Change Log

Change no.	Details	Date of Addendum Update
1	▪ Metric 1 Technical Specifications: Added clarification to numerator criteria of two visits.	▪ 1/1/2018
2	▪ Informational Metric Low Back Pain Technical Specifications: Added clarification to description criteria of a “principal” diagnosis of low back pain and removed “not”.	▪ 7/24/2018
3	▪ Informational Metric HIV Viral Load: Added additional primary or secondary diagnosis codes	▪ 7/24/2018
4	▪ Costs excluded from per beneficiary cost of care calculation: Added ICD-9 codes to the exclusion list. Included a hyperlink to a spreadsheet of ICD-10 codes to improve readability. *(Updated due to HIC3 code movement in drug classes and CDC ICD-10 release – slides 5 and 6) **(Updated due to HIC3 code movement in drug classes – slide 5. Included a hyperlink to a spreadsheet of HIC3 codes.)	▪ 7/24/2018 *(5/6/2019) **(8/15/2019)
5	▪ Updated base years for benchmark calculations from 2013, 2014, and 2015 to 2014, 2015, and 2016	▪ 4/1/2019
6	▪ Metrics 9, 10, and 11: Updated due to HIC3 code movement in drug classes.	▪ 5/6/2019

211.000 Enrollment Eligibility

Attributed Beneficiary Requirement

- At this time, there are no changes to the attributed beneficiary requirement. The requirement remains as defined in the PCMH provider manual.

223.000 of the PCMH provider manual
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 history[1], a RUB score of 0 is assigned.

Per beneficiary amounts

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

RUB score	Per Beneficiary Per Month Amount
0	$1
1	$1
2	$3
3	$5
4	$10
5	$30

- For attributed beneficiaries with fewer than 6 months of claims history[1] (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).

Per beneficiary amounts

- 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 Shared Savings Incentive Payments Eligibility

Shared Savings beneficiary exclusions

- At this time, there are no changes to the definitions of those beneficiaries not counted toward the 5,000 attributed beneficiary requirement. The requirement remains as currently defined in the PCMH provider manual.

235.000 Per Beneficiary Cost of Care Calculation – Additional detail for cost adjustments for, and cost exclusions from, per beneficiary cost of care

Costs adjusted in per beneficiary cost of care calculation

Claim type S adjustment	Each inpatient stay (claim type S) is adjusted so that the total cost of the claim reflects a standard per diem of $850 x (covered days + uncovered days).
Claim type D adjustment	Allowed amounts on pharmacy costs (Claim type D), after excluding behavioral health (BH) pharmacy costs, will be multiplied by 50%.
Cost-based adjustment	The per beneficiary cost of care is adjusted by the amount of supplemental payment incentives, both positive and negative, made under selected Episodes of Care.
Cost-based exclusions	Costs in excess of $100,000 for any individual beneficiary
Claim type exclusions	Allowed amounts on claims of type C, K, T
Service provider type exclusions[1]	Allowed amounts associated with service provider types 6, 8, 11, 13, 15, 22, 23, 24, 31, 32, 36, 39, 41, 46, 50, 51, 52, 53, 54, 55, 56, 57, 63, 65, 67, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 82, 83, 84, 85, 86, 87, 88, 89, 90, 92, 93, 94, 95, 96, 97, 98

[1] Provider type exclusions are made at the detail-level of the claim (i.e., it is not the case that the whole claim is excluded; rather, the allowed amount(s) associated with the excluded provider type are excluded).

235.000 Per Beneficiary Cost of Care Calculation – Additional detail for cost adjustments for, and cost exclusions from, per beneficiary cost of care (Cont.)

Costs excluded from per beneficiary cost of care calculation

Revenue code based exclusions	Allowed amounts on any claim with revenue codes 0171, 0172, 0173, or 0174
HIC-3-based exclusions	Allowed amount on type D claims with the following HIC-3 codes: A4B; H21; H22; H2E; H2G; H2H; H2M; H2S; H2U; H2V; H2W; H2X; H33; H3W; H7B; H7C; H7D; H7E; H7J; H7O; H7P; H7R; H7S; H7T; H7U; H7X; H7Y; H7Z; H8M; H8O; H8P; H8W; H8Z; J5B (Link to spreadsheet of HIC-3 based exclusion codes)

235.000 Per Beneficiary Cost of Care Calculation – Additional detail for cost adjustments for, and cost exclusions from, per beneficiary cost of care (Cont.)

