2024

IEHP DIRECT STARS

Incentive Program

IEHP DualChoice

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PROGRAM OVERVIEW

This program guide provides an overview of the 2024 IEHP Direct Stars Incentive Program for Primary Care Providers (PCPs). The 2024 IEHP Direct Stars Incentive Program has been designed to reward PCPs for high-quality care provided to IEHP Direct DualChoice (D-SNP) Members. IEHP encourages all PCPs to attend IEHP Provider Quality Incentive meetings held throughout the year to support their efforts to maximize earnings in this program.

If you would like more information about the 2024 IEHP's Direct Stars Incentive Program, email the Quality Team at QualityPrograms@iehp.org or call the IEHP Provider Relations Team at (909) 890-2054.

Performance Measures

Appendix 1 provides a list of the 13 measures in the 2024 IEHP Direct Stars Incentive Program and includes thresholds and benchmarks associated with the respective star ratings.

Measure List:

- Advance Care Planning
- Annual Wellness Visit
- Care for Older Adults – Pain Screening
- Care for Older Adults – Functional Status Assessment
- Care for Older Adults – Medication Review
- Colorectal Cancer Screening
- Post Discharge Follow-Up
- Transitions of Care – Medication Reconciliation Post Discharge
- Glycemic Status >9.0% - Poor Control
- Flu Vaccine
- Controlling High Blood Pressure
- Breast Cancer Screening
- Diabetes Eye Exam

☑ Eligibility and Participation

Provider Eligibility

To be eligible for incentive payments in the 2024 IEHP Direct Stars Incentive Program, PCPs must meet the following criteria:

- Primary Care Physicians (PCPs), Federally Qualified Health Centers (FQHCs), Indian Health Facilitates (IHFs) and Rural Health Clinics (RHCs) must have an IEHP Direct D-SNP contract with IEHP.
- Have at least 30 IEHP Direct D-SNP Members assigned as of January 2024.
- Have at least 10 IEHP Direct D-SNP Members in the denominator as of December 2024 for each measure to qualify for scoring.
- Have at least three measures meet the minimum denominator requirement to calculate a star rating.
- Must have an average assigned Membership risk adjustment factor score of 1.0 or higher.

Member Eligibility

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

☑ Minimum Data Requirements

Encounter Data

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

Program Terms and Conditions

- Good Standing: A Provider currently contracted with the Plan for the delivery of services, not pursuing any litigation or arbitration or has a pending claim pursuant to the California Government Tort Claim Act (Cal. Gov. Code Sections 810, et seq.) filed against the Plan at the time of program application or at the time additional funds may be payable, and has demonstrated the intent, in the Plan's sole determination, to continue to work together with Plan on addressing community and Member issues. Additionally, at the direction of the CEO or their designee, the Plan may determine that a Provider is not in good standing based on relevant quality, payment or other business concerns.
- Participation in the IEHP Direct Stars Incentive Program, as well as acceptance of incentive payments, does not in any way modify or supersede any terms or conditions of any agreement between IEHP and Providers, whether that agreement is entered into before or after the date of this communication.
- There is no guarantee that future funding for, or payment under, any IEHP Provider will be modified or terminated at any time, with or without notice, at IEHP's sole discretion.
- Criteria for calculating incentive payments are subject to change at any time, with or without notice, at IEHP's sole discretion.
- In consideration of IEHP's offering of the IEHP Direct Stars Incentive Program, participants agree to fully and forever release and discharge IEHP from all claims, demands, causes of action, and suits, of any nature, pertaining to or arising from the offering by IEHP of the IEHP Direct Stars Incentive Program.
- The determination of IEHP regarding performance scoring and payments under the IEHP Direct Stars Incentive Program is final.
- As a condition of receiving payment under the IEHP Direct Stars Incentive Program, Providers and IPAs must be active and contracted with IEHP and have active assigned Members at the time of payment.
- Providers will not charge IEHP for medical records for HEDIS, Risk Adjustment, and other health plan operational activities.

Financial Overview

The annual budget for the 2024 IEHP Direct Stars Incentive Program for PCPs is $1 million. Providers are eligible to receive financial rewards for performance excellence and meeting the CMS Star rating requirements. Financial rewards are based on a star rating system, increasing financial rewards as Providers reach each level of higher performance. The incentive payment for the 2024 performance period will be distributed via a monthly Per Member Per Month (PMPM) Quality Payment beginning in July 2025 and continuing through June 2026 and paid based on your IEHP Direct D-SNP monthly Membership.

☑ Scoring Methodology

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

☑ Payment Methodology

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

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

Calculating the Star Rating

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

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

Note:

