 6 years of age – The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. The comprehensive well-care visit includes:

- Health and developmental history (physical and mental)
- Complete physical exam
Pediatric measures

AWC – Adolescent Well Care – The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner by December 31st of the measurement year.

CIS – Childhood Immunization Status – The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

LSC – Lead Screening for Children – The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

W34 – Well-Child Visits 3, 4, 5, 6 years of age – The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

The comprehensive well-care visit includes:

• Health and developmental history (physical and mental)
• Complete physical exam

WCC BMI – Weight Assessment BMI – The percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of a BMI percentile documentation during the measurement year.
### Overview of all VBS Programs

#### Program and Measures Summary Table

<table>
<thead>
<tr>
<th>Program Type</th>
<th>NCQA 50th Percentile Target</th>
<th>Quality Incentive Program – Pediatrics</th>
<th>Quality Incentive Program – Adults</th>
<th>Quality Incentive Program – Family Practice</th>
<th>PCMH</th>
<th>Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel Size Requirements</td>
<td></td>
<td>&gt; 50 members</td>
<td>&gt; 50 members</td>
<td>&gt; 50 members</td>
<td>100-999 members</td>
<td>1000+ members</td>
</tr>
<tr>
<td>HEDIS Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity (BMI only)</td>
<td>75.55%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>88.56%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visit 34</td>
<td>73.89%</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td>80.08%³</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunizations: CIS Combo 10</td>
<td>35.28%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Access to Primary Care</td>
<td>81.57%</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>58.04%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (Medical Attention for Nephropathy)</td>
<td>90.51%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care Hba1c control (&lt;9%)</td>
<td>38.20%</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Well Care</td>
<td>54.57%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions All Cause (30 d)</td>
<td>12 readmissions / 1000 member months</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Utilization Rate</td>
<td>52 ER visits per 1000 member-months²</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Targets measure percentage of applicable members for each measure
2. Member months = the number of individuals participating in an insurance plan each month. For example, a member enrolled for a full year has 12 member months
3. State-required target is 75th percentile

All PCMH and Shared Savings Programs include measures of utilization in their quality metrics. Additional quality metrics eligible for program incentives (or disincentives) are selected from the measures above and agreed upon in the contract addendum for each participating practice.
Targets and Terms for PCMH and Shared Savings Programs

Targets

<table>
<thead>
<tr>
<th>2018 Measures</th>
<th>HEDIS 2017 National Medicaid 50th Percentile Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization Measures</td>
<td></td>
</tr>
<tr>
<td>PCR – Plan All Cause Readmissions</td>
<td>12 readmissions/1000 member months</td>
</tr>
<tr>
<td>AMB – Emergency Department Utilization</td>
<td>52 ER visits/1000 member months</td>
</tr>
</tbody>
</table>

Measure Definitions

Member months = the number of individuals participating in an insurance plan each month. For example, a member enrolled for a full year has 12 member months.

PCR – Plan All-Cause Readmissions – For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

  - Count of index hospital stays (IHS) (denominator)
  - Count of 30-day readmissions (numerator)
  - Expected readmissions rate

AMB – Emergency Department Utilization – This measure summarizes utilization of ambulatory care in ED visits.

Providers in a PCMH or Shared Savings Program will be required to select at least three additional measures from the pediatric, adult or family practice measures listed on pages 24-37, depending upon their practice population.

For additional details and coding tips, please refer to:
Gaps in Care Technical Specifications and PCP Billing Guide 2019

All New Jersey-required HEDIS measures used in our Value Based Programs are described in this guide, and are listed by alphabetical order, starting on page 24.
How to calculate my payment?