Costs excluded from per beneficiary cost of care calculation

ICD9 and ICD10-based claim Exclusions[1]	Allowed amounts on any claim with codes in primary diagnosis field with digits corresponding to: **ICD-9 (First three digits):** 291, 292, 293, 294 (Exclude codes 294.10, 294.11 and 294.20), 295, 296, 297, 298, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314 **ICD-10:** ICD-10 codes (Link to the ICD-10 codes)

[1] Exclusion only applies to claims for Tier 2 and 3 behavioral health clients.

236.000 Baseline and Benchmark Cost Calculations

Benchmark Trends

- At this time, current benchmark trends remain the same as described in the PCMH Provider Manual.

237.000 Shared Savings Incentive Payments Amounts

Minimum Shared Savings rate	▪ At this time, the minimum Shared Savings rate remains the same as is currently defined in the PCMH Provider Manual.
Thresholds	▪ At this time, the thresholds remain the same as currently defined in the PCMH Provider Manual.
Cost of Care Floor	▪ At this time, the Cost of Care floor remains the same as currently defined in the PCMH Provider Manual.

241.000 Activities Tracked for Practice Support – List of Activities for the 2018 Performance Period

- All PCMHs must meet 3-month activities by 3/31/18; 6-month activities by 6/30/18; and 12-month activities by 12/31/18.
- In order to be eligible for practice support, PCMHs must meet **all** activities by their specified deadlines.
- For information on remediation, please refer to the PCMH manual.

	Activity	3 Month	6 Month	12 Month
A	Identify top 10% of high-priority patients (including BH clients)	●		
B	Provide 24/7 access to care		●	
C	Document approach to expanding access to same-day appointments		●	
D	Capacity to receive direct e-messaging from the patients: Describe method of e-messaging used.		●	
E	Enrollment in the Arkansas Prescription Monitoring Program (PMP): All PCPs must enroll in PMP. Report method(s) used to monitor controlled substance prescriptions using PMP.		●	
F	Childhood/Adult Vaccination Practice Strategy			●
G	Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours			●

241.000 Activities Tracked for Practice Support – List of Activities for the 2018 Performance Period (Cont.)

- All PCMHs must meet 3-month activities by 3/31/18; 6-month activities by 6/30/18; and 12-month activities by 12/31/18.
- In order to be eligible for practice support, PCMHs must meet **all** activities by their specified deadlines.
- For information on remediation, please refer to the PCMH manual.

	Activity	3 Month	6 Month	12 Month
H	Incorporate e-prescribing into practice workflows			●
I	Care Plans for High Priority Beneficiaries: Create Care Plans			●
J	Patient Literacy Assessment Tool: Choose any health literacy tool and administer the screening to at least 50 beneficiaries (enrolled in the PCMH program) or their caregivers.			●
K	Ability to receive Patient Feedback: Indicate method used to receive patient feedback and describe how feedback is used to make improvements.			●
L	Care Instructions for HPB: Create and share with the patient an after-visit summary of the patient's visit. Include diagnosis, medication list, tests and results (if available), referrals (if applicable), and follow up instructions.			●
M	Medication Management: Describe the practices EHR reconciliation process. Document updates to active medication list in EHR for HPB			●
N	10-day follow-up after an acute inpatient hospital stay			●

241.000 Details on 2018 Activities Tracked for Practice Support

Using the provider portal, participating practices must complete and document the activities as described below by the deadline indicated. The reference point for the deadlines is the first day of the first calendar year in which the participating practice is enrolled in the PCMH program.

Activity name And deadline	Detailed description of activity
Activity A 3 months	Identify top 10% of high-priority beneficiaries (including behavioral health clients) using: 1. DMS patient panel data that ranks beneficiaries by risk at beginning of performance period and/or 2. The practice's patient-centered assessment to determine which beneficiaries are high-priority. Submit this list to DMS via the provider portal.
Activity B 6 months	Make available 24/7 access to care. 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. 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. The on-call professional must: 1. Provide information and instructions for treating emergency and non-emergency conditions, 2. Make appropriate referrals for non-emergency services and 3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.