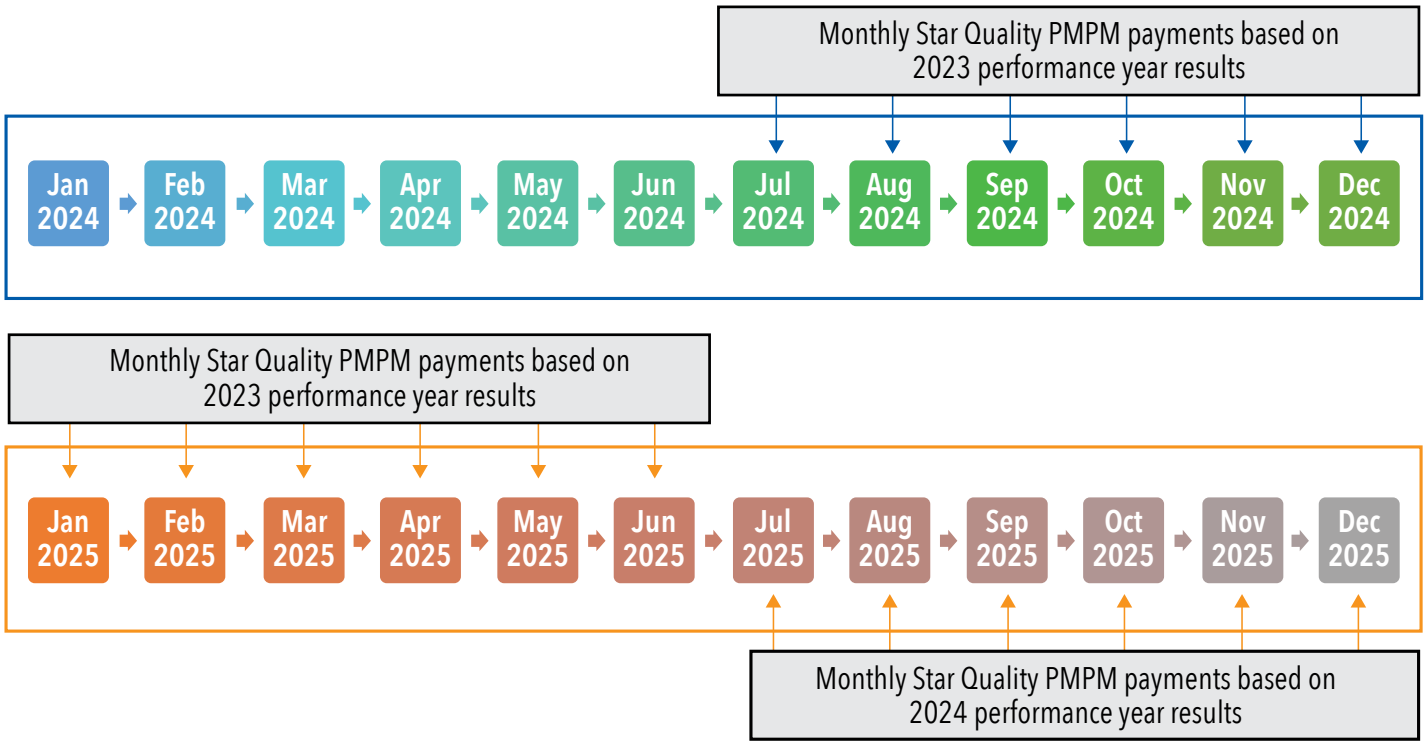
- Star rating will determine Star Quality PMPM awarded to Provider
- Overall star rating follows the rounding rules found in the 2024 IEHP Direct Stars Incentive Program - Incentive Payments table below.

Calculating Overall Star Quality PMPM Incentive

2024 IEHP DIRECT STARS INCENTIVE PROGRAM – INCENTIVE PAYMENTS:		
Initial Star Rating*	**Overall Star Rating**	**Star Quality PMPM Amount**
≥ 0.750000 and < 1.250000	1.0 Stars	**Not eligible for incentive dollars**
≥ 1.250000 and < 1.750000	1.5 Stars	
≥ 1.750000 and < 2.250000	2.0 Stars	
≥ 2.250000 and < 2.750000	2.5 Stars	
≥ 2.750000 and < 3.250000	3.0 Stars	$ 5.00
≥ 3.250000 and < 3.750000	3.5 Stars	$ 8.00
≥ 3.750000 and < 4.250000	4.0 Stars	$ 10.00
≥ 4.250000 and < 4.750000	4.5 Stars	$ 12.00
≥ 4.750000 and ≤ 5.000000	5.0 Stars	$ 14.00

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

☑ Incentive Payout Timeline



APPENDIX 1: 2024 IEHP Direct Stars Incentive Program Measures

2024 IEHP Direct Stars Incentive Program Star Performance Goals

Measure Name	Star 1 Rate	Star 2 Rate	Star 3 Rate	Star 4 Rate	Star 5 Rate	Weight
Advance Care Planning[3]	<13%	≥13% to <36%	≥36% to <55%	≥55% to <99%	≥99%	1
Annual Wellness Visit[2]	<89%	≥89% to <95%	≥95% to <97%	≥97% to <99%	≥99%	3
Care for Older Adults – Pain Assessment*	<74%	≥74% to <83%	≥83% to <91%	≥91% to <96%	≥96%	1
Care for Older Adults – Functional Status Assessment[3]	<56%	≥56% to <87%	≥87% to <93%	≥93% to <98%	≥98%	1
Care for Older Adults – Medication Review*	<72%	≥72% to <84%	≥84% to <93%	≥93% to <98%	≥98%	1
Colorectal Cancer Screening*	<50%	≥50% to <61%	≥61% to <71%	≥71% to <80%	≥80%	1
Post Discharge Follow-Up[2]	<71%	≥71% to <84%	≥84% to <90%	≥90% to <92%	≥92%	1
Transitions of Care – Med Rec Post Discharge*	<38%	≥38% to <52%	<52% to <68%	<68% to <82%	≥82%	1
HbA1c Poor Control >9*	≥83%	<83% to ≥75%	<75% to ≥62%	<62% to ≥39%	<39%	3
Flu Vaccine[1]	<63%	<63% to ≥71%	<71% to ≥78%	<78% to ≥83%	≥83%	1
Controlling High Blood Pressure*	<58%	≥58% to <68%	≥68% to <74%	≥74% to <82%	≥82%	3
Breast Cancer Screening*	<52%	≥52% to <63%	≥63% to <71%	≥71% to <79%	≥79%	1
Diabetes Eye Exam*	<52%	≥52% to <65%	≥65% to <73%	≥73% to <81%	≥81%	1

* *Medicare 2024 Part C & D Star Rating Technical Notes*
[1] *Goals set by 2023 (MY 2022) NCQA Quality Compass*
[2] *Goals set by 2023 (MY 2022) Proxy Measure Total Quality Compass*
[3] *Goals set by 2023 (MY 2022) Audit Means Percentile*

APPENDIX 2: 2024 IEHP Direct Stars Incentive Program Measures Overview

Advance Care Planning

Methodology: HEDIS®

Measure Description: The percentage of Members 66-80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and Members 81 years of age and older who had Advance Care Planning during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 66 years of age and older as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had evidence of Advance Care Planning during the measurement year (2024).

