

PCMH Program Policy Addendum

2019

Arkansas Medicaid
Arkansas Department of Human Services
Division of Medical Services

Change History

Description of Change	Date of Change
Added a brief list and description of exclusions from PBIP calculations (235.000)	5/28/2019
Updated the timeline of milestones for the 2019 Core Quality Metrics tracked for practice support (241.000)	6/18/2019
Specified that beneficiaries included for the Low Back Pain Information Metric had a “principal” diagnosis. (243.000)	6/25/2019
Added reconsideration period for Performance-Based Incentive Payment (PBIP) and Focus Measures to be performed during the Q2 2020 performance period. (237.000)	7/1/2019
Added additional exclusions to PBIP calculations (235.000) and clarifications on Chlamydia Screening and HIV Viral Load Informational metrics.	10/4/2019
Updated Technical Specification for HIV Viral Load Informational Metric to clarify that denominator includes beneficiaries with an HIV diagnosis attributed in either the performance year or the year prior (243.000)	7/22/2020
Updated wording of sections 235.000 and 237.000 regarding calculations of PBIP payments	10/6/2020
Updated PBIP Payment amounts for 2019 performance period in section 237.000 to reflect adjustments made after payouts exceeded the total amount allotted.	4/28/2021

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223.000 Explanation of Care Coordination Payments

Determination of Beneficiary Risk

- A Risk Utilization Band (RUB) score is calculated for all of the participating practice's attributed beneficiaries at the end of the preceding calendar year using the Johns Hopkins ACG® Grouper System, a tool for performing risk measurement and case mix categorization (<http://acg.jhsph.org>).
- For attributed beneficiaries with no claims history¹, a RUB score of 0 is assigned.

Per Beneficiary Per Month (PBPM) Amounts

- A per beneficiary per month amount is assigned based upon each beneficiary's RUB score in the table below.

RUB Score	PBPM Amount
0	\$1
1	\$1
2	\$3
3	\$5
4	\$10
5	\$30

- For attributed beneficiaries with fewer than 6 months of claims history¹ (for whom no RUB is assigned), the per beneficiary per month amount will be equal to that of the average per beneficiary per month amount for that beneficiary's demographic cohort (based on age and sex).
- The care coordination payment for each practice equals the average of the per beneficiary per month amount for the practice's attributed beneficiaries multiplied by the practice's number of attributed beneficiaries

¹ This will be based on the most recent claims available.

232.000 Performance Based Incentive Payment (PBIP) Eligibility

PBIP Beneficiary Exclusions

- At this time, there are no changes to the definitions of those beneficiaries not counted toward the required 1,000 attributed beneficiaries. The requirement remains as currently defined in the [2019 PCMH Provider Manual](#).

235.000 Performance Based Incentive Payment Methodology — Exclusions from the Calculation of Emergency Department Utilization and Acute Hospital Utilization

Emergency Department Utilization (EDU) — HEDIS² Exclusions

1. Emergency Department visits that result in an inpatient stay
2. A principal diagnosis of mental health or chemical dependency
3. Psychiatry
4. Electroconvulsive therapy
5. Hospice beneficiaries

Acute Hospital Utilization (AHU) — HEDIS Exclusions

1. Nonacute inpatient stay
2. A principal diagnosis of mental health or chemical dependency
3. A principal diagnosis of live-born infant
4. A maternity-related principal diagnosis
5. A maternity-related stay
6. Inpatient and observation stays with a discharge for death
7. Hospice beneficiaries

PCMH Program-specific Exclusions

1. Newborn Intensive Care Unit (NICU) stay
2. Provider types excluded from total cost of care
3. Medically Frail beneficiaries
4. Physician excluded beneficiaries
5. Unknown gender

² The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA). <https://www.ncqa.org/hedis/measures/>

236.000 Incentive Focus Metric

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries
4	Adolescent Wellness	Percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year	≥ 25

*[Percentile of performance and incentive bonus](#)

237.000 Performance Based Incentive Payment Amounts

Percentile of performance and incentive bonus³

- [Acute Hospital Utilization](#)
 - Shared Performance Entities that are in the top 10th Percentile for lowest inpatient AHU rates can receive up to \$12 times the number of attributed member months. For the 2019 performance period, this payout was capped at \$9.13 times the number of attributed member months.
 - Shared Performance Entities that fall within the top 11th to 35th percentiles for lowest inpatient AHU rates can receive up to \$6 times the number of attributed member months. For the 2019 performance period, this payout was capped at \$4.57 times the number of attributed member months.
- [Emergency Department Utilization](#)
 - Shared Performance Entities that are in the top 10th percentile for lowest EDU rates can receive up to \$8 times the number of attributed member months. For the 2019 performance period, this payout was capped at \$6.09 times the number of attributed member months.
 - Shared Performance Entities that fall within the top 11th to 35th percentiles for lowest EDU rates can receive up to \$4 times the number of attributed member months. For the 2019 performance period, this payout was capped at \$3.04 times the number of attributed member months.
- [Focus Metric](#)
 - Shared Performance Entities that are in the top 10th percentile for highest Focus Metric rates can receive up to \$5 times the number of attributed member months. For the 2019 performance period, this payout was capped at \$3.80 times the number of attributed member months.
 - Shared Performance Entities that fall within the top 11th to 35th percentiles for highest Focus Metric rates can receive up to \$2.50 times the number of attributed member months. For the 2019 performance period, this payout was capped at \$1.90 times the number of attributed member months.