241.000 Details on 2018 Activities Tracked for Practice Support (Cont.)

Activity name And deadline	Detailed description of activity
Activity B 6 months (Cont.)	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. PCPs must make the after-hours telephone number known by all beneficiaries by posting the after-hours number on all public entries to each site, and including the after-hours number on answering machine greetings. 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 6 months	Track same-day appointment requests by: 1. Using a tool to measure and monitor same-day appointment requests on a daily basis. 2. Recording fulfillment of same-day appointment requests. Provide a description of the tool used to track same-day appointment requests. 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 6 months	Indicate if the: ▪ Practice has the capacity to use electronic messaging to communicate with patients. ▪ Practice currently uses e-messaging, describe the method used. ▪ Messaging system is secure. ▪ Messaging system meets HIPAA guidelines. If the practices does not use e-messaging, indicate if a plan has been developed to implement the use of e-messaging 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

241.000 Details on 2018 Activities Tracked for Practice Support (Cont.)

Activity name And deadline	Detailed description of activity
Activity E 6 months	To meet this activity, all PCPs must enroll in the Arkansas Prescription Monitoring Program (PMP). ▪ Indicate if all PCPs in the practice are enrolled in the PMP. ▪ Describe the method used to monitor if providers check the PMP system before prescribing a controlled substance to a patient. 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 12 months	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. ▪ Indicate if there is an implemented process to identify vaccination gaps in care for both the pediatric and adult population. ▪ Indicate the ability to document historic immunization data into an EHR and review on each visit. ▪ Indicate the capability to submit data electronically to immunization registries or immunization information systems. 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 12 months	Indicate if the practice has joined SHARE. ▪ Indicate the ability to access inpatient discharge information via SHARE. ▪ Indicate the ability to access patient transfer information via SHARE. ▪ 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. 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

241.000 Details on 2018 Activities Tracked for Practice Support (Cont.)

Activity name And deadline	Detailed description of activity
Activity H 12 months	Indicate if the practice has incorporated e-prescribing into the practice workflow. ▪ Describe the technology platform used to e-prescribe. 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 12 months	At least 80% of high-priority beneficiaries whose care plan and/or note as contained in the medical record include the following four elements: 1. Documentation of the beneficiary's appropriate problem list ▪ The problem list should include any active, significant clinical condition (chronic and/or acute) ▪ Each visit related encounter should include a list of current problems (chronic and/or acute) 2. Instruction for follow-up ▪ The documentation should include the timing of a future follow-up visits (related to the problem) ▪ 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. ▪ 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. 3. Assessment of progress to date ▪ Documentation and assessment of each problem (stability or change of condition) ▪ 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 patients compliance with prescribed medication" is sufficient. ▪ If a problem noted in the problem list is no longer an active problem, a status such as "resolved" should be indicated. ▪ If a specialist follows the patient, the most recent findings should be documented, if available.

241.000 Details on 2018 Activities Tracked for Practice Support (Cont.)

Activity name And deadline	Detailed description of activity
Activity I 12 months (Cont.)	4. Updated at least twice within a 12 month period ▪ Documented update to the plan of care which would include active problems ▪ For new patient: initial care plan and one update (in person or phone call) ▪ 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. 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. Indicate if: ▪ At least 80% of the top 10% of high-priority beneficiaries have a care plan in the medical record. ▪ Each attested care plan includes all four required elements. For validation, 20% of the top 10% of high-priority beneficiaries will be randomly selected for review of care plans. To pass this activity, at least 80% of the care plans must include all four of the required elements stated above. 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 12 months	Choose any health literacy tool and administer the screening to at least 50 beneficiaries (enrolled in the PCMH program) or their caregivers. Returning practices should select 50 beneficiaries that have not had a health literacy screening. A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists. ▪ Provide an example of the tool used to assess health literacy. ▪ Provide a description of the overall results of the assessment. ▪ Develop and describe a plan to help low health literacy beneficiaries to understand instructions and education materials. 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.

241.000 Details on 2018 Activities Tracked for Practice Support (Cont.)

Activity name And deadline	Detailed description of activity
Activity K 12 months	Indicate if the practice has implemented a process to obtain feedback from the patients. Describe: ▪ The method used to obtain feedback from patients (surveys, suggestion box, advisory council, etc.). ▪ Who in the practice reviews the feedback. ▪ The capacity in which the feedback is shared with others within the practice (staff, providers). ▪ How the feedback is used to make improvements in the practice. 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 12 months	Compile relevant and actionable information including: diagnosis, medication list, tests and results (if available), referral information (if applicable), and follow up instructions. Create an after-visit summary of the information from patient's last visit. The patient will receive a copy of the after-visit summary based on the their preferred method of delivery. Methods by which a patient may choose to receive their after-visit summary include the following: ▪ The patient will receive a paper copy of the summary after their visit, prior to leaving the clinic. ▪ A copy of the summary will be mailed to the patient at the address listed in their record within three days of the visit, or completion of any lab test related to the visit. ▪ An electronic copy of the summary will be made available to the patient via a patient portal. 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.

