QUALITYBLUE[SM]
A PHYSICIAN PAY-FOR-PERFORMANCE PROGRAM

ADMINISTRATIVE MANUAL
July 2007 REVISION

CONTENTS

Program Overview

Purpose

The Highmark Blue Shield Physician Quality Pay-for-Performance Program (Program) is designed to reward physicians who support Highmark's goal of providing accessible, efficient, high-quality health care.

Definition

QualityBLUE offers Primary Care Physicians (PCPs) (Family Practice, General Practice, Internal Medicine, and Pediatric specialties) an opportunity to earn an additional reimbursement for providing efficient, high-quality health care.

- QualityBLUE provides an extra payment, which is offered in addition to the fee schedule.
- QualityBLUE focuses primarily on quality measures that enhance the health care received by Highmark members.

Eligibility Requirements

Providers in the PremierBlue℠ Shield Network can qualify for participation in QualityBLUE once the provider executes the Medical Practice Quality Payment-for-Performance Program Agreement and meets the following preliminary eligibility requirements:

- Each provider in the practice participates in the PremierBlue Shield Network and the FreedomBlue℠ Medicare Advantage PPO Network.
- The practice is NaviNet® enabled.

If the practice meets the above requirements, data are run to determine if the practice meets the following additional eligibility requirements.

- The practice achieves a 12-month claims volume of $\geq$\$40,000 for Highmark members' paid evaluation and management (E&M) services, based on allowed fees.
- The practice achieves a 12-month average electronic claims submission rate of $\geq$75%.

Program Overview (continued)

Maintaining Eligibility

Claims volume and electronic claims submission will be evaluated quarterly and must be maintained at the levels noted on the previous page to ensure continued program eligibility and participation.

If any provider within a practice is cited by Highmark for network non-compliance or is in the sanctioning process, the practice is ineligible to participate in QualityBLUE. The three categories of non-compliance are:

- Quality-of-care concerns
- Unacceptable resource utilization
- Administrative non-compliance

The practice is ineligible to participate in QualityBLUE for at least one full quarter immediately following the citation or sanctioning date.

Measurement Methodology

Quality Measurement

Program payments are based on QualityBLUE quality performance measures shown in the table below.

Measure	Based on…	Max Score	Page(s)
Clinical Quality	Specialty-specific clinical quality categories and the corresponding quality measures	65	8-35
Generic/Brand Prescribing Patterns	The percent of prescriptions written for generic drugs	30	36-38
Member Access	Average office hours and non-traditional office hours	5	40-42
Best Practice	Clinical quality improvement activity	5	43-44
Electronic Health Records	Implementation of electronic health records	5	45-46
Electronic Prescribing	Implementation of electronic prescribing systems	5	47-48
Maximum Total Quality Score		**115**	

Ongoing Changes to QualityBLUE

QualityBLUE continually evolves to meet the needs of Highmark network practitioners. Accordingly, this program will be revised as changes occur. Providers will be notified of changes to QualityBLUE prior to the effective date of the change. Vehicles of such notification may include:

- Special Bulletin
- PRN
- Behind the Shield
- NaviNet
- Clinical Views

Payment Methodology

Minimum Quality Score

To be eligible for payments under the QualityBLUE program, the practice must have a quality score of 65 or higher.

Quality Program Payment Level Scoring

The quality payment amount is based on the total quality score. Refer to the Quality Program Incentive Level Scoring Table below.

Total Quality Score Range	Incentive Level Description	Program Payment Amount	
0-64	Non-Eligible	$0	No Program Payment
65-89	Low Level	$3	Per E&M Service
90-100	Medium Level	$6	Per E&M Service
Over 100	High Level	$9	Per E&M Service

Payment Methodology

QualityBLUE payment amounts will be added to your claims payments. The payment amounts will be itemized separately on the Provider *Explanation of Benefits (EOB).*

Payment Schedule

When your practice submits claims with eligible E&M services, the QualityBLUE bonus will be calculated at the time the claims are processed. (**Payments will be made based on incurred dates not paid dates.)**

Products

Claims for the following network products and members are included for payment in QualityBLUE:

PremierBlue SM Shield Network*

- SelectBlue® POS
- PPOBlue SM
- DirectBlue® PPO
- EPOBlue SM
- adultBasic PPO
- CHIP

Medicare Advantage PPO Network

- FreedomBlue SM PPO

*Claims for BlueCard® PPO members will also be included in Program payments.