Reconsideration for Performance-Based Incentive Payment (PBIP) and Focus Measures will be performed during Q2 of the 2020 performance period. The Q2 2020 quarterly report will identify providers' current standing, and a special PHMR will identify those beneficiaries and events counted in these three measures. Requests for reconsideration on these measures will be accepted after Q2 2020 reports are posted to the PCMH Provider Portal, and such reconsideration requests must follow the guidance in the [2019 PCMH Provider Manual](#). (Sections 235.000, 236.000, 244.000)

³ The total of Performance Based Incentive Payment (PBIP) amounts must not exceed Medicaid's allotted dollar amount for total payout. If the total of PBIP amounts exceed Medicaid's allotted dollar amount for total payout, all PBIP amounts will be adjusted accordingly. Payout amounts for the 2019 performance period exceeded this allotted total, so they were adjusted. These adjusted rates are displayed on this page. Rounding to two decimal places occurs only in the last step of payment calculation.

241.000 Activities Tracked for Practice Support

Activities for the 2019 Performance Period

- All PCMHs must meet all activities by the following deadlines in order to be eligible for practice support:
 - 3-month activities by 3/31/19
 - 6-month activities by 6/30/19
 - 12-month activities by 12/31/19
- For information on remediation, please refer to the [2019 PCMH Provider Manual](#).

Activity	3-Month	6-Month	12-Month
A. Identify top 10% of high-priority patients	✓		
B. Make available 24/7 access to care.		✓	
C. Track same-day appointment requests.		✓	
D. Capacity to receive direct e-messaging from patients.		✓	
E. Childhood / Adult Vaccination Practice Strategy.		✓	
F. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours.		✓	
G. Medication Management		✓	
H. Care Plans for High Priority Patients			✓
I. Patient Literacy Assessment Tool			✓
J. Ability to receive patient feedback			✓
K. Care instructions for High Priority Patients			✓
L. 10-day Follow up after an Acute Inpatient Stay			✓
M. Developmental / Behavior Health Assessment for Children and Adolescents			✓

Details on Activities Tracked for Practice Support

Activity A: Identify top 10% of high-priority patients

Activity A Deadline: 3/31/19

1. Perform this by using:
 - a. DMS patient panel data that ranks patients by risk at beginning of performance period and/or
 - b. The practice's patient-centered assessment to determine which patients are high-priority.
2. Submit this list to DMS via the provider portal.

Activity B: Make available 24/7 access to care

Activity B Deadline: 6/30/19

1. Provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days per week.
 - a. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.
 - b. The on-call professional must:
 - i. Provide information and instructions for treating emergency and non-emergency conditions,
 - ii. Make appropriate referrals for non-emergency services, and
 - iii. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.
2. Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment.
 - a. PCPs must make the after-hours telephone number known by all patients; posting the after-hours number on all public entries to each site; and including the after-hours number on answering machine greetings.
3. Practices are to document completion of this activity via the provider portal, and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity C: Track same-day appointment requests

Activity C Deadline: 6/30/19

1. Perform this by:
 - a. Using a tool to measure and monitor same-day appointment requests on a daily basis
 - b. Recording fulfillment of same-day appointment requests
2. Provide a description of the tool used to track same-day appointment requests.
3. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity D: Capacity to receive direct e-messaging from patients

Activity D Deadline: 6/30/19

1. Indicate if the practice has the capacity to use electronic messaging to communicate with patients.
 - a. Indicate if the practice currently uses e-messaging, describe the method used.
 - b. Indicate if the messaging system is secure.
 - c. Indicate if the messaging system meets HIPAA guidelines.
2. If the practices do not use e-messaging, indicate if a plan has been developed to implement the use of e-messaging.
3. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity E: Childhood/Adult Vaccination Practice Strategy

Activity E Deadline: 6/30/19

1. Indicate and describe the practice's implemented process to deliver immunization to both the pediatric and adult population leading into administration of immunization for the upcoming year.
 - a. Indicate if there is an implemented process to identify vaccination gaps in care for both the pediatric and adult population.
 - b. Indicate the ability to document historic immunization data into an EHR and review on each visit.
 - c. Indicate the capability to submit data electronically to immunization registries or immunization information systems.
2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity F: Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours

Activity F Deadline: 6/30/19

1. Indicate if the practice has joined SHARE.
 - a. Indicate the ability to access inpatient discharge information via SHARE.
 - b. Indicate the ability to access patient transfer information via SHARE.
2. If the practice has not joined SHARE, indicate if the practice participates in a network that delivers hospital discharge information to the practices within 48 hours of discharge.
3. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity G: Medication Management

Activity G Deadline: 6/30/19

1. Define the practice's medication reconciliation process. For High Priority Beneficiaries, document updates to the active medication list in the EHR at least twice a year.
 - a. Indicate if the medication list is updated on a timely basis from the last visit.
 - b. Submit a short synopsis of the medication reconciliation process via the provider portal.
2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity H: Care Plans for High Priority Patients

Activity H Deadline: 12/31/19

1. At least 80% of high-priority patients whose care plan and/or note as contained in the medical record include the following elements:
 - a. Documentation of the patient's appropriate problem list
 - i. The problem list should include any active, significant clinical condition (chronic and/or acute)
 - ii. Each visit related encounter should include a list of current problems (chronic and/or acute)
 - b. Assessment of progress to date
 - i. Documentation and assessment of each problem (stability or change of condition)
 - ii. Each problem noted in the problem list must have an assessment as well as a status of the problem/diagnosis in the plan or in the note. For example, "diabetes well controlled based on HbA1c 6.7 and per patient's compliance with prescribed medication" is sufficient.
 - iii. If a problem noted in the problem list is no longer an active problem, a status such as "resolved" should be indicated.
 - iv. If a specialist follows the patient, the most recent findings should be documented, if available.
 - c. Plan of Care