241.000 Details on 2018 Activities Tracked for Practice Support (Cont.)

Activity name And deadline	Detailed description of activity
Activity M 12 months	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. ▪ Indicate if the medication list is updated on a timely basis from the last visit. ▪ Submit a short synopsis of the medication reconciliation process via the provider portal. 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 N 12 months	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. ▪ 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. ▪ 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. 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.

243.000 Quality Metrics Tracked for Shared Savings Incentive Payments and New Targets for the 2018 Performance Period

DMS assesses the following quality metrics tracked for shared savings incentive payments according to the targets below. The quality metrics are assessed only if the shared savings entity has at least the minimum number of attributed beneficiaries in the category described for the majority of the performance period. To receive a shared savings incentive payment, the shared savings 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 savings entity for voluntary pools and the petite pool. Quality Metrics for the default pool are assessed on an individual PCMH-level. Claims-based 2018 Quality Metric targets are set at a level no higher than the average performance of the shared savings entities in 2016.

Achievement of targets for Quality Metrics 14, 15, 16 and 17 can be calculated only if the required metric data is submitted through the AHIN Provider Portal. Failure to provide the required data by January 31, 2019 will cause failure to meet targets for Quality Metrics 14, 15, 16 and 17.

Metric	Description	Minimum Attributed Beneficiaries	2018 Target
Metric 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	>= 81
Metric 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	>= 58
Metric 3 Child Wellness	Percentage of beneficiaries 3-6 years of age who had one or more well-child visits during the measurement year	>= 25	>= 70

243.000 Quality Metrics Tracked for Shared Savings Incentive Payments and New Targets for the 2018 Performance Period

Metric	Description	Minimum Attributed Beneficiaries	2018 Target
Metric 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
Metric 5 Asthma	Percentage of beneficiaries 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed an asthma controller medication for at least 50% of their treatment period	>= 25	>= 47
Metric 6 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	>= 25	>= 40
Metric 7 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	<= 50
Metric 8 HbA1c	Percentage of diabetes beneficiaries who complete annual HbA1C, between 18-75 years of age	>= 25	>= 78
Metric 9 Diabetics on Statin	Percentage of diabetic beneficiaries between 40-75 years of age who are on statin medication	>= 25	>= 51

243.000 Quality Metrics Tracked for Shared Savings Incentive Payments and New Targets for the 2018 Performance Period

Metric	Description	Minimum Attributed Beneficiaries	2018 Target
Metric 10 Xanax	Percentage of beneficiaries age 18 years and older who were prescribed chronic Alprazolam (Xanax) during the measurement period	>= 25	<= 8
Metric 11 ODA	Percentage of beneficiaries at least 18 years of age as of the beginning of the measurement period with diabetes mellitus who had at least two prescriptions for a single oral diabetes agent or at least two prescriptions for multiple agents within a diabetes drug class and who have a Proportion of Days Covered (PDC) of at least 0.8 for at least one diabetes drug class during the measurement period (12 consecutive months)	>= 25	>= 33
Metric 12 Eye Exam	Percentage of diabetic beneficiaries 18-75 years of age who had an eye exam (retinal) performed	>= 25	>= 65
Metric 13 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	>= 25	>= 78

243.000 Quality Metrics Tracked for Shared Savings Incentive Payments and New Targets for the 2018 Performance Period

Metric	Description	Minimum Attributed Beneficiaries	2018 Target
Metric 14 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	>= 55
Metric 15 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	<= 38
Metric 16 BMI	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 (All payer source)	>= 25	>= 75
Metric 17 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	>= 70