CODES TO IDENTIFY ADVANCED CARE PLANNING:			
Service	**Code Type**	**Code**	**Code Description**
Advance Care Planning	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Advance Care Planning	CPT	99497	Advance Care Planning, including the explanation and discussion of Advance Directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
Advance Care Planning	CPT-CAT-II	1123F	Advance Care Planning discussed and documented Advance Care Plan or surrogate decision maker documented in the medical record (DEM) (GER, PALL CR).
Advance Care Planning	CPT-CAT-II	1124F	Advance Care Planning discussed and documented in the medical record, Patient did not wish or was not able to name a surrogate decision maker or provide an Advance Care Plan (DEM) (GER, PALL CR).
Advance Care Planning	CPT-CAT-II	1157F	Advance Care Plan or similar legal document present in the medical record (COA).
Advance Care Planning	CPT-CAT-II	1158F	Advance Care Planning discussion documented in the medical record (COA).
Advance Care Planning	HCPCS	S0257	Counseling and discussion regarding Advance Directives or End-of-Life Care Planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service).
Advance Care Planning	ICD10CM	Z66	Do not resuscitate

Annual Wellness Visit

Methodology: IEHP-Defined

Measure Description: The percentage of Members who received an annual wellness visit during the measurement year (2024). An annual wellness visit may include the following:

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

Denominator: Members 18 years of age and older.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had an annual wellness visit during the measurement year (2024).

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

Care for Older Adults – Functional Status Assessment

Methodology: HEDIS®

Measure Description: The percentage of Members who had a functional status assessment during the measurement year (2024). A functional status assessment may include the following:

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

   OR

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

   OR

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

- Eligible population in this measure meets all of the following criteria:
  1. Members who are 66 years of age and older as of December 31 of the measurement year (2024).
  2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a functional status assessment at least once during the measurement year (2024).

CODES TO IDENTIFY FUNCTIONAL STATUS ASSESSMENT:			
Service	**Code Type**	**Code**	**Code Description**
Functional Status Assessment	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Functional Status Assessment	CPT-CAT-II	1170F	Functional status assessed (COA) (RA).
Functional Status Assessment	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Functional Status Assessment	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.

Care for Older Adults – Medication Review

Methodology: HEDIS®

Measure Description: The percentage of Members who received at least one medication review conducted by a Provider or Clinical Pharmacist during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 66 years of age and older as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who received at least one medication review conducted by a Provider during the measurement year (2024).

Either of the following meets numerator criteria:

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

CODES TO IDENTIFY MEDICATION REVIEW:			
Service	**Code Type**	**Code**	**Code Description**
Medication Review	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Medication Review	CPT	99605	Medication Therapy Management Service(S) Provided By A Pharmacist, Individual, Face-To-Face With Patient, With Assessment And Intervention If Provided; Initial 15 Minutes, New Patient
Medication Review	CPT	99606	Medication Therapy Management Service(S) Provided By A Pharmacist, Individual, Face-To-Face With Patient, With Assessment And Intervention If Provided; Initial 15 Minutes, Established Patient
Medication Review	CPT	90863	Pharmacologic Management, Including Prescription And Review Of Medication, When Performed With Psychotherapy Services (List Separately In Addition To The Code For Primary Procedure)
Medication Review	CPT-CAT-II	1160F	Review Of All Medications By A Prescribing Practitioner Or Clinical Pharmacist (Such As, Prescriptions, Otcs, Herbal Therapies And Supplements) Documented In The Medical Record (COA)

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

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

Care for Older Adults – Pain Assessment

Methodology: HEDIS®

Measure Description: The percentage of Members who had a pain assessment at least once during the measurement year (2024). A pain assessment may include the following:

1. Documentation that Member was assessed for pain (may include positive or negative findings for pain)

   OR

2. Result of assessment using standardized pain assessment tool (not limited to the following):
   - Numeric rating scales (verbal or written).
   - Face, Legs, Activity, Cry Consolability (FLACC) scale.
   - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).
   - Pain Thermometer.
   - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).
   - Chronic Pain Grade.

NOTE: Notation alone of pain management, pain treatment, or screening for chest pain or documentation alone of chest pain does not meet criteria.

- Eligible population in this measure meets all of the following criteria:
  1. Members who are 66 years of age and older as of December 31 of the measurement year (2024).
  2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

Denominator: Members 66 years of age and older.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a pain assessment at least once during the measurement year (2024).

CODES TO IDENTIFY PAIN ASSESSMENT:			
Service	**Code Type**	**Code**	**Code Description**
Pain Assessment	CPT-CAT-II	1125F	Pain severity quantified; pain present (COA) (ONC)
Pain Assessment	CPT-CAT-II	1126F	Pain severity quantified; no pain present (COA) (ONC)

Colorectal Cancer Screening

Methodology: HEDIS®

Measure Description: The percentage of Members who are 45-75 years of age who had appropriate screening for colorectal cancer.