The table and data below are for illustrative purposes only.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Performance Target</th>
<th>Provider Annual Performance Rate</th>
<th>Points Earned</th>
<th>Measure Denominator</th>
<th>Total Points Earned</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD</td>
<td>50.60</td>
<td>52.60</td>
<td>35.80</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>AMBED**</td>
<td>72.42</td>
<td>102.60</td>
<td>60.00</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>AWC</td>
<td>59.98</td>
<td>68.25</td>
<td>55.42</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>URI</td>
<td>64.91</td>
<td>62.51</td>
<td>72.37</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>W34</td>
<td>56.04</td>
<td>80.08</td>
<td>85.61</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| Total Points Earned | 75 | 125 |
| Dollars per Point   | $234.96 | $234.96 |
| Total Dollars Earned | $17,622 | $29,370 |

*Inverse measure; lower is better
+Uses panel count, not denominator

Financial award calculation process

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

2. Calculate total points earned
   • Compare provider annual performance rate against designated performance target(s) for each quality measure included in the program.
   • For each quality measure where provider successfully met or exceeded the performance target, provider receives 1 point.
   • Multiply points earned by the number of members who met the inclusion criteria (measure denominator).

*Example*: Provider A, ADD measure, 1 x 40 = 40

*Example*: Total points earned (all providers): 75+125 = 200
3. Dollars per point
   • Determine funds available for distribution (total award pool)
   • Divide total funds by total potential points

   Based on 2017 results, payout would be **$234.96** dollars per point; actual dollar per point payment will change.

4. Calculate total dollars earned
   • Multiply total points earned for all quality measures by dollars per point

   Example: 75 x $234.96 = **$17,622.00**

NOTE: 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 ABH Treasury Department. Provider Relations staff will distribute incentive payment checks to providers in the Summer following the end of the performance period.
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, 2019 (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 12/31. Conversely, Jane Miller is a patient of Dr. Smith until November 2018 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 2019.

• 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 2020).

• 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 address on file; in some cases the check will be personally delivered by an Aetna Better Health of New Jersey Manager or above.

Provider incentive payments

• Incentive payments for the 2019 Value Based Program are generated at the TIN level and distributed to providers in the summer 2020.

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

• Final reconciliation will be completed by summer 2020.
VBS Reports and Performance Monitoring

As a participant in a Value Based Program, you can obtain access to reporting to support your efforts. Program performance is measured at the Tax Identification Number (TIN) level. All participants in PCMH or Shared Savings programs have access as part of their program. Participants in Pay for Quality may request access to the Provider Portal in order to see Gaps in Care (see below).

**Quality Incentive Program:** Participants can obtain access to the Quality Report, which provides individual and provider group performance against program quality measures and targets. The report highlights gaps in care (services that members should have received) and the actions required to successfully achieve program targets. An itemized list of all members for whom the quality measures apply is also included to assist with outreach efforts. Program participants can get access to view performance for all providers associated with their TIN.

The VBS Quality Reports are available on the Aetna Medicaid Provider Web Portal, with the first reporting of the year posted in June of each year and monthly for the rest of the year to help providers track progress of members toward meeting HEDIS measure goals. Providers can get access to the Web Portal by contacting Provider Services for the enrollment form and instructions. We encourage providers to log on frequently to review their data (once available) and identify opportunities for achieving quality care initiatives for their patients.

**PCMH and Shared Savings Programs:** Program participants will receive VBS Key Performance Indicators and Financial Reports, which are delivered via email.

**Key Performance Indicators Report:** includes both individual and provider group performance compared to quality and utilization benchmarks. This report contains 12 months of rolling clinical and quality data to drive clinical decision making and determine necessary interventions.

In addition to the VBS Key Performance Indicators reports, providers in these programs have access to **Gaps in Care** reports, which show, by individual measure, which members on your panel have not completed the measure; this data is available starting in July of 2019 and is refreshed monthly thereafter. These reports do not provide aggregate results – data is reported at the measure level, by member.

**Financial Report:** includes performance against program financial goals. Among the details are delineation of specific members included in the numerator and denominator for each measure and cumulative information by service location and provider. Data are refreshed periodically (at least quarterly).
A Cumulative Year-End Report: calculates financial rewards distributed at the conclusion of the 2019 performance year for participating practices in all Value Based Shared Savings programs. The report highlights performance within the entire program. The report allows for a 90-day claims run out (January through March 2020). The year-end report will highlight performance for the entire program and will be used to calculate financial rewards.