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual

Metric 1 PCP Visits	▪ Denominator includes beneficiaries designated high priority by practices according to Section 241.000 and attributed to the PCMH for at least 6 months ▪ Numerator includes the number of those high priority beneficiaries with 2 of the following visit types and criteria with their attributed PCMH: – HCPCS: T1015 with modifier U2 – CPT: 99201 – 99205, 99211 – 99215, 99241 – 99245, 99381 – 99386, 99391 – 99396, 99403 – 99404 – Revenue codes: 0510, 0516, 0517, 0519 – 0521, 0523, 0526 – Includes claims performed at provider type: 29 (RHC), 49 (FQHC) – Count the beneficiaries that also had at least two visits where the provider was any PCP within their attributed PCMH or the visit was billed by the PCMH over the measurement period – The second visit will be counted if it is at least 14 calendar days after the first visit. – Uses modified continuous enrollment logic excluding gaps >90 days
Metric 2 Infant Wellness	▪ Denominator includes number of beneficiaries who turned 15 months old during the measurement year. ▪ Numerator includes number of beneficiaries who had 5 or more wellness visits during “first 15 months of life” (0–15 months). ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 3 Child Wellness	▪ Denominator includes number of beneficiaries 3–6 years old on the anchor (last) date of the measurement year ▪ Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx
Metric 4 Adolescent Wellness	▪ Denominator includes number of beneficiaries 12–20 years old on the anchor (last) date of the measurement year ▪ Numerator includes number of beneficiaries who had one or more wellness visits during the measurement year ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx
Metric 5 Asthma	▪ Denominator includes number of beneficiaries 5 to 64 years of age with a diagnosis of persistent asthma ▪ Numerator includes number of beneficiaries who achieved a PDC of at least 50% for their asthma controller medication during the measurement year ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 6 ADHD	▪ Denominator includes a modified HEDIS metric to determine the percent of beneficiaries 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 ▪ Numerator includes those ADHD beneficiaries who had one follow-up visit (per the HEDIS 2017 definition, available at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx) with any practitioner with prescribing authority during the 30 days following initiation of the prescription (any provider with one of the following individual provider types): – 01 – 03 – 08 – 17 – 58 – 79 – 22 with provider specialty X4 – 99 with provider specialty N2 – 95 with provider specialty NU or NV *Specialties must be active on the date of the follow-up visit*

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 7
URI

- 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.
  - Primary or secondary diagnosis codes:
    - ICD-9: 460, 464.00, 464.01, 464.10, 464.20, 465.0, 465.8, 465.9
    - ICD-10: J00, J04.0, J04.10, J04.2, J05.0, J06.0, J06.9
  - CPT or HCPCS codes:
    - CPT: 99201 - 99205, 99211 - 99215, 99241 - 99245, 99281 - 99285
    - HCPCS with Modifier(s): T1015 with modifier 1 = U1, T1015 with modifier 1 = U2, T1015 with modifier 1 = U5, T1015 with modifier 2 = U1, T1015 with modifier 2 = U2, T1015 with modifier 2 = U5, T1015 with modifier 3 = U1, T1015 with modifier 3 = U2, T1015 with modifier 3 = U5, T1015 with modifier 4 = U1, T1015 with modifier 4 = U2, T1015 with modifier 4 = U5, T1015 with modifiers 1-4 = 00 or blank
  - Events are determined by the beneficiaries that had a claim where the performing provider was any PCP within their attributed PCMH over the measurement period. Measurement period for Metric 7 is defined as the start of the performance period until 20 days prior to the end of the performance period.
  - Excludes beneficiaries that have at least two of the same comorbidity codes 365 days prior to the event end date as identified from the list of co-morbidities ICD-9 codes or ICD-10 codes
- 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.
  - AHFS: 081206, 081212, 081216, 081218, 081220, 081224, 081228, 082400, 084000, 812120, 812240

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 8 HbA1c	▪ Denominator includes number of beneficiaries 18 to 75 years old and identified as being diabetic through either claim or pharmacy data. ▪ Numerator includes number of beneficiaries 18 to 75 years old, identified as diabetic, who completed a HbA1c test during the measurement period. ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx
Metric 9 Diabetics on Statin	▪ Denominator includes number of beneficiaries 40–75 years old and identified as being diabetic through either claim or pharmacy data. ▪ Numerator counts the number of beneficiaries that also had at least one of the HIC3 codes to identify statin drugs: HIC3: C4A, M4D, M4I, M4J, M4L, M4M
Metric 10 Xanax	▪ Denominator includes beneficiaries 18 years and older for whom prescriptions were written during the measurement period – Pharmacy detail-level claim ▪ Numerator includes the number of beneficiaries that had four unique distinct dispensing events (a unique dispensing event is defined as pharmacy claim with minimum drug quantity ≥ 15mg on a different first date of service as another dispensing event) of drug with an ‘Alprazolam’ description under the HIC3 code during the measurement period – HIC3: H20 and contains the description of ‘Alprazolam’