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 46 - 75 years of age and older as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

Denominator: Members 45-75 years of age.

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had appropriate screening for colorectal cancer during the measurement year (2024).

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	44389	Colonoscopy through stoma; with biopsy, single or multiple
Colorectal Cancer Screening	CPT	44390	Colonoscopy through stoma; with removal of foreign body(s)
Colorectal Cancer Screening	CPT	44391	Colonoscopy through stoma; with control of bleeding, any method
Colorectal Cancer Screening	CPT	44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
Colorectal Cancer Screening	CPT	44394	Colonoscopy through stoma; with removal of tumor(s), polyp(S), or other lesion(s) by snare technique
Colorectal Cancer Screening	CPT	44401	Colonoscopy through stoma; with ablation of tumor(s), polyp(S), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44402	Colonoscopy through stoma; with endoscopic stent placement (including pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	44403	Colonoscopy through stoma; with endoscopic mucosal resection

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance
Colorectal Cancer Screening	CPT	44405	Colonoscopy through stoma; with transendoscopic ballon dilation
Colorectal Cancer Screening	CPT	44406	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures
Colorectal Cancer Screening	CPT	44408	Colonoscopy through stoma; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
Colorectal Cancer Screening	CPT	45332	Sigmoidoscopy, flexible; with removal of foreign body(s)
Colorectal Cancer Screening	CPT	45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
Colorectal Cancer Screening	CPT	45334	Sigmoidoscopy, flexible; with control of bleeding, any method
Colorectal Cancer Screening	CPT	45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
Colorectal Cancer Screening	CPT	45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
Colorectal Cancer Screening	CPT	45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation
Colorectal Cancer Screening	CPT	45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
Colorectal Cancer Screening	CPT	45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
Colorectal Cancer Screening	CPT	45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection
Colorectal Cancer Screening	CPT	45350	Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)
Colorectal Cancer Screening	CPT	45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
Colorectal Cancer Screening	CPT	45379	Colonoscopy, flexible; with removal of foreign body(s)
Colorectal Cancer Screening	CPT	45380	Colonoscopy, flexible; with biopsy, single or multiple
Colorectal Cancer Screening	CPT	45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
Colorectal Cancer Screening	CPT	45382	Colonoscopy, flexible; with control of bleeding, any method
Colorectal Cancer Screening	CPT	45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
Colorectal Cancer Screening	CPT	45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
Colorectal Cancer Screening	CPT	45386	Colonoscopy, flexible; with transendoscopic balloon dilation
Colorectal Cancer Screening	CPT	45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
Colorectal Cancer Screening	CPT	45390	Colonoscopy, flexible; with endoscopic mucosal resection
Colorectal Cancer Screening	CPT	45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
Colorectal Cancer Screening	CPT	45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures
Colorectal Cancer Screening	CPT	45393	Colonoscopy, flexible; with decompression (for pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed
Colorectal Cancer Screening	CPT	45398	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)

CODES TO IDENTIFY COLORECTAL CANCER SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Colorectal Cancer Screening	CPT	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
Colorectal Cancer Screening	CPT	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material(s) including non-contrast images, if performed
Colorectal Cancer Screening	CPT	74263	Computed tomographic (CT) colonography, diagnostic, including image postprocessing
Colorectal Cancer Screening	CPT	81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 Dna markers (kras mutations, promoter methylation of Ndrg4 And Bmp3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
Colorectal Cancer Screening	CPT	82270	Blood, occult, by peroxidase activity (e.g., Guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (e.g., patient was provided three cards or single triple card for consecutive collection)
Colorectal Cancer Screening	CPT	82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
Colorectal Cancer Screening	HCPCS	G0104	Colorectal cancer screening; flexible sigmoidoscopy
Colorectal Cancer Screening	HCPCS	G0105	Colorectal cancer screening; colonoscopy on individual at high risk
Colorectal Cancer Screening	HCPCS	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high hisk
Colorectal Cancer Screening	HCPCS	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, one to three simultaneous determinations

These are the codes that IEHP will use to determine the numerator compliance for the Colorectal Cancer Screening measure. These codes would be submitted by the testing Provider, not by the PCP.

Controlling High Blood Pressure

Methodology: HEDIS®

Measure Description: The percentage of Members who are 18-85 years of age, with a diagnosis of hypertension (HTN), and whose blood pressure (BP) is controlled (<140/90 mmHg) during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18 - 85 years of age and older as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

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

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a BP reading taken during the measurement year (2024) in any of the following settings: office visits, e-visits or telephone visits. The most recent BP of the measurement year (2024) will be used to determine compliance with this measure. The Provider must bill one diastolic code, one systolic code and one visit type code.