Activity H Deadline: 12/31/19

- i. The documentation should include a specific plan of care related to the problem. For example, “continue Lisinopril 5mg daily”, “ordering labs”, “referral to OT/PT for evaluation and treatment”, “continue therapy sessions”, “prescribed Vyvanse 30 mg daily”, are acceptable.
 - d. Instruction for follow-up
 - i. The documentation should include the timing of a future follow-up visits (related to the problem)
 - ii. If multiples problems are addressed, a single clearly defined future visit (return to clinic date) is acceptable. For example, “return to office in 6 months” is acceptable; “return if no improvement or as needed” is not acceptable.
 - iii. If problems/conditions are followed by a specialist, the timing of the follow up visit with the specialists should be noted. For example, “follow up with endocrinologist in 6 months” is acceptable; “follow up with endocrinologist” is not acceptable.
2. A minimum of two care plans should be completed within a 12-month period and submitted for validation review.
 - a. Documented update to the plan of care which would include active problems
 - b. For new patient: initial care plan and one update (in person or phone call)
 - c. For established patients: one care plan update must be completed by a face-to-face visit and one update may be completed via a phone call.
3. Addendums to the care plans are acceptable if completed within a reasonable period of no more than two weeks after the care plan has been created or updated.
4. Indicate if at least 80% of the top 10% of high-priority patients have a first and second care plan in the medical record. Each attested care plan includes all required elements listed in number 1.
5. For validation audit, 20% of the top 10% of high-priority patients with a first and second care plan, will be randomly selected for review of care plans. To pass this activity, at least 80% of the care plans must include all the required elements listed in number 1.
6. PCMHs that successfully pass two consecutive years of care plan validation audits without going into remediation will be eligible for a “Fast Track” audit.
 - a. The Fast Track audit includes:
 - i. Sample audit of five care plans
 - ii. Sample audits will be conducted at the same time as regular care plan validation audits and for the same performance period

Activity H Deadline: 12/31/19

- b. The PCMH must successfully pass the audit with at least an 80% total score
- c. The scoring methodology will remain the same for the sample audit
- d. If the practice passes the Fast Track audit, no further care plan audit will be required for the performance period.
- e. If a practice fails the sample Fast Track audit, care plan validation will revert to the standard audit process and the PCMH will be required to submit the full 20% of care plans randomly selected for high-priority patients with a first and second care plan.
 - i. If the PCMH passes the secondary audit the PCMH will remain in good standing and will be eligible for the Fast Track audit in the upcoming performance period.
 - ii. If the PCMH does not meet the 80% target for the secondary audit, the PCMH will be required to follow the remediation process as stated in Section 242.000 of the [2019 PCMH Provider Manual](#) and will not be eligible for the Fast Track audit for the upcoming year.

7. Scoring methodology:

- a. Each element of the care plan will be scored accordingly with a total of eight possible points per High Priority Patient (HPP). The scoring methodology is the same for a regular care plan audit and a Fast Track audit.

Care Plan Element	Point Value (Care Plan 1)	Point Value (Care Plan 2)	Total Possible Points per HPP
Problem list	1	1	2
Assessment of problems	1	1	2
Plan of Care	1	1	2
Instruction for follow up	1	1	2
Total possible points per HPP	4	4	8

- b. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity I: Patient Literacy Assessment Tool

Activity I Deadline: 12/31/19

1. Choose any health literacy tool and administer the screening to at least 75 beneficiaries (enrolled in the PCMH program) or their caregivers. Returning practices should select 75 beneficiaries that have not had a health literacy screening.
 - a. A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists.
 - i. Provide an example of the tool used to assess health literacy.
 - ii. Provide a description of the overall results of the assessment.
 - iii. Develop and describe a plan to help low health literacy beneficiaries to understand instructions and education materials.
2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity J: Ability to Receive Patient Feedback

Activity J Deadline: 12/31/19

1. Indicate if the practice has implemented a process to obtain feedback from the patients.
 - a. Describe:
 - i. The method used to obtain feedback from patients (surveys, suggestion box, advisory council, etc.)
 - ii. Who in the practice reviews the feedback
 - iii. The capacity in which the feedback shared with other within the practice (staff, providers)
 - iv. How the feedback is used to make improvements in the practice
2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity K: Care Instructions for High Priority Patients

Activity K Deadline: 12/31/19

1. Compile relevant and actionable information including: diagnosis, medication list, tests and results (if available), referral information (if applicable), and follow up instructions.
2. Create an after-visit summary of the information from patient's last visit.
3. The patient will receive a copy of the after-visit summary based on the patient's preferred method of delivery. Methods by which a patient may choose to receive their after-visit summary include the following:
 - a. The patient will either receive a paper copy of the summary after their visit, prior to leaving the clinic.
 - b. A copy of the summary will be mailed to the patient at the address listed in the record within three days of the visit, or completion of any lab test related to the visit
 - c. An electronic copy of the summary will be made available to the patient via a patient portal
4. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity L: 10-day Follow up after an Acute Inpatient Stay

Activity L Deadline: 12/31/19

1. Attest to at least 40% of beneficiaries with an inpatient stay have had an in-person follow-up visit or a follow-up phone call with any provider within 10 business days of discharge but during the performance period being measured.
 - a. Indicate if the practice has a written policy or process for monitoring follow-up visits/ phone calls within 10 business days of an inpatient stay. The practice will be able to produce documentation of an in-person follow-up visit or a follow-up phone call.
 - b. Validation of this activity will occur by random selection of documentation from beneficiaries with an inpatient stay within the performance period. To pass this activity at least 40% of the selected documentation for review must include proof of an in-person follow-up visit or a follow-up phone call.
2. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity M: Developmental/Behavior Health Assessment for Children and Adolescents:

Activity M Deadline: 12/31/19

1. Indicate and describe the practice's process to assess children and adolescents for developmental and behavioral health disorders.
2. Indicate the frequency of assessing children and adolescents for developmental and behavioral health disorders.
3. Indicate if a standardized developmental assessment tool is used by the practice.
 - a. If a tool is used, indicate what type is used and how it is used to develop a plan of treatment.
4. If referrals are made for treatment outside of the practice, indicate if a mechanism is used to track progress.
5. PCMHs may choose any developmental and behavior health assessment tool to administer to children and adolescent beneficiaries.
 - a. The following links offer information and examples of tools to assist with implementing developmental and behavior health assessments:
 - i. Centers for Disease Control and Prevention – Child Development: Development Monitoring and Screening: <https://www.cdc.gov/ncbddd/childdevelopment/screening.html>
 - ii. American Academy of Pediatrics – Bright Futures: <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx>
6. Practices are to document completion of this activity via the provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Low Performance Core Metrics for the 2019 Performance Period

DMS will assess the following wellness metrics for practice support starting on the first day of the performance period in which the practice is enrolled in the PCMH program, through the full calendar year (January through December). To be eligible for continued practice support, PCMHs must meet the target rate stated below. If a PCMH fails to achieve the stated target rate for the metric, then the PCMH must remediate performance to avoid suspension or termination of practice support.

Metric	Description	Target Rate	Condition for Remediation	Minimum Attributed Beneficiaries
<p>Core Metric 1: Infant Wellness (0-1 visits)</p> <p>*Claims-based</p>	<p>The purpose of the infant wellness core metric is to identify low performers of infant wellness visits. The metric measures the percentage of beneficiaries who turned 15 months old during the performance period who only received zero to one wellness visit in their first 15 months (0 – 15 months)</p>	<p>20% or less of the patient panel, ages 0-15 months, having zero to one wellness visit</p>	<p>A PCMH will be placed in remediation for Core Metric 1 (Infant Wellness) tracked for Practice Support if more than 20% of the patient panel (0 – 15 months) have 0 – 1 wellness visits AND if the PCMH does not meet the target of 62% or greater for Quality Metric 2 (Infant Wellness)</p>	<p>25</p>
<p>Core Metric 2: Body Mass Index (BMI)</p> <p>*Self-reported by entering numerator and denominator data in the PCMH Provider Portal</p>	<p>The purpose of the BMI core metric is to identify low performers of BMI measurement. The metric measures the percentage of patients 3 – 17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of height, weight, and body mass index (BMI) percentile documentation during the measurement period.</p>	<p>At least 60% of the patient panel, ages 3-17 years, having evidence of BMI measurement during the measurement period.</p>	<p>A PCMH will be placed in remediation for the Core Metric 2 (BMI) tracked for Practice Support if less than 60% of the patient panel (3-17 years) have a BMI measurement.</p>	<p>25</p>

DMS will verify whether the PCMH has met the target for the Core Metrics by reviewing the PCMH reports issued during the second quarter following the completion of the measured performance period.

Failure to meet the targets will result in a “Notice of Failure to Meet Core Metrics Tracked for Practice Support.” PCMHs that receive this notice will be subject to completion of a Quality Improvement Plan (QIP) and a 90-day remediation period.

- The PCMH will have 15 calendar-days to submit a sufficient QIP — failure to submit a sufficient QIP within 15 calendar-days of receiving the notice will result in suspension of practice support.
- PCMHs that receive a notice will have 90 calendar-days, from the date of the notice, to remediate performance of the metric.

Successful completion of remediation will be determined by DMS based on the Core Metric results reported in the monthly PCMH report, posted in the PCMH Provider Portal, the following month after remediation ends. If a PCMH fails to meet the deadlines or targets for the Core Metrics tracked for practice support within the specified remediation time, then DMS will suspend practice support.

The following is the timeline of milestones for the 2019 Core Quality Metrics tracked for practice support:

2019 Milestones	Description
June 2020	<ul style="list-style-type: none"> • Quarter 2 PCMH Report posted to PCMH Provider Portal (report includes data for January – December 2019) • DMS reviews reports and determines if targets, stated above, are met by PCMHs • Notice of Failure to Meet Core Metrics Tracked for Practice Support is issued to PCMHs that are deficient in meeting set targets
15 days from date notice received	Deadline for the PCMH to submit a sufficient QIP outlining a plan to correct the deficiency stated in the Notice of Failure to Meet Core Metrics Tracked for Practice Support
July – September 2020	90-day remediation period
October 2020	<ul style="list-style-type: none"> • DMS will review the results of the metrics posted in the PCMHs monthly report to determine successful remediation • PCMH will receive notice of remediation completion • If the PCMH fails to remediate performance, then DMS will suspend practice support

Technical Specifications for Low Performance Core Metrics

Infant wellness (0 - 1 visits)

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who had 0 - 1 wellness visits during first 15 months of life (0-15 months)	Denominator includes number of beneficiaries who turned 15 months old during the measurement year	Core Metric: 0 - 1 wellness visits	NCQA	Child

Body Mass Index (BMI)

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of patients who had a height, weight, and BMI percentile recorded during the measurement period (All payer source)	Denominator includes number of patients 3-17 years of age with at least one outpatient visit with a PCP or an OB/GYN during the measurement period (All payer source)	Core Metric: BMI	eCQM (Community, Population and Public Health)	Child

243.000 Quality Metrics Tracked for Performance Based Incentive Payments

DMS assesses the following Quality Metrics tracked for Performance-Based Incentive Payments (PBIP) according to the targets below. The quality metrics are assessed only if the Shared Performance Entity has at least the minimum number of attributed beneficiaries in the category described for the majority of the performance period. To receive a PBIP, the Shared Performance Entity must meet at least two-thirds of the Quality Metrics on which the entity is assessed.

The Quality Metrics are assessed at the level of the shared performance entity for Voluntary pools and the Petite Pool. Quality Metrics for the default pool are assessed on an individual PCMH-level.

Achievement of targets for Quality Metrics 9, 10, and 11 can be calculated only if the required metric data is submitted through the PCMH Provider Portal. Failure to provide the required data by January 31, 2020 will cause failure to meet targets for Quality Metrics 9, 10, and 11.