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 11 ODA	▪ Denominator includes number of beneficiaries at least 18 years of age as of the beginning of the measurement period with diabetes mellitus and at least two prescriptions for a single oral diabetes agent or at least two prescriptions for multiple agents within a diabetes drug class during the measurement period (12 consecutive months). – For specifications used to identify diabetics, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx ▪ Numerator includes number of beneficiaries with diabetes mellitus with at least two prescriptions for oral diabetes agents, in any diabetes drug class, with a PDC of at least 0.8 for at least one diabetes drug class – HIC3 codes used for Oral Diabetic Agents: C4A, C4C, C4D, CDE, C4F, C4J, C4K, C4L, C4M, C4N, C4R, C4S, C4T, C4W ▪ For specifications, please see website for NQF specifications: http://www.qualityforum.org/QPS/QPSTool.aspx and measure search on “ODA”
Metric 12 Eye Exams	▪ Denominator includes number of beneficiaries 18 to 75 years old and identified as being diabetic through either claim or pharmacy data. ▪ Numerator includes number of beneficiaries 18 to 75 years old and identified as diabetic, who had an eye exam (retinal) performed. ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 13 Medication Therapy	▪ 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 ▪ 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 ▪ For specifications, please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx ▪ Metric 13 will not include the annual monitoring for beneficiaries on digoxin
Metric 14 Controlling BP	▪ 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) ▪ 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 period (All payer source) ▪ For specifications, please see website for CMS165v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 15 HbA1c Poor Control	▪ Denominator includes number of patients 18-75 years of age with diabetes with a visit during the measurement period (All payer source) ▪ Numerator includes number of patients whose most recent HbA1c level (performed during the measurement period) is >9.0% (All payer source) ▪ For specifications, please see website for CMS122v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep
Metric 16 BMI	▪ 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) ▪ Numerator includes number of patients who had a height, weight, and BMI percentile recorded during the measurement period (All payer source) ▪ For specifications, please see website for CMS155v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep

Technical specifications for quality metrics tracked for shared savings Incentive Payments as described in Section 243.000 of the PCMH Provider Manual (Cont.)

Metric 17 Tobacco Use	▪ 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) ▪ 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) ▪ For specifications, please see website for CMS138v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep

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. Cervical Cancer Screening, Colorectal Cancer Screening, Breast Cancer Screening, and Low Back Pain are collected as Meaningful Use metrics and are due through the PCMH provider portal by January 31, 2019.

Metric	Description
Informational Metric Inpatient Admissions	Number of inpatient admissions per 1000 attributed beneficiaries. ▪ Denominator includes number of beneficiaries with at least six months of attribution to the PCMH during the performance period ▪ Numerator includes number of inpatient stays among beneficiaries attributed to the PCMH (x 1000)
Informational Metric Thirty-Day Readmissions Rate	Percentage of thirty-day readmissions. ▪ Denominator includes number of hospitalizations for beneficiaries with at least six months of attribution to the PCMH during the performance period ▪ Numerator includes number of hospitalizations for each attributed beneficiary with an admit date within 30 days of discharge date
Informational Metric ED Visits	Number of billed emergency department visits per 1000 attributed beneficiaries. ▪ Denominator includes number of beneficiaries with at least six months of attribution to the PCMH during the performance period ▪ Numerator includes number of emergency department visits (definition of "emergency department" eligible claims can be found in the "emergency department" care category description) among beneficiaries attributed to the PCMH (x 1000)
Informational Metric ED Visits 6 or More	X of your attributed beneficiaries went to the emergency room 6 or more times this year. ▪ Number of attributed beneficiaries who went to the emergency room 6 or more times during the latest performance period

Informational Metrics (Cont.)

Metric	Description
Informational Metric Prescriptions	Number of prescriptions per attributed beneficiary per month. ▪ Denominator includes the total number of months that beneficiaries with six months of attribution to that PCMH were eligible for Medicaid during the performance period ▪ Numerator includes the total number of prescriptions filled for beneficiaries included in the denominator over the performance period
Informational Metric Imaging Services	Number of imaging services per 1000 attributed beneficiaries per month. ▪ Denominator is the total number of months that beneficiaries with six months of attribution to that PCMH were eligible for Medicaid during the performance period ▪ Numerator counts the total number of imaging services for beneficiaries included in the denominator, over the measurement period (x 1000)
Informational Metric 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. ▪ Denominator includes number of beneficiaries 18 years and older who are chronic Warfarin therapy ▪ Numerator includes number of beneficiaries who received an INR test during each 12 week interval

Informational Metrics (Cont.)