Payment Methodology (continued)

Eligible E&M Codes

12 E&M categories and 106 individual codes are eligible for reimbursement under the Quality Pay-for-Performance Program. The table below lists all E&M codes included in QualityBLUE.

E&M Category Description and Range	Number of Codes	Individual Codes
Office/Outpatient 99201 – 99215	10	99201-99205 99211-99215
Office/Preventative 99381 – 99412	20	99381-99387 99391-99397 99401-99404 99411-99412
Hospital Visit 99221 – 99239	11	99221-99223 99231-99236, 99238-99239
Outpatient Consults 99241 – 99245	5	99241-99245
Hospital Consults 99251 – 99255	5	99251-99255
Newborn 99431 – 99440	6	99431-99433, 99435-99436 99440
Observation 99217 – 99220	4	99217-99220
Nursing Home 99304 – 99318	10	99304-99309, 99310 99315-99316, 99318
Critical Care 99289-99300	11	99289 99290-99296, 99298-99299, 99300
ER 99281 – 99288	6	99281-99285,99288
Rest Home 99324 – 99337	9	99324-99328 99334-99337
Home Visit 99341 – 99350	9	99341-99345, 99347-99350

Reporting

Program Results

Program results are generated quarterly and are based on:

- Clinical quality measures
- Generic/brand prescribing patterns
- Member access
- Best practices
- Electronic health records implementation
- Electronic prescribing implementation

All reports are available on NaviNet at the Plan Central page, under the QualityBLUE section on the menu.

Detail Report

The *QualityBLUE Fee for Service Detail Report* provides the outcomes for each of the QualityBLUE components and the incentive amount earned for the quarter. It varies in length based on the type of specialty or the detail used for each category, and the available data.

Patient Names Report

The *Clinical Quality Patient Names Report* is an adjunct to the Detail report above. It includes patient name, ID number, and date of birth and indicates (yes or no) whether or not the quality guideline was met. This report can be viewed online or opened as an Excel version. Opening in Excel allows it to be sorted for ease of follow-up with patients not meeting the guideline.

Trend Report

The *Incentive Trend Report/Fee-for-Service* provides two separate reports. The first report is a summary listing the QualityBLUE incentive payment, and the level and number of select E&M services for a 12-month reporting period.

The second report is a claim detail report listing claim number, procedure code, member ID, DOS, paid date, incentive level ($3, $6, or $9) based on the number of select E&M services, and the claim payment.

Note: No data will appear in this report until your practice has been in QualityBLUE for two quarters.

Clinical Quality Performance Measurement

Description

The clinical quality performance measures identify clinical quality categories that are specific to each PCP specialty and directly correspond to a quality guideline. This measure compares practitioners to others in their specialty.

Maximum Quality Score

The maximum quality score for this measure is 65 points.

Measurement Year

The measurement year is a moving 12-month span of demographic and/or illness occurrence data for Highmark members that may not correspond to a calendar or fiscal year. In general, the span will move by three months every measurement quarter. The 12-month span used is the same for all indicators. For information pertaining to specific clinical quality measures, refer to pages 13 through 35.

Measurement Year and Payment Quarter

Refer to the following chart to determine the measurement year for Clinical Quality performance measurement that corresponds to a particular payment quarter.

Payment Quarter	Measurement year
1st Quarter – January through March	October 1 through September 30
2nd Quarter – April through June	January 1 through December 31
3rd Quarter – July through September	April 1 through March 31
4th Quarter – October through December	July 1 through June 30

Measurement Period

In general, one to four years of paid claims data is used to determine if a clinical quality guideline is met. A few of the clinical categories have the same measurement period as the measurement year.

