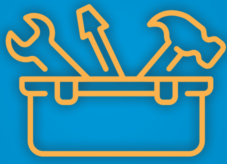

# Physician’s Quality Toolkit

## AHCCCS and CMS Performance Metrics

Quality Improvement Specialist (QIS) Program

Blue Cross® Blue Shield® of Arizona (BCBSAZ)/Health Choice employs a team of quality experts called Quality Improvement Specialists. They will work with your practice and consider your unique needs to help your performance on AHCCCS and CMS Quality Measures. If your practice already has an assigned QIS, reach out to them anytime with questions. If you do not have a QIS and are interested in learning more about the program and how it may benefit your practice, please email **PerformanceImprovement@azblue.com.**

## Child and Adolescent Performance Metrics

### Pediatric Well-Care Visits (WCV)

**Age:** Birth to 21

**Frequency:** 6 visits by 15 months, 2 visits between 15 and 30 months, then annually ages 3 to 21

**Qualifying CPT Codes:**
New patient well visit: **99381-99385**
Established patient well visit: **99391-99395**

***NOTE:** Well visits can be scheduled at any time during the year; BCBSAZ Health Choice does not impose any restrictions around timing of well visits. Per measure specifications, a minimum of 2 weeks between visit dates is required for well-care visit measures to be included in the related quality measure.

### Developmental Screening in the First Three Years of Life (DEV-CH)

**Description:** Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

**Qualifying Codes:** CPT 96110 combined with ICD-10 Code Z13.42 Encounter for Screening of Global Developmental Delays (Milestones)

### Annual Dental Visits, Fluoride Varnish, and Dental Sealants

**Oral Evaluation, Dental Services (OED):** Members under 21 years who received a comprehensive or periodic oral evaluation with a dental provider.

**Topical Fluoride for Children** (2 measures reported):
**TFL-CH,** dental (DQA) measure: The percentage of children ages 1 - 21 years who received at least two topical fluoride applications within the reporting year
**TFC,** HEDIS measure: Medicaid members 1-4 years of age who received at least 2 fluoride varnish applications
**Qualifying CPT Codes: 99188 (PCP), D1206, D1208**

AHCCCS covers dental screening and treatment for members under age 21. Be sure to ask your pediatric patient families if they are taking advantage or their dental benefits. A formal referral is not necessary but may facilitate a dental visit.

You can help your patients find a contracted Dental Provider on the Health Choice Website: **https://providerdirectory.healthchoiceaz.com**

### Child and Adolescent Recommended Immunization Schedule*

For the latest immunization recommendations please refer to: **cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**
To assist with accurate data collection, have parents/guardians correct names with AHCCCS when applicable (Example Baby Girl Smith).
*Note: All immunizations must be logged in ASIIS.
If multiple immunizations are administered on the same visit, ensure that all immunizations are included on the claim.

### Childhood Immunization Combo 3

**Description:** Children who turned two years of age during the measurement period who had four diphtheria, tetanus and acellular pertussis (DTaP); four pneumococcal (PCV); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); on or before their second birthday.

## Adolescent and Adult Performance Metrics

### Weight Assessment and Counseling for Nutrition/Physical Activity

**Age:** 3–17

**Frequency:** Every year (must include all 3 components)

**BMI Percentile:** Height, Weight, and BMI percentile (not value) must be calculated and documented
**Qualifying ICD-10 Codes: Z68.51-Z68.54, E63.6, E66.3, E66.09**

**Counseling for Nutrition:** Documentation of counseling for nutrition or referral for nutrition education
**Qualifying ICD-10 Codes: Z71.3 or HCPCS: G0447**

**Counseling for Physical Activity:** Documentation of counseling for physical activity or referral
**Qualifying ICD-10 Codes: Z02.5, Z71.82 or HCPCS: G0447**
*Documentation showing counseling and/or a record of providing a handout on nutrition and physical activity at the visit is acceptable.

### Chlamydia Screening in Women (CHL)

**Age:** 16–24

**Frequency:** Every year

**Description:** Women 16–24 years of age who were identified as sexually active* and who had at least one test for chlamydia during the measurement year
**Qualifying CPT Codes: 87110, 87270, 87320, 87490-92, 87810**
*Women are identified as sexually active if they have claims for pregnancy testing, STIs, contraceptives, and/or infertility treatment.
**Suggested workflow:** Screen all female patients aged 16–24 at time of OCP annual refills and/or with any pregnancy testing.