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2019 Target
Quality Metrics: Incentive Payment (Claims-Based)				
1	PCP visits	Percentage of a practice's high priority beneficiaries who have been seen by any PCP within their PCMH at least twice in the past 12 months	25	84%
2	Infant wellness	Percentage of beneficiaries who turned 15 months old during the performance period who receive at least five wellness visits in their first 15 months (0 – 15 months)	25	62%
3	Child wellness	Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year	25	71%
4	Adolescent wellness	Percentage of beneficiaries 12-20 years of age who had one or more well-care visits during the measurement year	25	50%
5	URI	Percentage of beneficiary, age 1 year and older, events with a diagnosis of non-specified URI that had antibiotic treatment during the measurement period	25	<=47%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2019 Target
Quality Metrics: Incentive Payment (Claims-Based)				
6	HbA1c	Percentage of diabetes beneficiaries who complete annual HbA1C, between 18-75 years of age	25	75%
7	COB	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines	25	<=35%
8	Tamiflu	Percentage of beneficiaries 1-18 years of age who received Tamiflu and respiratory antibiotics on the same day	25	<=20%
eCQMs Quality Metrics: w/Target				
9	Controlling BP	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source)	25	58%
10	HbA1c Poor control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (All payer source)	25	<= 33%
11	Tobacco Use	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user during the measurement period (All payer source)	25	75%

Technical Specifications for Quality Metrics Tracked for PBIP

Metric 1: PCP Visits

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes the number of those high priority beneficiaries with 2 of the selected visit types and criteria with their attributed PCMH	Denominator includes beneficiaries designated high priority by practices according to Section 241.000 and attributed to the PCMH for at least 6 months	Quality Metric: w/Target	Homegrown	Child/Adult

Metric 2: Infant Wellness

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who had 5 or more wellness visits during first 15 months of life (0-15 months)	Denominator includes number of beneficiaries who turned 15 months old during the measurement year	Quality Metric: w/Target	NCQA	Child

Metric 3: Child Wellness

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year	Denominator includes number of beneficiaries 3 to 6 years old on the anchor (last) date of the measurement year	Quality Metric: w/Target	NCQA	Child

Metric 4: Adolescent Wellness

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year	Denominator includes number of beneficiaries 12 to 20 years old on the anchor (last) date of the measurement year	Quality Metric: w/Target; Incentive Focus	NCQA	Child

*[Focus Metric for the 2019 Performance Period](#)

Metric 5: URI

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes those beneficiary events that were dispensed a prescription for an antibiotic, at least one AHFS code, within twenty days from the initial event's start date	Denominator includes all events for attributed beneficiaries, who are 1 year of age and older, on the detail "from" date of service with a primary or secondary diagnosis of non-specified URI in combination with a CPT or HCPCS code	Quality Metric: w/Target	DMS (Homegrown) EOC (URI Non-Specified)	Child/Adult

Metric 6: HbA1c

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries 18 to 75 years old with a diagnosis of diabetes who completed a HbA1c test during the measurement period	Denominator includes number of beneficiaries 18 to 75 years who have a diagnosis of diabetes	Quality Metric: w/Target	NCQA	Adult

Metric 7: Concurrent Opioids and Benzodiazepines Use

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries with two or more prescription claims for any benzodiazepine with unique dates of service and concurrent use of opioids and benzodiazepines for 30 or more cumulative days	Denominator includes number of beneficiaries age 18 and older on the anchor (first) date of the measurement year with an IPSD and with 2 or more prescriptions for opioids with unique dates of service, for which the sum of the days' supply is 15 or more	Quality Metric: w/Target	Pharmacy Quality Alliance	Adult

Metric 8: Tamiflu

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who received Tamiflu and respiratory antibiotics on the same day	Denominator includes number of beneficiaries 1-18 years old on the first date of the measurement period and received a Tamiflu prescription	Quality Metric: w/Target	DMS (Homegrown)	Child

Metric 9: Controlling Blood Pressure

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement (All payer source)	Denominator includes number of patients 18 to 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period (All payer source)	Quality Metric: w/Target	eCQM (Effective Clinical Care)	Adult

Metric 10: HbA1c Poor Control

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of patients whose most recent HbA1c level (performed during the measurement period) is >9.0% (All payer source)	Denominator includes number of patients 18-75 years of age with diabetes with a visit during the measurement period (All payer source)	Quality Metric: w/Target	eCQM (Effective Clinical Care)	Adult

Metric 11: Tobacco Use

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user (All payer source)	Denominator includes number of patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period (All payer source)	Quality Metric: w/Target	eCQM (Community, Population and Public Health)	Adult

Incentive Utilization Metrics Tracked for PBIP

Metric #	Metric Name	Description
Incentive Utilization Metric: PBIP Payment (Claims-Based)		
1	Emergency Department Utilization	The ratio of observed to expected emergency department (ED) visits during the measurement period
2	Acute Hospital Utilization	The ratio of observed to expected acute inpatient or observation stay discharges during the measurement period

Technical Specifications for Incentive Utilization Metrics Tracked for PBIP

Metric 1: Emergency Department Utilization

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of observed ED visits during the measurement period	Denominator includes number of expected ED visits during the measurement period	Incentive Utilization Metric: PBIP Payment	NCQA; GDIT	Child/Adult

[*Percentile of performance and incentive bonus](#)

Metric 2: Acute Hospital Utilization

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of observed inpatient or observation stay discharges during the measurement period	Denominator includes number of expected inpatient or observation stay discharges during the measurement period	Incentive Utilization Metric: PBIP Payment	NCQA; GDIT	Child/Adult

[*Percentile of performance and incentive bonus](#)

Informational Metrics

DMS assesses the following informational metrics tracked for the PCMH program. The Informational Metrics are reported as “claims-based metrics” with at least the one minimum number of attributed beneficiaries in the category described for the majority of the performance period on the PCMH provider report. Breast Cancer Screening, Cervical Cancer Screening, and Colorectal Cancer Screening are collected as “Effective Clinical Care” metrics, while Low Back Pain is collected as an “Efficiency and Cost Reduction Use of Healthcare Resources” metric. All eCQM Informational Metrics are due through the PCMH Provider Portal by January 31, 2020.