Clinical Quality Performance Measurement (continued)

Measurement Method

The method used to measure clinical quality is called the Clinical Quality Tool. The Clinical Quality Tool uses historical inpatient, outpatient, professional and pharmacy claims and encounter data for valid ICD-9-CM procedure and diagnostic codes, CPT-4/HCPCS procedure codes, revenue codes, DRGs and NDC numbers for drugs that reflect services that were performed, documented, and reported for applicable Highmark members.

ICD-9-CM, CPT or HCPCS codes that have been previously listed as valid for the numerator or denominator may be deleted from the coding manuals for 2006. Deleted codes may not appear in the code listings of the clinical category descriptions. However, because QualityBLUE uses historical claims data for some clinical quality measures, these codes are retained and captured when necessary to obtain past claims.

Quality Criteria

The expected quality guidelines are based on nationally accepted standards of preventive and disease oriented basic clinical care. The majority of these expected quality guidelines mirror HEDIS® as closely as possible. To measure the expected quality guideline for the inclusion in the numerator[1], a set of unique criteria must be met for each of the clinical categories. To assess what is included in the denominator[2], the review consists of unique enrollment and/or diagnostic requirements for each of the clinical categories.

[1]*The numerator can be defined as the patient population that met the expected quality guideline.*
[2]*The denominator describes the total patient population evaluated for the inclusion of the expected quality guideline.*

For information pertaining to specific clinical quality categories, refer to Quality Indicators section.

Calculating the Practice Quality %

The practice quality percentage is based on the claims assigned members in the practice treated per quality guidelines out of the total patients in the category.

Clinical Quality Performance Measurement (continued)

Calculating the Specialty Quality %

The specialty quality percentage is based on the claims assigned members in the specialty (Family Practice, Internal Medicine, Pediatrics) who were treated according to the quality guidelines out of the total patients in the category.

Calculating the Practice % to Specialty %

This result is a comparison of the practice quality % to specialty quality % and is reported at a maximum of 100%.

Calculating the Clinical Quality Score

There are three steps to calculate the clinical quality score:

Step	Action
1	Divide the practice quality percentage by the specialty quality percentage.
2	Compare the result to the earned points table to determine points earned for each clinical category. (Refer to the table below.) The total possible points for each specialty is as follows: • Internal Medicine – 9 • Family Practice – 14 • Pediatrics – 7
3	Multiply by the maximum clinical quality score (65) to determine the clinical quality score.

Earned Points Table

Refer to the following table to determine points earned for each clinical category.

Practice to Specialty Quality Percent	Points Earned
Greater than or equal to 100% of specialty average	1.00
Greater than or equal to 90% but less than 100%	0.50
Less than 90%	0.00

Clinical Quality Indicators

Clinical Quality Criteria by Category

The following table is a summary of each clinical quality indicator, which are further explained in the following section.

Category	Standard	FP/GP	IM	Peds
Acute Pharyngitis Testing	Throat culture or rapid strep test on day of, or 3 days prior to, or 3 days following the sole diagnosis of acute pharyngitis and antibiotic prescription	✓	✓	✓
Adolescent Well-Care	One or more E&M visits in each measurement year	✓		✓
Appropriate Asthma Medications	One or more prescriptions for appropriate asthma medications in the measurement year	✓	✓	✓
Atrial Fibrillation Annual Care	One E&M visit, and 6 prothrombin times (under age 75) within 365 days of diagnosis	✓	✓	
Beta-Blocker Treatment after AMI	Dispensed beta-blocker prescription within 7 days of discharge for AMI	✓	✓	
Breast Cancer Screening	One or more mammograms in measurement year or preceding year	✓	✓	
Cervical Cancer Screening	One or more PAP tests in measurement year or the 2 preceding years	✓	✓	
Cholesterol Management For Patients With Cardiovascular Conditions.	LDL-C test in the measurement year.	✓	✓	
Comprehensive Diabetes Care	One HbA1c, Screening for nephropathy, and LDL-C in the measurement year and one dilated retinal eye exam in the measurement year or the year prior	✓	✓	
CHF Advanced Annual Care	Two E&M visits and 1 BUN (blood urea nitrogen) and 1 creatinine and 1 potassium and 1 or more ACE inhibitor/beta blocker/ARB prescriptions within 365 days of diagnosis	✓	✓	
MMR Vaccination Status	Measles, mumps or rubella vaccination from ages 4 to 7	✓		✓
Varicella Vaccination Status	Varicella vaccination from ages 12 to 18 months	✓		✓
Well-Child Care-First 15 Months	Five well-child PCP visits in first 15 months of life	✓		✓
Well-Child Care-Age 3 to 6 years	One or more well-child visits in the measurement year	✓		✓