Accessing reports

*Please contact your Aetna Better Health of New Jersey Provider Relations Liaison to request Web Portal access. If you need to identify your Liaison, please call Provider Services at 1-855-232-3596.*

Once access is obtained:

- **Step 1:** Log on to the Aetna Medicaid Web Portal https://medicaid.aetna.com/MWP/selectPlan/showPlans
- **Step 2:** Enter your Plan Code (provided once access is obtained) and Group Provider ID (The health plan is pre-selected upon login)
- **Step 3:** Select your group by name to display performance data

Additional details on accessing reports and reviewing program data will be provided during our HEDIS seminars for providers to be held in February, 2019. Additional information will be provided on seminars and dates in January.

Gaps in Care Technical Specifications and PCP Billing Guide 2019

Disclaimer

This material serves as a tool to assist providers, their clinical team, and billing staff with information to improve HEDIS performance.

HEDIS 2019 Volume 2 Technical Specifications for Health Plans was used to generate this Provider Billing Guide. The Technical Specifications were current at the time of publication (November 2018).

HEDIS indicators have been designed by NCQA to standardize performance measurement and do not necessarily represent the ideal standard of care.

Information contained in this report is based on claims data only.
Tips and Best Practices

General tips and information that can be applied to most HEDIS measures:

1. Use your member roster to contact patients who are due for an exam or are new to your practice.
2. Take advantage of this guide, coding information, and the on-line resources that can assist the practice with HEDIS measure understanding, compliance, and requirements.
3. Use your Gaps in Care member list to outreach to patients in need of services/procedures.
4. You can provide evidence of completed HEDIS services and attach the supporting chart documentation by contacting the Quality Management department.
5. Schedule the members’ next well-visit at the end of the current appointment.
6. Assign a staff member at the office knowledgeable about HEDIS to perform internal reviews and serve as a point of contact with plans and their respective Quality Management staff.
7. Set up your Electronic Health Records (EHRs) so that the HEDIS alerts and flags alert office personnel of patients in need of HEDIS services.

HIPAA

Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS is permitted, and the release of this information requires no special patient consent or authorization. Please be assured our members' personal health information is maintained in accordance with all federal and state laws. HEDIS results are reported collectively without individual identifiers or outcomes. All of the health plans' contracted providers' records are protected by these laws.

- HEDIS data collection and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities
- The records you provide us during this process help us to validate the quality of care our members received
Importance of Documentation

Adherence to principles governing the medical record and proper documentation:

1. Enables physician and other healthcare professionals to evaluate a patient's healthcare needs and assess the efficacy of the treatment plan.
2. Serves as the legal document to verify the care rendered and date of service.
3. Ensures date care was rendered is present and all documents are legible.
4. Serves as a communication tool among providers and other healthcare professionals involved in the patient's care, for improved continuity of care.
5. Facilitates timely claim adjudication and payment.
6. When done appropriately, will reduce many of the “hassles” associated with claims processing and HEDIS chart requests.
7. ICD-10 and CPT codes reported on billing statements should be supported by the documentation in the medical record.

Common reasons members who have seen their PCP visits will not receive “credit” for recommended services/procedures:

1. Missing or lack of all required documentation components.
2. Service provided without claim/encounter data being submitted.
3. Lack of referral note in chart directing member to obtain the recommended service (e.g. diabetic member eye exam to check for retinopathy).
4. Service provided but outside of the required timeframe or anchor date (i.e. lead screening performed after age 2).
5. Incomplete services (e.g. no documentation of anticipatory guidance during a well visit for the adolescent well-child measure).
6. Failure to document or code exclusion criteria for a measure.

