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

Child and Adolescent Well Visits and Developmental Screening

Age: Birth to 21

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

Description: All patients to age 21 should receive one or more EPSDT visits with a doctor, NP, or PA every year

Qualifying CPT Codes:
New patient well visit: **99381-99385**
Established patient well visit: **99391-99395**
Developmental screening: **96110***

***NOTE:** Well visits can be scheduled at any time during the year; Health Choice Arizona does not impose any restrictions around timing of well visits. Please refer to AHCCCS EPSDT Periodicity Schedule to ensure completion of age-appropriate screenings: **https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430_AttachmentA.docx**

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 (TFC): Members 1–20 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 patients if they are taking advantage or their dental benefits. A formal referral is not necessary but may facilitate a dental visit.

Refer to AHCCCS Dental Periodicity Schedule to ensure age-appropriate screenings are completed: **https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/431_AttachmentA.pdf**

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*

*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.

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).

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.

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

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 Standalone Postpartum Visit: 59430, 0503F
If you submitted a global OB code prior to the postpartum visit, submit a $0 claim with **CPT-II code 0503F** on the day of the PPV.

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.

Ambulatory Care Emergency Department Visits

Age: All

Description: Observed versus expected Emergency Department (ED) use for the Medicaid population

Why it matters: ED visits are a high-intensity service and a cost burden on the healthcare system, as well as on patients. Some ED events may be attributed to preventable or treatable conditions. A high rate of ED utilization may indicate poor care management, inadequate access to care, or poor patient choices, resulting in ED visits that could be prevented.
Possible interventions: Appointment blocks for same-day visits; extended hours (evenings, weekends); scheduled periodic follow-up visits for patients with high ED utilization history and/or multiple chronic health conditions.

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: 50–74

Description: Women 50–74 years of age must have a mammogram to screen for breast cancer every two years.

CPT-II code 3014F Screening mammography results documented & reviewed

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

CPT-II code 3015F Cervical cancer screening results documented and reviewed

EXCLUSION Z90.710 Acquired absence of both cervix and uterus

Use of Opiates at High Dosage in Persons Without Cancer

Age: 18+

Description: Percentage of adults who received opioids with an average daily dosage ≥ 90 morphine milligrams equivalents (MME) over a period ≥ 90 days

Recommendations: Coordination of care between prescribers and periodic assessment of treatment plan

Diabetes Care: A1c Control, BP Control, Eye Exam, and Kidney Health Controlling Blood Pressure (CBP)

Age: 18–75

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 with results in control (< 9.0%)
- Retinal eye exam
- BP measurement and treatment if 140/90 or higher

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

Frequency: Every year

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%

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

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

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

Frequency: Every year

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

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.

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

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

This measure is closed through LOINC data. Codes can be captured by sharing supplemental data files OR through using Contexture's SDOH closed loop screening and referral program.

Transitions of Care (TRC)

Age: 18+

Description: This is a combined measure made up of the following 4 components:
1. **Notification of inpatient admission:** Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days)
2. **Receipt of discharge information:** Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days)
3. **Patient engagement after inpatient discharge:** Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
4. **Medication reconciliation post-discharge (MRP):** Reference MRP measure information

Qualifying CPT Codes: 99495 and 99496 Transitional Care Management