### Timely Prenatal and Postpartum Visits

**Prenatal Visits:** Pregnant patients should receive at least one prenatal care visit during the first trimester
**Qualifying Services:** Prenatal office visit
**Qualifying Codes:T1015, 99201-99205, 99211-99215, 99241-99245, 0502F ; ICD-10 diagnosis code of pregnancy (Z32.x, Z33.x or Z34.x) must be submitted with EM codes**

**Postpartum Visits:** Patients who give birth should receive a postpartum visit between 7 and 84 days post-delivery
**Qualifying Services:** Postpartum office visit, IUD insertion, Pap exam
**Qualifying Codes for Postpartum Visit: 57170, 58300, 59430, 99501, 0503F, G0101, Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2**

## Adult Performance Metrics

### Medicare Annual Wellness Visits (AWV) / Comprehensive Health Evaluation (CHE)

**Age:** All patients covered by Medicare (Traditional, Dual/Special Needs, and Advantage plans)

**Description:** A yearly “Wellness” visit to develop or update a personalized plan to help prevent disease and disability, based on current health and risk factors. The yearly “Wellness” visit isn’t a physical exam.

**Qualifying CPT Codes: G0438/G0439/G0468 ONLY**
***NOTE:** 99499 may be used in addition to G Codes for patients with 12+ diagnoses.
Health Choice Pathway recommends one AWV per calendar year (no minimum required time between AWVs as with traditional Medicare).
**www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html**

## Breast Cancer Screening

**Age**: 40–74*

**Description:** Women 40–74 years of age must have a mammogram to screen for breast cancer every two years.

*Age range lowered from 50 years to 40 years in anticipation of 2024 update to this measure

**EXCLUSION Z90.13** History of bilateral mastectomy

## Colorectal Cancer Screening

**Age**: 45–75

**Description:** Individuals 45–75 years screened for colorectal cancer

**Frequency:** Varies based on screening type:
- FOBT/FIT Kit: Every year
- Sigmoidoscopy: Every 5 years
- Colonoscopy: Every 10 years
- FIT DNA/Cologuard®: Every 3 years
- CT Colonography: Every 5 years

**CPT-II code to help in collecting data from prior year screening results when applicable: 3017F** Colorectal cancer screening results documented and reviewed

## Cervical Cancer Screening

**Age**: 21–64

**Frequency:** Age 21–64, cervical cytology every 3 years
Age 30–64, cervical cytology + HPV test every 5 years

**Description:** The percentage of women 21–64 years of age who were screened for cervical cancer in the previous 3–5 years

**Qualifying CPT if performed in-office: Q0091**

**EXCLUSION Z90.710** Acquired absence of both cervix and uterus

## Concurrent Use of Opioids and Benzodiazepines (COB-AD)

**Description:** Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines for 30 or more cumulative days.

**Numerator:** Beneficiaries with two or more prescription claims for any benzodiazepine and concurrent use of opioids and benzodiazepines for 30 or more cumulative days

**Denominator:** Beneficiaries with two or more opioid prescription claims, for which the sum of the days' supply is greater than or equal to 15

## Diabetes Care: Glycemic Status Assessment for Patients with Diabetes (GSD), BP Control, Eye Exam, and Kidney Health Controlling Blood Pressure (CBP)

**Age**: 18–75

**Frequency:** Every year

**Description:** Diabetic patients (type 1 and type 2) 18–75 years of age should receive each of the following every year:
- Hemoglobin A1c (HbA1c) test or glucose management indicator with A1c 9.0 or less.
- Retinal eye exam
- BP measurement and treatment if 140/90 or higher

*NCQA revised and renamed Hemoglobin A1c Control for Patients with Diabetes to include a glucose management indicator with hemoglobin A1c. Two measures are reported for GSD: Members with A1c 8 or less and members with A1c >9.