Future category additions or modifications

Please remember that upon review of the QualityBLUE program, Highmark may add or delete clinical indicators as deemed appropriate. Advance notice will be given.

Acute Pharyngitis Testing

Description

Identifies members with the sole diagnosis of acute pharyngitis who had appropriate testing done prior to antibiotics being prescribed.

Applies to

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Measurement Period

The measurement period is the current measurement year.

Denominator

•	Age	No age limit
•	Enrollment	Continuously enrolled 30 days preceding and 7 days following each time the diagnosis is documented during the measurement year
•	Diagnostic	Member must be identified with the sole diagnosis of acute pharyngitis in the measurement year and have an antibiotic dispensed within 7 days of diagnosis

Note: A member is counted in the denominator each time the requirements are met in the measurement year.

Denominator Codes

Codes that may be valid for the denominator are shown in the following table.

Note: NDC numbers are also used in the denominator to identify antibiotics.

ICD-9-CM Diagnosis Codes	
034.0	462
034.1	

Acute Pharyngitis Testing (continued)

Numerator

The numerator consists of those in the denominator who have a throat culture or rapid screening test on the day of diagnosis or in the period 3 days before or 3 days after the sole diagnosis of acute pharyngitis.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes		
87070	87081	87651
87071	87430	87652
87650		87880

Adolescent Well-Care

Description

Identifies adolescents who received comprehensive well-care visits.

Applies to

- Family Practice
- General Practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year.

Denominator

• Age	12-21 by the end of the measurement year
• Enrollment	Continuously enrolled through the measurement year – with no more than one break of up to 45 days in enrollment
• Membership	Member of the plan at the end of the measurement year
• Diagnostic	Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in the denominator who have had one or more adolescent well-care visits in the measurement year.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9-CM Diagnosis Codes		*CPT Codes*
V20.2	V70.5	99383-99385
V70.0	V70.6	99393-99395
V70.3	V70.8-V70.9	

Appropriate Asthma Medications

Description

Identifies members with persistent asthma who received appropriate asthma medications.

Applies to

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the preceding year.

Denominator

- Age — 5-56 by the end of the measurement year
- Enrollment — Continuously enrolled in the measurement year and the preceding year with no more than one break of up to 45 days in enrollment each year
- Membership — Member of the plan at the end of the measurement year
- Diagnosis — Identified with persistent asthma in both the measurement year and the preceding year

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Denominator Codes

To be included in the denominator, the coding combination listed below or a drug combination may be required on one or more claims.

Note: NDC numbers may also be used in the denominator

Combination Codes (ICD-9-CM Diagnosis Codes must be used with a Revenue Code or a CPT Code)					
ICD-9-CM Diagnosis Codes	*CPT Codes*			*Revenue Codes*	
493.00-493.92	99201-99205	99238-99239	99281-99285	100-114	456, 459,
	99211-99215	99241-99245	99291	119-124	510-519
	99217-99223	99251-99255	99341-99345	129-134	520-523
	99231-99233	99261-99263	99347-99350	139-144	526-529
	99401-99404		99382-99386	149-154	570-599
	99411-99412		99392-99396	159-169	720-729
	99420-99429			220-229	770-771
	99499			450-452	779
					981-983, 987

Appropriate Asthma Medications (continued)

Numerator

The numerator consists of those in the denominator who were dispensed one or more prescriptions for appropriate asthma medications in the measurement year.