CODES TO IDENTIFY BLOOD PRESSURE SCREENING:			
Service	**Code Type**	**Code**	**Code Description**
Blood Pressure Screening	CPT-CAT-II	3078F	Most recent diastolic blood pressure less than 80 Mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT-CAT-II	3079F	Most recent diastolic blood pressure 80-89 Mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT-CAT-II	3080F	Most recent diastolic blood pressure greater than or equal to 90 Mm Hg (HTN, CKD, CAD) (DM)
Blood Pressure Screening	CPT-CAT-II	3074F	Most recent systolic blood pressure less than 130 Mm Hg (DM) (HTN, CKD, CAD)
Blood Pressure Screening	CPT-CAT-II	3075F	Most recent systolic blood pressure 130-139 Mm Hg (DM) (HTN, CKD, CAD)
Blood Pressure Screening	CPT-CAT-II	3077F	Most recent systolic blood pressure greater than or equal to 140 Mm Hg (HTN, CKD, CAD) (DM)

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
Office Visit	CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99241	Office consultation for a new or established patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99242	Office consultation for a new or established patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99243	Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99244	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99245	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99341	Home visit for the evaluation and management of a new patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99342	Home visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99343	Home visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99344	Home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99345	Home visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99347	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem-focused interval history; A problem-focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99348	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem-focused interval history; An expanded problem-focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99349	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99350	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.
Office Visit	CPT	99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years.
Office Visit	CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older.
Office Visit	CPT	99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years.
Office Visit	CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older.
Office Visit	CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
Office Visit	CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
Office Visit	CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
Office Visit	CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
Office Visit	CPT	99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.
Office Visit	CPT	99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.
Office Visit	CPT	99429	Unlisted preventive medicine service.
Office Visit	CPT	99455	Work-related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
Office Visit	CPT	99456	Work-related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

CODES TO IDENTIFY OFFICE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Office Visit	HCPCS	G0071	Payment for communication technology-based services for five minutes or more of a virtual (non-face-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or five minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.
Office Visit	HCPCS	G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
Office Visit	HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
Office Visit	HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit.
Office Visit	HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	HCPCS	T1015	Clinic Visit/encounter, All-inclusive (t1015)

CODES TO IDENTIFY E-VISITS:			
Service	**Code Type**	**Code**	**Code Description**
E-Visit	CPT	98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.
E-Visit	CPT	98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.
E-Visit	CPT	98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.
E-Visit	CPT	99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5-10 minutes.
E-Visit	CPT	99422	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11-20 minutes.
E-Visit	CPT	99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.
E-Visit	HCPCS	G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
E-Visit	HCPCS	G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

CODES TO IDENTIFY TELEPHONE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Telephone Visit	CPT	98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
Telephone Visit	CPT	99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	CPT	98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
Online Assessment	CPT	98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	CPT	99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
Online Assessment	CPT	99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
Online Assessment	HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
Online Assessment	HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Diabetes Eye Exam

Methodology: HEDIS®

Measure Description: The percentage of Members 18-75 years of age and have a diagnosis of diabetes (type 1 or 2) who had an eye exam (retinal) performed during the measurement year (2024).

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years of age as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

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

- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had an eye exam (retinal) performed during the measurement year (2024).

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT	65091	Evisceration of ocular contents; without implant
Diabetes Eye Care	CPT	65093	Evisceration of ocular contents; with implant
Diabetes Eye Care	CPT	65101	Enucleation of eye; without implant
Diabetes Eye Care	CPT	65103	Enucleation of eye; with implant, muscles not attached to implant
Diabetes Eye Care	CPT	65105	Enucleation of eye; with implant, muscles attached to implant
Diabetes Eye Care	CPT	65110	Exenteration of orbit (does not include skin graft), removal of orbital contents; only
Diabetes Eye Care	CPT	65112	Exenteration of orbit (does not include skin graft), removal of orbital contents; with therapeutic removal of bone
Diabetes Eye Care	CPT	65114	Exenteration of orbit (does not include skin graft), removal of orbital contents; with muscle or myocutaneous flap
Diabetes Eye Care	CPT	67028	Intravitreal injection of a pharmacologic agent (separate procedure)
Diabetes Eye Care	CPT	67030	Discission of vitreous strands (without removal), pars plana approach

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT	67031	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)
Diabetes Eye Care	CPT	67036	Vitrectomy, mechanical, pars plana approach
Diabetes Eye Care	CPT	67039	Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation
Diabetes Eye Care	CPT	67040	Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulatio
Diabetes Eye Care	CPT	67041	Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (e.g., macular pucker)
Diabetes Eye Care	CPT	67042	Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (e.g., for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (e.g., air, gas or silicone oil)
Diabetes Eye Care	CPT	67043	Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (e.g., choroidal neovascularization), includes, if performed, intraocular tamponade (e.g., air, gas or silicone oil) and laser photocoagulation
Diabetes Eye Care	CPT	67101	Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy
Diabetes Eye Care	CPT	67105	Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation
Diabetes Eye Care	CPT	67107	Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid
Diabetes Eye Care	CPT	67108	Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique
Diabetes Eye Care	CPT	67110	Repair of retinal detachment; by injection of air or other gas (e.g., pneumatic retinopexy)
Diabetes Eye Care	CPT	67113	Repair of complex retinal detachment (e.g., proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens
Diabetes Eye Care	CPT	67121	Removal of implanted material, posterior segment; intraocular
Diabetes Eye Care	CPT	67141	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage; cryotherapy, diathermy
Diabetes Eye Care	CPT	67145	Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage; photocoagulation