Look for the ‘Common chart deficiencies and tips’ sections for guidance with some of the more challenging HEDIS measures
AAP Adults’ Access to Preventive/Ambulatory Health Services

Measure definition:
Members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Common chart deficiencies and tips:
1. Each adult Medicaid or Medicare member should have a routine outpatient visit annually
2. Utilize your Gaps in Care report to identify members who have not had a visit

<table>
<thead>
<tr>
<th>Billing Reference – AAP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td><strong>Ambulatory Visits</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>ICD 10</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| **Other Ambulatory Visits** | 92002, 92004, 92012, 92014, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 |
| **Telehealth CPT Modifier** | 95, GT |
| **Online Assessments** | 98969, 99444 |
| **Telephone Visits** | 98966-98968, 99441-99443 |

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ABA Adult BMI Assessment

Measure definition:
The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented in 2017 or 2018.

For members 20 years of age or older on the date of service: BMI in 2017 or 2018 must be documented from the same data source.

For members younger than 20 years of age on the date of service: BMI percentile must be documented in 2017 or 2018. Chart documentation should include height, weight and BMI percentile (as a value e.g. 85th or plotted on a growth chart). Documentation of ranges or thresholds do not meet criteria for this indicator.

Common chart deficiencies and tips:
1. Common deficiency: Height and weight documented but no documentation of the BMI
2. ICD-10 Z68 codes can be used to show a member as compliant without chart review
3. ICD-9 codes should not be used for services in 2016

Billing Reference – ABA

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>Z68.1, Z68.20-Z68.29, Z68.30-Z68.39, Z68.41-Z68.45</td>
</tr>
<tr>
<td>BMI Percentile</td>
<td>Z68.51-Z68.54</td>
</tr>
</tbody>
</table>

Measure Exclusion Criteria

Optional exclusion for this measure is pregnancy. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the 2017 or 2018 visit.

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AWC Adolescent Well-Care Visits

Measure definition:
The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

The comprehensive well care must visit include evidence of all of the following:

- **Health history** – Health history is an assessment of the member’s history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.

- **Physical development history** – Physical developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.

- **Mental development history** – Mental developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.

- **Physical exam**

- **Health education/anticipatory guidance** – Health education/anticipatory guidance is given by the health care provider to the member and/or parents or guardians in anticipation of emerging issues that a member and family may face.

**Common chart deficiencies and tips:**

1. Missing or undocumented anticipatory guidance
2. Sick visit in calendar year without well-child visit – turn a sick visit into a well-child visit
3. Schedule next visit at end of each appointment
4. Educate parent/guardian on importance of annual well visit
Examples of documentation that DOES NOT meet criteria:

- **Health history** – notation of allergies or medications or immunization status alone does not meet. If all three are documented this does meet criteria.

- **Physical development history** – notation of “appropriate for age” without specific mention of development or “well-developed/nourished appearing” does not meet criteria.

- **Mental development history** – notation of “appropriately responsive for age”, “neurological exam” or “well-developed” does not meet criteria.

- **Physical exam** – vital signs alone or a visit to OB/GYN for OB/GYN topics only do not meet criteria.

- **Health Education/Anticipatory Guidance** – information regarding medications or immunizations or their side effects do not meet criteria.

<table>
<thead>
<tr>
<th>Billing Reference – AWC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
</tr>
<tr>
<td>Office Visit</td>
</tr>
</tbody>
</table>

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BCS Breast Cancer Screening

Measure definition:
The percentage of women who are 52–74 years of age in 2018 and had a mammogram to screen for breast cancer from October 2016 through December 31, 2018.

Billing Reference – BCS

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>UB Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>77055-77057, 77061-77067</td>
<td>G0202, G0204, G0206</td>
<td>0401, 0403</td>
</tr>
</tbody>
</table>

Measure Exclusion Criteria

A female who had the following: Bilateral mastectomy or any combination of unilateral mastectomy codes that indicate a mastectomy on both the left and right side before December 31, 2018.