Numerator Codes

Codes that may be valid for the numerator are those as indicated by NDC numbers for the following:

- Inhaled corticosteroids
- Nedocromil
- Cromolyn sodium
- Leukotriene modifiers
- Methylxanthines

Beta-Blocker Treatment Following AMI

Description

Identifies members who received beta-blocker prescriptions after hospitalization for AMI (acute myocardial infarction).

Applies to

- Family Practice
- General Practice
- Internal Medicine

Measurement Period

The measurement period is the current measurement year.

Denominator

• Age	35 and older by the end of the measurement year
• Enrollment	Continuously enrolled for 7 days after discharge for AMI with no breaks in enrollment
• Membership	Member of the plan in the measurement year
• Diagnosis	Identified as being hospitalized with AMI and discharged alive

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Denominator Codes

Codes that may be valid for the denominator are shown in the following table.

ICD-9-CM Diagnosis Codes			*DRG*
410.01	410.31	410.61	121
410.11	410.41	410.71	122
410.21	410.51	410.81	516
		410.91	526

Numerator

The numerator consists of those in the denominator who had a beta-blocker prescription filled on an ambulatory basis while hospitalized for AMI or within seven days of discharge.

Numerator Codes

Codes that may be valid for the numerator are NDC numbers for specified beta-blockers.

Breast Cancer Screening

Description

Identifies female members who had mammograms for breast cancer screening.

Applies to

- Family Practice
- General Practice
- Internal Medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Denominator

• Age	42-69 by the end of the measurement year
• Enrollment	Continuously enrolled in the measurement period with no more than one break of up to 45 days in enrollment each year
• Membership	Member of the plan at the end of the measurement year
• Diagnostic	Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in denominator who had one or more mammograms within the measurement period.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9-CM Codes		*CPT/HCPCS Codes*	*Revenue Codes*
Diagnosis	V76.11	76090-76092	
	V76.12	G0202	403
Procedure	87.36	G0204	
	87.37	G0206	
		77055-77057	

Cervical Cancer Screening

Description

Identifies female members who were screened for cervical cancer with Pap tests.

Applies to

- Family Practice
- General Practice
- Internal Medicine

Measurement Period

The measurement period is the current measurement year and the two preceding years.

Denominator

- Age — 24-64 in the measurement year
- Enrollment — Continuously enrolled in the measurement period with no more than one break of up to 45 days in enrollment each year
- Membership — Member of the plan at the end of the measurement year
- Diagnostic — Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in the denominator who received a Pap test within the measurement period.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9-CM Codes		*CPT/HCPCS Codes*		*Revenue Codes*
Diagnosis	V76.2	88141-88145	88174-88175	923
	V72.32	88147-88148	G0123-G0124	
	V71.31	88150, 88152-88155	G0143-G0145	
Procedure	91.46	88164-88167	P3000-P3001	
			G101, G141	
			G147-G148	
			Q0091	

Cholesterol Management for Patients with Cardiovascular Conditions

Description

Identifies members with an acute cardiovascular event or a diagnosis of ischemic vascular disease who were tested for cholesterol. A cardiovascular event is one of the following:

- AMI – acute myocardial infarction
- PTCA – percutaneous transluminal coronary angioplasty
- CABG – coronary artery bypass graft

Applies to

- Family Practice
- General Practice
- Internal Medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Denominator

• Age	18-75 by the end of the measurement year
• Enrollment	Continuously enrolled during the measurement year and the preceding year with no more than one break in enrollment of up to 45 days
• Diagnosis	Hospitalized and discharged alive after CV event in the year prior to the measurement year or with a visit and diagnosis of ischemic vascular disease in both the measurement year and the prior year.

Denominator Codes

Codes that may be valid for the denominator for AMI, PTCA or CABG are shown in the following table.