**CPT and CPT-II Codes for A1c Control:**

**83036** Hemoglobin; glycosylated (A1C) test
**3044F** Most recent HbA1c < 7.0%
**3051F** Most recent HbA1c ≥ 7.0% and < 8.0%
**3046F** Most recent HbA1c > 9.0%
**3052F** Most recent HbA1c ≥ 8.0% < or = 9.0%

**Blood Pressure Control:** BDP (controlling Blood Pressure in Diabetes) and CBP (Controlling Blood Pressure) – patients 18–75 with a diagnosis of hypertension and/or a diagnosis of diabetes meet the measure(s) when their most recent blood pressure reading is <140/90.

**CPT-II codes for CDC-BP control and CBP:**
**3074F** Most recent systolic blood pressure < 130 mm Hg
**3075F** Most recent systolic blood pressure 130-139 mm Hg
**3077F** Most recent systolic blood pressure > 140 mm Hg
**3078F** Most recent diastolic blood pressure < 80 mm Hg
**3079F** Most recent diastolic blood pressure 80-89 mm Hg
**3080F** Most recent diastolic blood pressure >90 mm Hg

**Diabetic Eye Exams:** Current year dilated retinal screening w/ evidence of retinopathy: **CPT-II: 2022F, 2024F, 2026F**

Current year dilated retinal screening w/o evidence of retinopathy: **CPT-II: 2023F, 2025F, 2033F**

Prior year dilated negative retinal screening: **CPT-II: 3072F**

**Kidney Health Evaluation for Patients with Diabetes (KED):**
Diabetic patients aged 18–85.
The measure evaluates adults who have received an annual kidney health evaluation by an estimated glomerular filtration rate (eGFR) **AND** a urine albumin-creatinine ratio (uACR) during the measurement year.

## Care for Older Adults (COA) Medication Review, Functional Status Assessment, Pain Assessment

**Age**: 66 years and older

**Frequency:** Every year

**Description:** The percentage of adults 66 years and older who had:
- Functional status assessment
- Pain assessment
- Medication review

**Functional Status Assessment**: An individual's functional status should be assessed using ADLs, IADLs, or other standardized tool

**Qualifying CPT-II Codes: 1170F Functional Status Assessed**

**Pain Assessment:** Pain can be quantified using a numerical scale, face scale, or other method. Pain assessment in any single body system except the chest qualifies.

**Qualifying CPT-II Codes:**
**1125F** Pain severity quantified; pain present
**1126F** Pain severity quantified; no pain present

**Medication Review:** At least one medication review by a prescribing practitioner or clinical pharmacist during the measurement year. **BOTH** documentation of the medication list and documented review by a prescriber must be present.

**Qualifying CPT-II Codes (both required to satisfy the measure):**

**1159F** Medication list documented in medical record **AND**
**1160F** Review of all medications by a prescribing practitioner

## Medication Reconciliation Post Discharge (MRP)

**Age**: 18+

**Description:** Percentage of discharges in the current measurement year for patients 18 years of age and older whose medications were reconciled on the date of discharge through 30 days after discharge (a total of 31 days) *No in-office visit required.

Evidence of reconciliation should be in the outpatient medical record and signed by a prescribing provider, RN, NP, PA, or clinical pharmacist.

**Qualifying CPT and CPT-II codes: 1111F** Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.

## Social Need Screening and Intervention (SNS-E)

**Age**: All

**Description:** Members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

**Related codes:** G0136 Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment;

96160, Administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument;

96161, Administration of caregiver-focused health risk assessment instrument for the benefit of the patient, with scoring and documentation, per standardized instrument.

LOINC and SNOMED codes (from EMR data)

## Plan All Cause Readmissions

**Description:** Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio.

**Two Proven Strategies to Reduce Readmissions:**
1. Follow-up phone call after discharge
2. Follow-up appointment within 7 days of discharge

## Care Management

BCBSAZ Health Choice Pathway Care Managers assist members to obtain resources and healthcare services to meet member needs. By supporting members, they support you, the primary care provider.

Care Managers educate members on the importance of the treatment plan you developed and the importance of the preventive and treatment services you ordered such as labs, imaging studies, medications.

Please contact Care Management when you need that extra support to close quality and preventive service care gaps.
HCHHCACaseManagement@azblue.com or **480-350-2232**