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
30-day readmissions	Thirty-day readmissions rate
Asthma Medication Ratio (Child)	Percentage of beneficiaries 5–18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Asthma Medication Ratio (Adult)	Percentage of beneficiaries 19–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
ADHD	Percentage of beneficiaries 6-12 years of age with an ambulatory prescription dispensed for ADHD medication that was prescribed by their PCMH, who had a follow-up visit within 30 days by any practitioner with prescribing authority
Warfarin	Percentage of beneficiaries age 18 years and older who are on chronic Warfarin (Coumadin) therapy and who receive an INR test during each 12 week interval with Warfarin during the measurement period
Chlamydia Screening (Child)	The percentage of women 16-20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period
Chlamydia Screening (Adult)	The percentage of women 21-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period
Eye exam	Percentage of diabetic beneficiaries 18-75 years of age who had an eye exam (retinal) performed
Diabetes Short-Term Complications	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid beneficiaries age 18 and older
COPD or Asthma Admissions	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for beneficiaries age 40 and older

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
Medication therapy	Percentage of beneficiaries 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) or diuretics) during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
HIV Viral Load	Percentage of beneficiaries with a diagnosis of HIV with at least one HIV viral load test during the measurement year
Childhood Immunization	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Breast Cancer Screening	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer
Cervical Cancer Screening	"Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: Women age 21-64 who had cervical cytology performed every 3 years Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years
Colorectal Cancer Screening	Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer
Low Back Pain	Percentage of beneficiaries 18-50 years of age with a principal diagnosis of low back pain who did have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis

Technical Specifications for Informational Metrics

30-Day Readmissions

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator counts the number of hospitalizations (using the same logic as above) for each attributed beneficiary with an admit date within 30 days of discharge date	Denominator is the number of hospitalizations for beneficiaries with at least six months of attribution in the last year to the PCMH	Informational Metric: w/PCMH State Average	Homegrown	Child/Adult

Asthma Medication Ratio

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year	Denominator includes number of beneficiaries 5 to 18 years of age with a diagnosis of persistent asthma	Informational Metric: w/PCMH State Average	NCQA	Child

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year	Denominator includes number of beneficiaries 19 to 64 years of age with a diagnosis of persistent asthma	Informational Metric: w/PCMH State Average	NCQA	Adult

ADHD

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes those ADHD patients who had one follow-up visit with any practitioner with prescribing authority during the 30 days following initiation of the prescription	Denominator includes a modified HEDIS metric to determine the percent of patients between 6-12 years of age with a first ambulatory prescription dispensed for ADHD medication that was prescribed by their attributed PCMH. The intake period is modified from the HEDIS metric to be the first 11 months of the performance period	Informational Metric: w/PCMH State Average	NCQA	Child

Warfarin

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries who received an INR test during each 12 week interval	Denominator includes number of beneficiaries 18 years and older who are chronic Warfarin therapy	Informational Metric: w/PCMH State Average	Homegrown	Adult

Chlamydia Screening

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of women with at least one chlamydia test during the measurement period	Denominator includes number of women ages 16 to 20 on the anchor (last) date of the measurement period	Informational Metric: w/PCMH State Average	NCQA	Child

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of women with at least one chlamydia test during the measurement period	Denominator includes number of women ages 21 to 24 on the anchor (last) date of the measurement period	Informational Metric: w/PCMH State Average	NCQA	Adult

Eye Exam

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries 18 to 75 years old with a diagnosis of diabetes who had an eye exam (retinal) performed	Denominator includes number of beneficiaries 18 to 75 years who have a diagnosis of diabetes	Informational Metric: w/PCMH State Average	NCQA	Adult

Diabetes Short-Term Complications

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes all inpatient hospital admissions with ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma)	Denominator includes total number of months of enrollment for beneficiaries age 18 and older during the measurement period	Informational Metric: w/PCMH State Average	Agency for Healthcare Research and Quality (AHRQ)	Adult

COPD or Asthma Admissions

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes all non-maternal inpatient hospital admissions with an ICD-10-CM principal diagnosis code for COPD or Asthma	Denominator includes total number of months of enrollment for beneficiaries age 40 and older during the measurement period	Informational Metric: w/PCMH State Average	AHRQ	Adult

Medication Therapy

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries 18 years of age and older with at least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year.	Denominator includes number of beneficiaries 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs or diuretics, during the measurement year.	Informational Metric: w/PCMH State Average	NCQA	Adult

HIV Viral Load

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries with at least one HIV viral load test during the measurement year	Denominator includes number of beneficiaries with a primary or secondary diagnosis of HIV during the measurement year or year prior	Informational Metric: w/PCMH State Average	Homegrown	Child/Adult

Childhood Immunization

Numerator	Denominator	Category	Measure Steward	Population Base
Numerator includes number of children age 2 who had vaccines by their second birthday	Denominator includes number of children age 2 during the measurement year	Informational Metric: w/PCMH State Average	NCQA	Child

Breast Cancer Screening

Numerator	Denominator	eQIM Informational Metric Reference	Category	Measure Steward	Population Base
Numerator includes number of women with one or more mammograms during the measurement year or the 15 months prior to the measurement year	Denominator includes number of women 52-74 years of age on the anchor (last) date of the measurement year	https://ecqi.healthit.gov/ecqm/measures/cms125v7 (All payer source)	Informational Metric: w/PCMH State Average	NCQA	Child