<table>
<thead>
<tr>
<th>Exclusion Description</th>
<th>ICD-10 CM</th>
<th>ICD-10 PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral Mastectomy</td>
<td></td>
<td>0HTV0ZZ</td>
</tr>
<tr>
<td>Hx. Bilateral Mastectomy</td>
<td>Z90.13</td>
<td></td>
</tr>
</tbody>
</table>

Unilateral Mastectomy with Bilateral Modifier

<table>
<thead>
<tr>
<th>Exclusion Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral Mastectomy</td>
<td>19180, 19200, 19220, 19240, 19303-19307</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>With LT (left) or RT (right) modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion Description</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Unilateral Mastectomy</td>
</tr>
<tr>
<td>Absence of Breast</td>
</tr>
<tr>
<td>Absence of Breast</td>
</tr>
</tbody>
</table>

Additional Exclusion Criteria

Exclude from Medicare reporting members age 66 and older as of December 31st of the measurement year who were enrolled in an Institutional SNP (I-SNP) any time during the measurement year or living long-term in an institution any time during the measurement year.

Exclude members age 66 and older as of 12/31 of the measurement year with both advanced illness and frailty: A claim for an advanced illness condition from the measurement year or the year prior and a claim for frailty during the measurement year are required.

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CDC Comprehensive Diabetes Care – HbA1c Testing

Measure definition:
Members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.

Common chart deficiencies and tips:
1. Educate member on importance of completing A1C test
2. Lab results not documented in chart
3. Lab values show poor control (>9)

<table>
<thead>
<tr>
<th>Billing Reference – CDC</th>
<th>ICD-10 CM</th>
<th>CPT II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c Screening</td>
<td>83036, 83037</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Lab Result</td>
<td></td>
</tr>
<tr>
<td>HbA1c Result</td>
<td>&lt;7%</td>
<td>3044F</td>
</tr>
<tr>
<td></td>
<td>7.0%-9.0%</td>
<td>3045F</td>
</tr>
<tr>
<td></td>
<td>&gt;9.0%</td>
<td>3046F</td>
</tr>
</tbody>
</table>

Measure Exclusion Criteria:
Identify members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior and who meet either of the following criteria:
A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior, with no encounters in any setting with a diagnosis of diabetes.

<table>
<thead>
<tr>
<th>Exclusion Description</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Exclusions</td>
<td>E08.00-E09.9, O24.410-O24.439, O24.911-O24.93</td>
</tr>
</tbody>
</table>

Additional Exclusion Criteria
Exclude from Medicare reporting members age 66 and older as of December 31st of the measurement year who were enrolled in an Institutional SNP (I-SNP) any time during the measurement year or living long-term in an institution any time during the measurement year.
Exclude members age 66 and older as of 12/31 of the measurement year with both advanced illness and frailty: A claim for an advanced illness condition from the measurement year or the year prior and a claim for frailty during the measurement year are required.

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CDC Comprehensive Diabetes Care – Medical Attention for Nephropathy

Measure definition:
Members 18-75 years of age with diabetes (type 1 and type 2) who received medical attention for nephropathy in during the measurement year through one of the following:

- Documentation of medical attention for any of the following: diabetic nephropathy, ESRD, CRF, CKD, renal insufficiency, proteinuria, albuminuria, renal dysfunction, ARF, dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy.
- A urine test for protein with minimum documentation of date and result.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.

Common chart deficiencies and tips:
1. Failure to order lab tests for nephropathy screening
2. Failure to document monitoring for nephropathy
3. Incomplete or missing information from specialists who may be monitoring nephropathy

<table>
<thead>
<tr>
<th>Billing Reference – CDC Description</th>
<th>ICD-10 CM</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>CPT II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine Protein Tests</td>
<td>81000-81003, 81005, 82042-82044, 84156</td>
<td>3060F, 3061F, 3062F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT II</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment for Nephropathy</td>
<td>3066F, 4010-F</td>
<td>E08.21-E08.29, E09.21-E09.29, E10.21-E10.29, E11.21-E11.29, E13.21-E13.29, I12.0-I13.2, I15.0-I15.1, N00.0-N08, N14.0-N14.4, N17.0-N19, N25.0-N26.9, Q60.0-Q61.9, R80.0-R80.9</td>
</tr>
</tbody>
</table>
### Measure Exclusion Criteria:

Identify members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior, with no encounters in any setting with a diagnosis of diabetes.