ICD-9-CM Diagnosis Codes		*ICD-9-CM Procedure Codes*	*CPT Codes*		*DRG*
410.01	410.51	00.66	33140	92980-92982	106-107
410.11	410.61	36.06-36.07	33510-33514	92984	109
410.21	410.71	36.09	33516-33519	92995	121-122
410.31	410.81	36.10-36.19	33521-33523	92996	516-518
410.41	410.91	36.2	33533-33536	33572	526-527
				35600	547-550
					555-558

Cholesterol Management for Patients with Cardiovascular Conditions (continued)

Denominator Codes

Codes that may be valid for the denominator for ischemic vascular disease are shown in the following table.

Combination Codes (ICD-9-CM Diagnosis codes must be combined with a CPT or Revenue Code)							
ICD-9-CM Diagnosis Codes			*CPT Codes*		*Revenue Codes*		*DRGs*
411.0-411.1	444.0-444.1		99201-99205	99411-99412	100-114	770-779	140
411.81	444.21-444.22		99211-99215	99420	119-124	982-983	559
411.89	444.81		99217-99223	99429	129-134	987	
413.0-413.1	444.89		99231-99233	99455-99456	139-144		
413.9	445.01-445.02		99238-99239	99499	149-154		
414.00-414.07	445.81		99241-99245		159-169		
429.2	445.89		99251-99255		190-199		
433.00-433.91			99261-99263		200-229		
434.00-434.11			99341-99357		510-523		
434.90-434.91	440.1		99384-99387		526-529		
414.8-414.89	440.20-440.24		99394-99397		570-599		
414.9-414.99	440.29		99401-99404		720-729		

Numerator

The numerator consists of those in the denominator who received an LDL-C (low-density lipoprotein cholesterol) test in the measurement year.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes	
80061	83704
83700-83701	83721

Comprehensive Adult Diabetes Care

Description

Identifies adult members who received annual comprehensive care for diabetes.

Applies to

- Family Practice
- General Practice
- Internal Medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Denominator

• Age	18-75 by the end of the measurement year
• Enrollment	Continuously enrolled through the measurement year with no more than one break of up to 45 days in enrollment
• Membership	Member of the plan at the end of the measurement year
• Diagnosis	Identified as diabetic in the measurement period

Denominator Codes

The coding combination shown on the table on the next page may be required on one or more claims for denominator inclusion.

Note: NDC numbers may also be used to identify insulin and hypoglycemic drugs.

Comprehensive Adult Diabetes Care (continued)

Combination Codes	*(ICD-9-CM Diagnosis codes must be combined with CPT or Revenue Code or DRG)*				
ICD-9-CM Diagnosis Codes	*CPT Codes*		*Revenue Codes*		*DRG*
250.00-250.93	92002-92014	99291	100-114	570-599	294
357.2	99201-99205	99304-993010	119-124	660-669	295
362.01-362.02	99211-99215	99315-99316	129-134	720-729	
366.41	99217-99223	99324-99328	139-144	770-779	
648.0-648.04	99231-99233	99334-99337	149-154	800-809	
	99238-99239	99341-99345	159-169	820-859	
	99241-99245	99384-99387	190-199	880-889	
	99251-99255	99394-99397	200-229	981-983	
	99261-99263	99401-99404	450-452	987	
	99411-99412	99455-99456	456		
	99281-99285	99420, 99429	459		
	99318	99499	510-529		
	99347-99350		550-559		

Numerator This category has four numerators with the same common denominator.

- Those in the denominator who received one HbA1c (glycosylated hemoglobin) during the measurement year.
- Those in the denominator who received one LDL-C (low-density liproprotein cholesterol) test during the measurement year.
- Those in the denominator who had evidence of nephropathy, or who were screened for it during the measurement year.
- Those in the denominator who had a retinal eye examination by an eye care professional during the measurement year or the preceding year.

Comprehensive Adult Diabetes Care (continued)

Numerator Codes Codes that may be valid for the numerators are shown in the following tables.