Cervical Cancer Screening

Numerator	Denominator	eCQM Informational Metric Reference	Category	Measure Steward	Population Base
<p>Numerator includes number of women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:</p> <ul style="list-style-type: none"> -Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test -Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test 	<p>Denominator includes number of women 24-64 years of age with a visit during the measurement period</p>	<p>https://ecqi.healthit.gov/ecqm/measures/cms124v7 (All payer source)</p>	<p>Informational Metric: w/PCMH State Average</p>	<p>NCQA; eCQM (Effective Clinical Care)</p>	<p>Adult</p>

Colorectal Cancer Screening

Numerator	Denominator	eCQM Informational Metric Reference	Category	Measure Steward	Population Base
<p>Numerator includes number of beneficiaries with one or more screenings for colorectal cancer. Any of the following meet criteria:</p> <p>Fecal occult blood test (FOBT) during the measurement year</p> <ul style="list-style-type: none"> ▪ Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year ▪ Colonoscopy during the measurement year or the nine years prior to the measurement year ▪ CT colonography during the measurement year or the four years prior to the measurement year ▪ FIT-DNA test during the measurement year or the two years prior to the measurement year 	<p>Denominator includes number of beneficiaries 51-75 years of age during the measurement year</p>	<p>https://ecqi.healthit.gov/ecqm/measures/cms130v7 (All payer source)</p>	<p>Informational Metric: w/PCMH State Average</p>	<p>NCQA; eCQM (Effective Clinical Care)</p>	<p>Adult</p>

Low Back Pain

Numerator	Denominator	eCQM Informational Metric Reference	Category	Measure Steward	Population Base
Numerator includes number of beneficiaries with an imaging study with a diagnosis of low back pain on the IESD or in the 28 days following the IESD	Denominator includes number of beneficiaries 18-50 years of age with outpatient or ED visit with principal diagnosis of low back pain	https://ecqi.healthit.gov/ecqm/measures/cms166v7 (All payer source)	Informational Metric: w/PCMH State Average	NCQA; eCQM (Efficiency and Cost Reduction Use of Healthcare Resources)	Adult

*This 2019 PCMH informational metric deviates from the above referenced specification in that it is not calculated as an inverse metric; rather it reflects the percentage of denominator beneficiaries who DID receive an imaging study within 28 days.

Technical Specifications for Care Categories as Displayed in the PCMH Report

Pharmacy

Description of Pharmacy category logic

- Claim Type is prescription drug claims
- OR Detail Procedure Code is one of HCPCS codes S4981 – S5014 (pharmacy)

Inpatient Facility

Description of Inpatient Facility category logic

- Claim Type is inpatient claims
- OR Detail Procedure Code is one of HCPCS codes S2400 – S2411 (fetal surgery)

Inpatient Professional

Description of Inpatient Professional category logic

- Claim Type is professional claims
- AND Detail Place Of Service is 21 (inpatient hospital)

Outpatient Professional

Description of Outpatient Professional category logic

- Professional claims from physician's office:
 - Claim Type is professional claims
 - AND Detail Place Of Service is 11
 - AND Detail Procedure Code is one of CPT codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
- Professional claims from outpatient clinic at hospital:
 - Claim Type is professional claims
 - AND Detail Place Of Service is 22 OR 24
 - AND Detail Procedure Code is one of CPT codes 99241 – 99245

It is not possible to distinguish outpatient clinic consult at hospital from consult in ED for a non-emergent visit. All consults are placed in outpatient professional. ASC consults are treated like consults at outpatient clinic in hospital.

- Professional claims from clinic:
 - Claim Type is professional claims
 - AND Detail Procedure Code is CPT T1015 with Detail Modifier U2
 - AND Detail Type Of Service is 1
 - AND Detail Place Of Service is 22
- Professional claims from nurse midwife:
 - Claim Type is professional claims
 - AND Detail Procedure Code is one of CPT codes 99201 – 99205, 99211 – 99215
 - AND Detail Place Of Service is 11
 - AND Provider Type is 30 OR 99. Provider Type is identified using the last two digits of the Billing Provider Number.
 - AND Provider Specialty is N2

Description of Outpatient Professional category logic

- Facility claim for clinic visit:
 - Claim Type is outpatient claims
 - AND Detail Procedure Code is CPT T1015 with Detail Modifier U1
 - AND Detail Type Of Service is G
- Facility claim for family planning:
 - Claim Type is outpatient claims
 - AND Detail Procedure Code is one of CPT codes 99401, 99402 with Detail Modifier UA
 - AND Detail Type Of Service is L
- Rural Health Center:
 - Claim Type is outpatient claims
 - AND Detail Revenue Code is one of revenue codes 0520, 0521, 0524, 0525
 - AND Provider Type is 29. Provider Type is identified using the last two digits of the Billing Provider Number.
- Federally Qualified Health Center:
 - Claim Type is professional
 - AND Detail Procedure Code is CPT T1015 with Detail Modifier U5
 - AND Provider Type is 49. Provider Type is identified using the last two digits of the Billing Provider Number.
- Certain visits within the 90000s:
 - Detail Place Of Service is NOT 21
 - AND Detail Procedure Code is one of the CPT codes from the following list:

CPT codes	Description
▪ 90281-90399	Immune Globulins, Serum or Recombinant Products
▪ 90460-90474	Immunization Administration for Vaccines/Toxoids
▪ 90476-90749	Vaccines, Toxoids