### Exclusion Description | ICD-10 CM  
---|---  
Diabetes Exclusions | E08.00-E09.9, O24.410-O24.439, O24.911-O24.93
**Billing Reference - CDC continued**

**Additional Exclusion Criteria**

Exclude from Medicare reporting members age 66 and older as of December 31st of the measurement year who were enrolled in an Institutional SNP (I-SNP) any time during the measurement year or living long-term in an institution any time during the measurement year.

Exclude members age 66 and older as of 12/31 of the measurement year with BOTH advanced illness and frailty: A claim for an advanced illness condition from the measurement year or the year prior and a claim for frailty during the measurement year required.

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CIS Childhood Immunization Status

Measure definition:
The percentage of children turning 2 years of age during the measurement year who received recommended vaccinations prior to their second birthday. Recommended vaccinations and number in series to meet compliance are listed below.

The measure calculates a rate for each vaccine and nine separate combination rates.

Common chart deficiencies and tips:
1. Vaccinations for DTaP, IPV, HiB, or PCV given before 42 days after birth date do not count toward vaccine compliance
2. Participate in state Immunization registries, where available
3. Devote time during each visit to review immunization record and look for opportunities to catch up on missing immunizations
4. Document date of first hepatitis B vaccination if given at hospital and note the hospital
5. Document history of illness in chart if child has had varicella zoster or measles

<table>
<thead>
<tr>
<th>Billing Reference – CIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization Description</td>
</tr>
<tr>
<td>DTaP</td>
</tr>
<tr>
<td>IPV</td>
</tr>
<tr>
<td>MMR</td>
</tr>
</tbody>
</table>

Any combination of the following to satisfy recommendation of one MMR

<table>
<thead>
<tr>
<th>Immunization Description</th>
<th># in Series</th>
<th>CPT</th>
<th>HCPCS</th>
<th>CVX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles Only</td>
<td>1</td>
<td>90705</td>
<td></td>
<td>05</td>
</tr>
<tr>
<td>Mumps Only</td>
<td>1</td>
<td>90704</td>
<td></td>
<td>07</td>
</tr>
<tr>
<td>Rubella Only</td>
<td>1</td>
<td>90706</td>
<td></td>
<td>06</td>
</tr>
<tr>
<td>Measles and Rubella</td>
<td>1</td>
<td>90708</td>
<td></td>
<td>04</td>
</tr>
</tbody>
</table>

Table continued on next page
### Billing Reference – CIS continued

<table>
<thead>
<tr>
<th>Immunization Description</th>
<th># in Series</th>
<th>CPT</th>
<th>HCPCS</th>
<th>CVX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rotavirus 2-dose or 3-dose vaccinations satisfy Rotavirus recommendations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotavirus 2-dose</td>
<td>2</td>
<td>90681</td>
<td></td>
<td>119</td>
</tr>
<tr>
<td>Rotavirus 3-dose</td>
<td>3</td>
<td>90680</td>
<td></td>
<td>116, 122</td>
</tr>
<tr>
<td>Influenza</td>
<td>2</td>
<td>90655, 90657, 90661, 90662, 90673, 90685-90688</td>
<td>G0008</td>
<td>88, 135, 140, 141, 150, 153, 155, 158, 161</td>
</tr>
</tbody>
</table>

### ICD-10 CM Codes for Illnesses

<table>
<thead>
<tr>
<th>Illness</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td>B15.0, B15.9</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51</td>
</tr>
<tr>
<td>Measles</td>
<td>B05.0-B05.4, B05.81, B05.89, B05.9</td>
</tr>
<tr>
<td>Rubella</td>
<td>B06.00-B06.02, B06.09, B06.81-B06.82, B06.89, B06.9</td>
</tr>
<tr>
<td>Varicella Zoster</td>
<td>B01.0, B01.11-B01.2, B01.81-B01.9, B02.0, B02.1, B02.21-B02.29, B02.30-B02.39, B02.7-B02.9</td>
</tr>
</tbody>
</table>

### CIS Measure Exclusion Criteria

Exclusion: Exclude children who had a contraindication for a specific vaccine.