Numerator	*ICD-9-CM Diagnosis Codes*	*ICD-9-CM Procedure Codes*	*CPT Codes*	*Revenue Codes*	*DRG*
1-HbA1c			83036, 83037		
2-LDL-C			80061 83700-83701 83721, 83704	367	
3-Nephropathy*	250.40-250.43	39.27	36800, 36145	800-804	316
	403.00-404.93	39.42-39.43	36810, 36815	809	317
	405.01	39.53	36818-36821	820-825	
	405.11	39.93-39.95	50300, 50320	829-835	
	405.91	54.98	50340, 50360	839-845	
	581.81	55.4-55.69	82042-82044	849-855	
	582.9		84156, 90993	859-882	
	583.81		90920-90921	889	
	584.5-586		90924-90925		
	588.0-588.9		90935, 90937		
	753.0-753.19		90945, 90947		
	791.0		90989, 99512		
	V42.0		90997-90999		
	V45.1		36831-36833		
	V56.0-V56.8		50365, 50370		
			50380		
			90939-90940		
			G0257, S9339		`
			G0314-G0319		
			G0322-G0323		
			G0326-G0327		

NOTE:

*Any nephrologists' visit identified by specialty code may also be valid for this numerator.

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Comprehensive Adult Diabetes Care (continued)

Numerator Codes Codes that may be valid for the numerators are shown in the following table.

Numerator	*ICD-9-CM Diagnosis & Procedure Codes*	*CPT Codes*		
Eye Exam	14.11-14.59	67101	67218	92226, 92230
Must be	14.9	67105	67227	92235, 92240
completed by	95.02-95.04	67107	67228	92250, 92260
an eye care	95.11-95.12	67108	92002	92287
professional	95.16	67110	92004	99203-99205
	V72.0	67112	92012	99213-99215
		67141	92014	99242-99245
		67145	92018	S0620-S0621
		67208	92019	
		67210	92225	
		S3000	S0625	

Congestive Heart Failure Annual Care, Advanced Care

Description

Identifies members with congestive heart failure who received advanced annual care.

Applies to

- Family Practice
- General Practice
- Internal Medicine

Measurement Period

The measurement period is the current measurement year and the preceding year.

Denominator

• Age	No age limit
• Enrollment	Continuously enrolled in the measurement year and enrolled the preceding year with no more than one break of up to 45 days in enrollment
• Membership	Member of the plan in the measurement year
• Diagnosis	Identified with CHF in the year preceding the measurement year

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Denominator Codes

Codes that may be valid for the denominator are shown in the following table.

ICD-9-CM Diagnosis Codes			
398.91	404.01	404.91	428.30-428.33
402.01	404.03	428.0-428.1	428.40-428.43
402.11	404.11	428.20-428.23	428.9
402.91	404.13		

Congestive Heart Failure Annual Care, Advanced Care (continued)

The numerator consists of those in the denominator who received advanced care for CHF in the measurement year:

- 2 E&M visits and
- 1 BUN (blood urea nitrogen) test and
- 1 Potassium test and
- 1 Creatinine test and
- One or more defined prescriptions

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

Note: ACE inhibitors/beta-blockers/ARBs as indicated by NDC numbers may be valid for the numerator.

CPT Codes			
99318	80069	99201-99205	99341-99350
80048	82565	99211-99215	99381-99397
80050-80051	84132	99304-99310	99401-99404
80053	84520	99324-99328	99334-99337

MMR Vaccination Status

Description

Identifies members 7 years of age who received MMR (measles, mumps or rubella) vaccination from ages 4 to 7.

Applies to

- Family Practice
- General Practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the three preceding years.

Denominator

The member enrollment requirements are as follows:

- Age — Turned 7 years of age during the measurement year
- Enrollment — Continuously enrolled through the measurement year and the three preceding years with no more than one break of up to 45 days in enrollment each year
- Membership — Member of the plan at the end of the measurement year
- Diagnostic — Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in the denominator who have had a mumps, measles, or rubella vaccination or any combination of the three.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes	
90704	90707
90705	90708
90706	90709
90710	

Varicella Vaccination Status

Description

Identifies members 18 months of age who received a varicella vaccination between the ages of 12 to 18 months.