Metric	Description
Informational Metric Cervical CS	Percentage of women 21-64 years of age who were screened for cervical cancer based on either women age 21-64 who had cervical cytology performed every 3 years, or women age 30-64 who had cervical cytology/HPV co-testing performed every 5 years. ▪ Denominator includes number of women 24-64 years of age on the anchor (last) date during the measurement period ▪ Numerator includes number of women with one or more screenings for cervical cancer ▪ For specifications (claims-based), please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx ▪ For specifications (electronic health record based), please see website for CMS124v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep
Informational Metric Colorectal CS	Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer. ▪ Denominator includes number of beneficiaries 51-75 years of age on the anchor (last) date during the measurement year ▪ Numerator includes number of beneficiaries with one or more screenings for colorectal cancer ▪ For specifications (claims-based), please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx ▪ For specifications (electronic health record based), please see website for CMS130v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep

Informational Metrics (Cont.)

Metric	Description
Informational Metric BCS	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer. ▪ Denominator includes number of women 52-74 years of age on the anchor (last) date of the measurement year ▪ Numerator includes number of women with one or more mammograms during the measurement year or the 15 months prior to the measurement year ▪ For specifications (claims-based), please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx ▪ For specifications (electronic health record based), please see website for CMS125v6 Meaningful Use measurements: https://ecqi.healthit.gov/ep
Informational Metric 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. ▪ Denominator includes number of beneficiaries 18-50 years of age with outpatient or ED visit with principal diagnosis of low back pain ▪ 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 ▪ For specifications (claims-based), please see website for HEDIS 2017 measurements: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx ▪ For specifications (electronic health record based), please see website for CMS166v7 Meaningful Use measurements: https://ecqi.healthit.gov/ep

Informational Metrics (Cont.)

Metric	Description
Informational Metric HIV Viral Load	Percentage of beneficiaries with a diagnosis of HIV 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 – Primary or secondary diagnosis codes: ICD-9: V08, V6544, 042, 07953; ICD-10: Z21, Z717, B20, O98711, O98712, O98713, O98719, B9735 ▪ Numerator includes number of beneficiaries with at least one HIV viral load test during the measurement year ▪ CPT or HCPCS code: 87536, 87539
Informational Metric Inpatient Stay[1]	Number of beneficiaries who had an inpatient stay.

[1] Values represent inpatient stays within the calendar year only.

Technical specifications for care categories as displayed in the PCMH report

Care category	Description of category logic
Pharmacy	▪ *Claim Type* is prescription drug claims ▪ OR *Detail Procedure Code* is one of HCPCS codes S4981 – S5014 (pharmacy)
Inpatient facility	▪ *Claim Type* is inpatient claims ▪ OR *Detail Procedure Code* is one of HCPCS codes S2400 – S2411 (fetal surgery)
Inpatient professional	▪ *Claim Type* is professional claims ▪ AND *Detail Place Of Service* is 21 (inpatient hospital)
Outpatient professional	▪ 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

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Outpatient professional (Cont.)	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

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Outpatient professional (Cont.)	▪ 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.

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Outpatient professional (Cont.)	▪ 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
90801-90899	Psychiatry
90901-90911	Biofeedback
96040	Medical Genetics and Genetic Counseling Services
96101-96125	CNS Assessments/Tests (eg, 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 Nonphysician Services
99000-99091	Special Services, Procedures, and Reports
99500-99602	Home Health Procedures/Services
99605-99607	Medication Therapy Management Services

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Outpatient professional (Cont.)	▪ 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	▪ 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

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Emergency department (Cont.)	▪ 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 – 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

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Emergency department (Cont.)	▪ 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	▪ 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. ▪ HCPCs ultrasound – *Detail Procedure Code* is CPT code S8055

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Outpatient radiology / outpatient procedures (Cont.)	▪ 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 Otorhinolaryngologic 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

Technical specifications for care categories as displayed in the PCMH report (Cont.)

Care category	Description of category logic
Outpatient laboratory	▪ 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	▪ 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	▪ All other claims