Description of Outpatient Professional category logic	
▪ 90801-90899	Psychiatry
▪ 90901-90911	Biofeedback
▪ 96040	Medical Genetics and Genetic Counseling Services
▪ 96101-96125	CNS Assessments/Tests (e.g., Neuro Cognitive)
▪ 96150-96165	Health and Behavior Assessment/Intervention
▪ 96360-96549	Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, Chemotherapy, Other Highly Complex Drugs
▪ 97001-97799	Physical Medicine and Rehabilitation
▪ 97802-97804	Medical Nutrition Therapy
▪ 97810-97814	Acupuncture
▪ 98925-98929	Osteopathic Manipulative Treatment
▪ 98940-98943	Chiropractic Manipulative Treatment
▪ 98960-98962	Education and Training for Patient Self-Management
▪ 98966-98969	Non-Face-to-Face Non-physician Services
▪ 99000-99091	Special Services, Procedures, and Reports
▪ 99500-99602	Home Health Procedures/Services
▪ 99605-99607	Medication Therapy Management Services
• HCPCS outpatient professional:	
○	Detail Procedure Code is one of HCPCS codes J0100 – J9999 (Injectables), S9208 – S9214 (Home management of medical conditions), H0004, H0046, H2001, H2012, H2015, H2017, T1502 (Psychiatric care)

Emergency Department

Description of Emergency Department category logic

- Professional claims from ED – true emergency:
 - Claim Type is professional claims
 - AND Detail Procedure Code is one of CPT codes 99281 – 99285, 99241 – 992451 (modifier exists, but not needed to identify claims), 99218 - 99220
 - AND Detail Place Of Service is 23
- Professional claims from ED – non-emergent visit:
 - Claim Type is professional claims
 - AND Detail Place Of Service is 22
 - AND one of the following:
 - Detail Procedure Code is CPT code T1015 with Detail Modifier U1
 - Detail Procedure Code is T1015 with no Detail Modifier AND Detail Type Of Service N OR 1
 - Detail Procedure Code is one of CPT codes 99218 – 99220 AND Detail Type Of Service 1
- Facilities claims from ED – emergent visit:
 - Claim Type is outpatient claims
 - AND Header Condition Code is 88
 - AND Detail Revenue Code is one of revenue codes 0450, 0622, 0250, 0760
- Facilities claims from ED – non-emergent visit:
 - Claim Type is outpatient claims
 - AND Detail Revenue Code is 0459 OR 0451 (this code corresponds to the assessment only)
 - AND Detail Place Of Service is 22
- Nurse midwife professional claim – non-emergent:
 - Claim Type is professional claims

Description of Emergency Department category logic

- AND Detail Procedure Code is CPT code T1015 with Detail Modifier U3, OR one of CPT codes 99218 – 99220
- AND Detail Type Of Service is 9
- AND Provider Specialty is N2
- AND Provider Type is 99. Provider Type is identified using the last two digits of the Billing Provider Number.
- AND Detail Place Of Service is 22
- Nurse midwife professional claim – emergent:
 - Claim Type is professional claims
 - AND Detail Procedure Code is one of CPT codes 99218 – 99220, 99281 – 99285
 - AND Detail Type Of Service is 9
 - AND Provider Specialty is N2
 - AND Provider Type is 99. Provider Type is identified using the last two digits of the Billing Provider Number.
 - AND Detail Place Of Service is 23

Outpatient Radiology / Outpatient Procedures

Description of Outpatient Radiology / Outpatient Procedures category logic

- Radiology claims:
 - Detail Procedure Code is one of the CPT codes in the 70000s
 - AND Detail Place Of Service is 11 OR 22 OR 24
- Radiology claims:
 - Detail Procedure Code is one of the CPT codes in the 70000s
 - AND Provider Type is 10 OR 01 OR 02 OR 03 OR 04 OR 05 OR 28. Provider Type is identified using the last two digits of the Billing Provider Number.

Description of Outpatient Radiology / Outpatient Procedures category logic

- HCPCs ultrasound:
 - Detail Procedure Code is CPT code S8055
 - Certain procedures within the 90000s:
 - Detail Place Of Service is NOT 21
 - AND Detail Procedure Code is one of the CPT codes from the following list:

CPT codes	Description
▪ 90935-90999	Dialysis
▪ 91010-91299	Gastroenterology
▪ 92002-92499	Ophthalmology
▪ 92502-92700	Special Otorhinolaryngology Services
▪ 92950-93799	Cardiovascular
▪ 93875-93990	Noninvasive Vascular Diagnostic Studies
▪ 94002-94799	Pulmonary
▪ 95004-95199	Allergy and Clinical Immunology
▪ 95250-95251	Endocrinology
▪ 95800-96020	Neurology and Neuromuscular Procedures
▪ 96567-96571	Photodynamic Therapy
▪ 96900-96999	Special Dermatological Procedures
▪ 99100-99140	Qualifying Circumstances for Anesthesia
▪ 99143-99150	Moderate (Conscious) Sedation
▪ 99170-99199	Other Services and Procedures

Outpatient Laboratory

Description of Outpatient Laboratory category logic

- Laboratory claims:
 - Detail Procedure Code is one of the CPT codes in the 80000s
 - AND Detail Place Of Service is 11 OR 22 OR 24
- Laboratory claims:
 - Detail Procedure Code is one of the CPT codes in the 80000s
 - AND Provider Type is 09 OR 01 OR 02 OR 03 OR 04 OR 05 OR 28 OR 29 OR 49. Provider Type is identified using the last two digits of the Billing Provider Number.
- HCPCS outpatient labs:
 - Detail Procedure Code is one of CPT codes Q0091, Q0111 – Q0115, S3625 – S3652

Outpatient Surgery

Description of Outpatient Surgery category logic

- Professional claims:
 - Claim Type is professional claims
 - AND Detail Procedure Code is one of CPT codes 10000 – 69999
 - AND Detail Place Of Service is NOT 21
 - AND Detail Type Of Service is 2 OR 8 OR A OR J
- Facility claim from hospital:
 - Claim Type is outpatient claims
 - AND Detail Procedure Code is one of CPT codes 10000-69999
 - AND Provider Type is 05 OR 28. Provider Type is identified using the last two digits of the Billing Provider Number.

Other

Description of Other category logic
<ul style="list-style-type: none">• All other claims