<table>
<thead>
<tr>
<th>Exclusion Description</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any particular vaccine – Anaphylactic reaction</td>
<td>T80.52XA, T80.52XD, T80.52XS</td>
</tr>
<tr>
<td>DTaP – Encephalopathy with adverse effect</td>
<td>G04.32 with T50.A15A, T50.A15D, T50.A15S</td>
</tr>
<tr>
<td>MRR, VZV and Influenza – Immunodeficiency, lymphoreticular cancer, multiple myeloma or leukemia or HIV</td>
<td>D80.0-D81.2, D81.4, D81.6-D82.4, D82.8-D83.2, D83.8-D84.1, D84.8-D84.9, D89.3, D89.810-D89.13, D89.82, D89.89, D89.9, B20, Z21, B97.35, C81.00-C86.6, C88.2-C88.9, C90-C96.2</td>
</tr>
<tr>
<td>Rotavirus – Severe combined immunodeficiency or a history of intussusception</td>
<td>D81.0-D81.2, D81.9, K56.1</td>
</tr>
</tbody>
</table>

### General Exclusion Criteria

<table>
<thead>
<tr>
<th>Exclusion Description</th>
<th>General Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRR, VZV and Influenza</td>
<td>Anaphylactic reaction to neomycin</td>
</tr>
<tr>
<td>IPV</td>
<td>Anaphylactic reaction to streptomycin, polymyxin B, or neomycin</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Anaphylactic reaction to common baker’s yeast</td>
</tr>
</tbody>
</table>

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LSC Lead Screening in Children

Measure definition:
The percentage of children turning 2 years of age in the measurement year who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Common chart deficiencies and tips:
1. Lead screening is considered late if performed after the child turns 2 years of age
2. A lead risk assessment does not satisfy the blood lead test requirement for Medicaid members regardless of the risk score
3. Options exist for in-office lead testing, including blood lead analyzer and MedTox filter paper testing

Billing Reference – LSC

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Tests</td>
<td>83655</td>
</tr>
</tbody>
</table>

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W34 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Measure definition:
The percentage of members 3-6 years of age who had one or more well-child visits with a PCP in the measurement year.

The comprehensive well-care visit includes:
• Physical developmental history – assessment of specific age appropriate physical development milestones
• Mental development history – assessment of specific age appropriate mental development milestones
• Physical exam
• Health history – assessment of history of disease or illness and family health history
• Health education/anticipatory guidance – guidance given in anticipation of emerging issues that a child/family may face

Common chart deficiencies and tips:
1. Missing or undocumented anticipatory guidance
2. Sick visit in calendar year without well-child visit – turn a sick visit into a well-child visit
3. Schedule next visit at end of each appointment
4. Call parent/guardian to reschedule when a visit is missed

Billing Reference – W34

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT</th>
<th>HCPCS</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>99382-99383, 99392-99393</td>
<td>G0438, G0439</td>
<td>Z00.121-Z00.129, Z00.5, Z00.8, Z02.0-Z02.9</td>
</tr>
</tbody>
</table>

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### WCC Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

**Measure definition:**
The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.

**Common chart deficiencies and tips:**
1. BMI percentile or BMI percentile plotted on growth chart for members 3-17 years of age required to meet measure (BMI value alone does NOT meet compliance)
2. Must include documentation indicating counseling for nutrition and physical activity

<table>
<thead>
<tr>
<th>Billing Reference – WCC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>BMI Percentile</td>
</tr>
<tr>
<td>Nutrition Counseling</td>
</tr>
<tr>
<td>Physical Activity Counseling</td>
</tr>
</tbody>
</table>

**Measure Exclusion Criteria**
Any diagnosis of pregnancy during the measurement year counts as an exclusion for this measure

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