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT	67208	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; cryotherapy, diathermy
Diabetes Eye Care	CPT	67210	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; photocoagulation
Diabetes Eye Care	CPT	67218	Destruction of localized lesion of retina (e.g., macular edema, tumors), one or more sessions; radiation by implantation of source (includes removal of source)
Diabetes Eye Care	CPT	67220	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photocoagulation (e.g., laser), one or more sessions
Diabetes Eye Care	CPT	67221	Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)
Diabetes Eye Care	CPT	67227	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy), cryotherapy, diathermy
Diabetes Eye Care	CPT	67228	Treatment of extensive or progressive retinopathy (e.g., diabetic retinopathy), photocoagulation
Diabetes Eye Care	CPT	92002	Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program; intermediate, new patient
Diabetes Eye Care	CPT	92004	Ophthalmological services: medical examination and evaluation, with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
Diabetes Eye Care	CPT	92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient
Diabetes Eye Care	CPT	92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
Diabetes Eye Care	CPT	92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
Diabetes Eye Care	CPT	92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited
Diabetes Eye Care	CPT	92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
Diabetes Eye Care	CPT	92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT	92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral
Diabetes Eye Care	CPT	92230	Fluorescein angioscopy with interpretation and report
Diabetes Eye Care	CPT	92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral
Diabetes Eye Care	CPT	92250	Fundus photography with interpretation and report
Diabetes Eye Care	CPT	92260	Ophthalmodynamometry
Diabetes Eye Care	CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
Diabetes Eye Care	CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Diabetes Eye Care	CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
Diabetes Eye Care	CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Diabetes Eye Care	CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
Diabetes Eye Care	CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

CODES TO IDENTIFY DIABETES EYE CARE:			
Service	**Code Type**	**Code**	**Code Description**
Diabetes Eye Care	CPT	99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
Diabetes Eye Care	CPT	99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.
Diabetes Eye Care	CPT-CAT-II	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)
Diabetes Eye Care	CPT-CAT-II	3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year) (DM)
Diabetes Eye Care	HCPCS	S3000	Diabetic indicator; retinal eye exam, dilated, bilateral
Diabetes Eye Care	HCPCS	S0620	Routine ophthalmological examination including refraction; new patient
Diabetes Eye Care	HCPCS	S0621	Routine ophthalmological examination including refraction; established patient

**A retinal or dilated eye exam must be completed by an eye care professional (Optometrist or Ophthalmologist) during the measurement year (2024).*

Flu Vaccine

Methodology: IEHP – HEDIS Modified Measure

Measure Description: The percentage of Members 19 years of age and older, who received an influenza vaccine between July 1 of the year prior to the measurement year (2023) and June 30 of the measurement year (2024).

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

- Anchor Date: June 30, 2024

Numerator: Members in the denominator who received an influenza vaccine between July 1, 2023 –June 30, 2024.

CODES TO IDENTIFY FLU VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
Flu Vaccine	CPT	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use
Flu Vaccine	CPT	90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use
Flu Vaccine	CPT	90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, for intradermal use
Flu Vaccine	CPT	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 ml dosage, for intramuscular use
Flu Vaccine	CPT	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 ml Dosage, for intramuscular use
Flu Vaccine	CPT	90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
Flu Vaccine	CPT	90661	Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 ml dosage, for intramuscular use
Flu Vaccine	CPT	90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
Flu Vaccine	CPT	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
Flu Vaccine	CPT	90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant Dna, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
Flu Vaccine	CPT	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 ml dosage, for intramuscular use
Flu Vaccine	CPT	90682	Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

CODES TO IDENTIFY FLU VACCINE:			
Service	**Code Type**	**Code**	**Code Description**
Flu Vaccine	CPT	90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 ml dosage, for intramuscular use
Flu Vaccine	CPT	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 ml dosage, for intramuscular use
Flu Vaccine	CPT	90689	Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 ml dosage, for intramuscular use
Flu Vaccine	CPT	90694	Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 ml dosage, for intramuscular use
Flu Vaccine	CPT	90756	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5ml dosage, for intramuscular use

Glycemic Status >9.0% - Poor Control

Methodology: HEDIS®

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

- Glycemic Status (>9.0%)
- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18-75 years of age as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with no more than one gap in continuous enrollment with IEHP up to 45 days during the measurement year (2024).

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

- Anchor Date: December 31, 2024

Numerator: Members in the denominator with the most recent glycemic status assessment that has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year (2024).

Note: A lower rate is better.

CODES TO IDENTIFY GLYCEMIC STATUS RESULTS:			
Service	**Code Type**	**Code**	**Code Description**
Glycemic Status Result	CPT	83036	Hemoglobin; glycosylated (A1c)
Glycemic Status Result	CPT	83037	Hemoglobin; glycosylated (A1c) by device cleared by FDA for home use
Glycemic Status Result	CPT-CAT-II	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
Glycemic Status Result	CPT-CAT-II	3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)
Glycemic Status Result	CPT-CAT-II	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
Glycemic Status Result	CPT-CAT-II	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)

Post Discharge Follow-Up

Methodology: IEHP-Defined

Measure Description: The percentage of Members who had a follow-up visit with a Provider within seven days of a hospital discharge from an acute or non-acute inpatient stay during the measurement year (2024).

Denominator: All acute and non-acute inpatient discharges during the measurement year (2024).

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

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
Office Visit	CPT	99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99241	Office consultation for a new or established patient, which requires these three key components: A problem-focused history; A problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99242	Office consultation for a new or established patient, which requires these three key components: An expanded problem-focused history; An expanded problem-focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99243	Office consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99244	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99245	Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
Office Visit	CPT	99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years.
Office Visit	CPT	99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years.
Office Visit	CPT	99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years.
Office Visit	CPT	99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years.
Office Visit	CPT	99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older.
Office Visit	CPT	99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
Office Visit	CPT	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.
Office Visit	CPT	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.
Office Visit	CPT	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.
Office Visit	CPT	99411	Preventive Medicine Counseling And/or Risk Factor Reduction Intervention(s) Provided To Individuals In A Group Setting (separate Procedure); Approximately 30 Minutes
Office Visit	CPT	99412	Preventive Medicine Counseling And/or Risk Factor Reduction Intervention(s) Provided To Individuals In A Group Setting (separate Procedure); Approximately 60 Minutes
Office Visit	CPT	99429	Unlisted Preventive Medicine Service
Office Visit	CPT	99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
Office Visit	CPT	99456	Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.

CODES TO IDENTIFY FOLLOW-UP VISIT:			
Service	**Code Type**	**Code**	**Code Description**
Office Visit	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.
Office Visit	CPT	99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge medical decision making of high complexity during the service period face-to-face visit, within seven calendar days of discharge.
Office Visit	HCPCS	G0402	Initial Preventive Physical Examination; Face-to-face Visit, Services Limited To New Beneficiary During The First 12 Months Of Medicare Enrollment (g0402)
Office Visit	HCPCS	G0438	Annual Wellness Visit; Includes A Personalized Prevention Plan Of Service (pps), Initial Visit (g0438)
Office Visit	HCPCS	G0439	Annual Wellness Visit, Includes A Personalized Prevention Plan Of Service (pps), Subsequent Visit (g0439)
Office Visit	HCPCS	G0463	Hospital outpatient clinic visit for assessment and management of a patient.
Office Visit	HCPCS	T1015	Clinic visit/encounter, all-inclusive.

CODES TO IDENTIFY TELEPHONE VISITS:			
Service	**Code Type**	**Code**	**Code Description**
Telephone Visit	CPT	98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.
Telephone Visit	CPT	99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Telephone Visit	CPT	99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
Telephone Visit	CPT	99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	CPT	98969	Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network
Online Assessment	CPT	98970	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	98971	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	98972	Qualified Nonphysician Health Care Professional Online Digital Assessment And Management, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
Online Assessment	CPT	98980	Remote Therapeutic Monitoring Treatment Management Services, Physician Or Other Qualified Health Care Professional Time In A Calendar Month Requiring At Least One Interactive Communication With The Patient Or Caregiver During The Calendar Month; First 20 minutes
Online Assessment	CPT	98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes
Online Assessment	CPT	99421	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 5-10 Minutes
Online Assessment	CPT	99422	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 11-20 Minutes
Online Assessment	CPT	99423	Online Digital Evaluation And Management Service, For An Established Patient, For Up To 7 Days, Cumulative Time During The 7 Days; 21 Or More Minutes
Online Assessment	CPT	99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network
Online Assessment	CPT	99457	Remote Physiologic Monitoring Treatment Management Services, Clinical Staff/physician/other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/caregiver During The Month; First 20 Minutes
Online Assessment	CPT	99458	Remote Physiologic Monitoring Treatment Management Services, Clinical Staff/physician/other Qualified Health Care Professional Time In A Calendar Month Requiring Interactive Communication With The Patient/caregiver During The Month; Each Additional 20 Minutes

CODES TO IDENTIFY ONLINE ASSESSMENTS:			
Service	**Code Type**	**Code**	**Code Description**
Online Assessment	HCPCS	G0071	Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only
Online Assessment	HCPCS	G2010	Remote Evaluation Of Recorded Video And/or Images Submitted By An Established Patient (e.g., Store And Forward), Including Interpretation With Follow-up With The Patient Within 24 Business Hours, Not Originating From A Related E/m Service Provided Within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
Online Assessment	HCPCS	G2061	Qualified Nonphysician Healthcare Professional Online Assessment And Management Service, For An Established Patient, For Up To Seven Days, Cumulative Time During The 7 Days; 5-10 Minutes (g2061)
Online Assessment	HCPCS	G2062	Qualified Nonphysician Healthcare Professional Online Assessment And Management Service, For An Established Patient, For Up To Seven Days, Cumulative Time During The 7 Days; 11-20 Minutes (g2062)
Online Assessment	HCPCS	G2063	Qualified Nonphysician Healthcare Professional Online Assessment And Management Service, For An Established Patient, For Up To Seven Days, Cumulative Time During The 7 Days; 21 Or More Minutes (g2063)
Online Assessment	HCPCS	G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
Online Assessment	HCPCS	G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
Online Assessment	HCPCS	G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related EM service provided within the previous 7 days nor leading to an EM service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Note: Visits with an Urgent Care will not be accepted for the Post Discharge Follow-Up measure.

The following are excluded from the measure:

1. Hospice
2. Skilled Nursing Facility
3. Deliveries

Transitions of Care – Medication Reconciliation Post Discharge

Methodology: HEDIS®

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

- Eligible population in this measure meets all of the following criteria:
    1. Members who are 18 years of age and older as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP during the measurement year (2024) with the date of discharge through 30 days after discharge (31 total days).

Denominator: Members 18 years or older.

- Discharges will be counted from January 1 through December 1 of the measurement year (2024).
- Anchor Date: December 31, 2024

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

CODES TO IDENTIFY MEDICATION RECONCILIATION POST DISCHARGE:			
Service	**Code Type**	**Code**	**Code Description**
Medication Reconciliation	CPT	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, Medical decision making of moderate or high complexity, Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (e.g., home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
Medication Reconciliation	CPT	99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge, medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge.
Medication Reconciliation	CPT	99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge, medical decision making of high complexity during the service period face-to-face visit, within seven calendar days of discharge.
Medication Reconciliation	CPT-CAT-II	1111F	Discharge medications reconciled with the current medication list in outpatient medical record (COA) (GER).

Breast Cancer Screening

Methodology: HEDIS®

Measure Description: The percentage of members 50-74 years of age who had a mammogram to screen for breast cancer during the past two measurement years (2023 and 2024).

- The eligible population in the measure meets all of the following criteria:
    1. Members 52-74 years as of December 31 of the measurement year (2024).
    2. Continuous enrollment with IEHP from October 1 two years prior to the measurement year (2022) through December 31 of the measurement year (2024) with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment with IEHP. No gaps in enrollment are allowed from October 1 two years prior to the measurement year (2022) through December 31 two years prior to the measurement year (2022).

Denominator: Members 50-74 years of age.

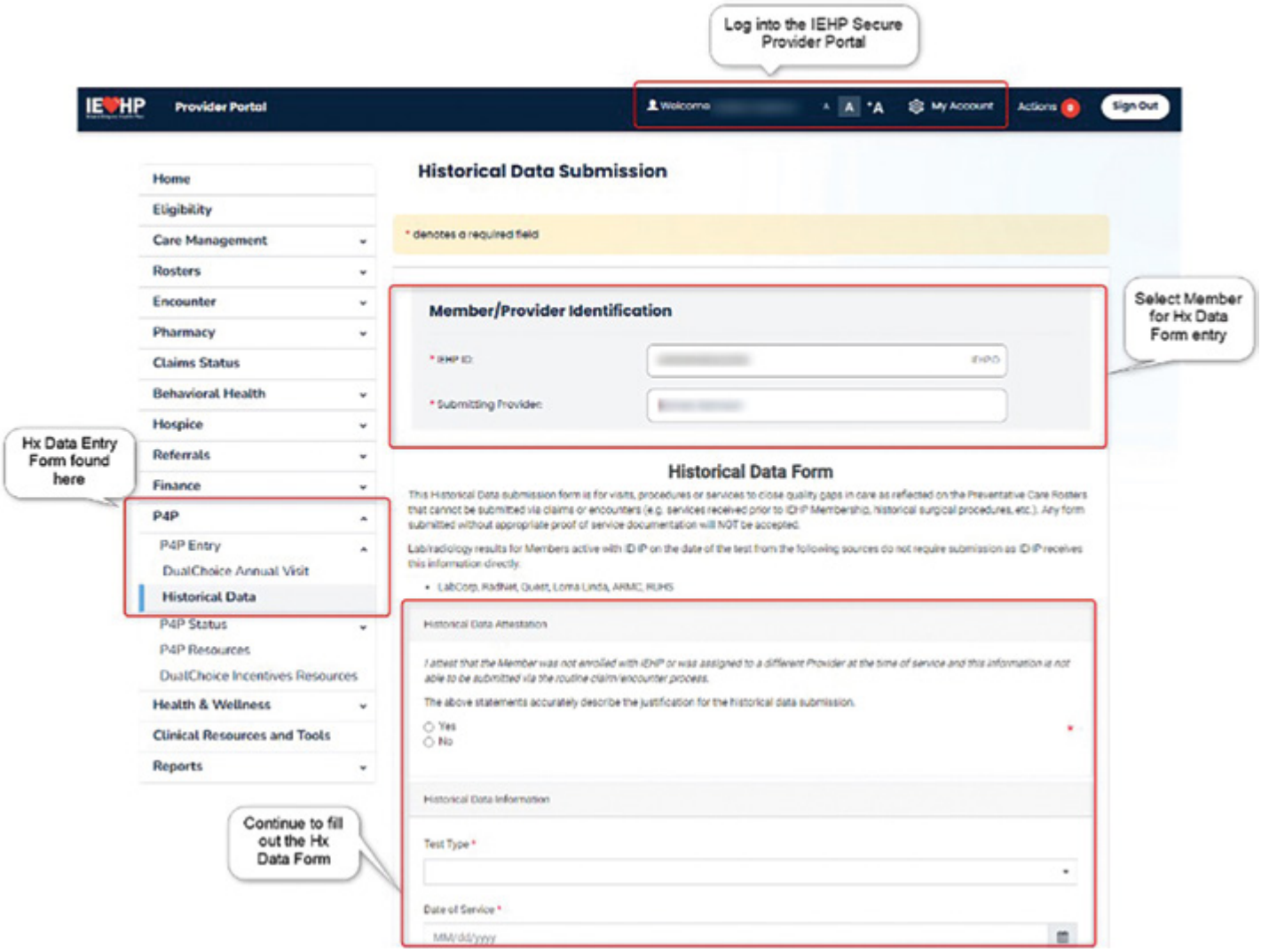
- Anchor Date: December 31, 2024

Numerator: Members in the denominator who had a mammogram to screen for breast cancer during the past two measurement years (2023 and 2024).

CODES TO IDENTIFY MAMMOGRAPHY:			
Service	**Code Type**	**Code**	**Code Description**
Breast Cancer Screening	CPT	77061	Diagnostic digital breast tomosynthesis; unilateral
Breast Cancer Screening	CPT	77062	Diagnostic digital breast tomosynthesis; bilateral
Breast Cancer Screening	CPT	77063	Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)
Breast Cancer Screening	CPT	77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
Breast Cancer Screening	CPT	77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
Breast Cancer Screening	CPT	77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

APPENDIX 3: Historical (Hx) Data Form

The IEHP Historical (Hx) Data Form is located in the secure Provider Portal. Providers seeking to submit medical records to close quality gaps in care can enter Member information and upload documentation via an online process. As a reminder, this process should be utilized for the submission of visits, procedures, or services that cannot be submitted via claims or encounters (e.g., services received prior to IEHP Membership, historical surgical procedures, etc.). Please see below for more details.



Note: All Historical Data submissions for the 2024 performance year must be submitted to IEHP no later than December 31, 2024.

NOTES

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PROVIDER RELATIONS TEAM

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