Applies to

- Family Practice
- General Practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the preceding six months.

Denominator

• Age	Turned 18 months of age during the measurement year
• Enrollment	Continuously enrolled through the measurement year with no more than one break of up to 45 days in enrollment
• Membership	Member of the plan at the end of the measurement year
• Diagnostic	Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in the denominator who had a varicella vaccination from 12-18 months of age.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

CPT Codes
90710
90716

Well-Child Care – First 15 Months

Description

Identifies children who received well-care visits in the first 15 months of life.

Applies to

- Family Practice
- General Practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year and the preceding 15 months.

Denominator

• Age	15 months of age reached by the end of the measurement year
• Enrollment	Continuously enrolled in the plan from 31 days to 15 months old with no more than one break of up to 45 days in enrollment
• Membership	Member of the plan at reaching 15 months
• Diagnostic	Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in the denominator who had 5 well-child PCP visits in the first 15 months of life.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9-CM Diagnosis Codes		*CPT Codes*
V20.2	V70.6	99381-99382
V70.0	V70.8	99391-99392
V70.3	V70.9	99432
V70.5		

Well-Child Care – 3, 4, 5, 6 Years Old

Description

Identifies 3, 4, 5 and 6-year-old children who received annual well-care visits.

Applies to

- Family Practice
- General Practice
- Pediatrics

Measurement Period

The measurement period is the current measurement year.

Denominator

• Age	3, 4, 5, or 6 by the end of the measurement year
• Enrollment	Continuously enrolled through the measurement year with no more than one break of up to 45 days in enrollment
• Membership	Member of the plan at the end of the measurement year
• Diagnostic	Not applicable

Denominator Codes

ICD-9-CM, CPT, or revenue codes are not required for the denominator.

Numerator

The numerator consists of those in the denominator who received one or more well-child visits in the measurement year.

Numerator Codes

Codes that may be valid for the numerator are shown in the following table.

ICD-9-CM Diagnosis Codes		*CPT Codes*
V20.2	V70.6	99382-99383
V70.0	V70.8	99392-99393
V70.3	V70.9	
V70.5		

Generic/Brand Prescribing Patterns

Description

The generic/brand prescribing quality performance measurement is based on the percentage of generic drugs prescribed compared to the total number of drugs prescribed.

Maximum Quality Score

The maximum quality score for this indicator is 30 points.

Network Specialty Average

The practice is compared to other practices in the same specialty to ensure equivalent measurement. The specialty averages are calculated on a quarterly basis for each primary care specialty: Family Practice, Interanl Medicine and Pediatrics, using a three month measurement period (see table below).

Points Vary

The points earned vary by specialty. Refer to the earned points tables on the next page.

Measurement Period

Network averages and practice scores are based on paid prescription claims for a moving three-month span.

Payment Period	Measurement Period
1st Quarter: January through March	July 1 through September 30
2nd Quarter: April through June	October 1 through December 31
3rd Quarter: July through September	January 1 through March 31
4th Quarter: October through December	April 1 through June 30

Generic/Brand Prescribing Patterns (continued)

Measurement Method

The measurement method is shown in the following table.

Step	Action
1	Total the number of prescriptions written for eligible members by each PCP within a practice.
2	Separate the number of all prescriptions into either the brand or generic category.
3	Calculate the percentage of generic prescriptions by dividing total generic prescriptions by the total prescriptions.
4	Compare the percentage to the PCP specialty average. Refer to the earned points tables to determine the score.

Earned Points Tables

Refer to table below to determine potential earned points..

Percentage	Points earned
+8% or more	30
+6 to +7%	27
+4 to -5%	24
+2 to +3%	22
-1 to +1%	20
-4 to -2%	16
-6 to -5%	12
-8 to -7%	8
Less than -8%	0

Member Access

Description

The member access measure is based on the practice's office hours and non-traditional hours.

Maximum Quality Score

The maximum quality score for this measure is 5.

Criteria

This table outlines the criteria for measuring access.

If the practice:	**The practice earns:**
Meets or exceeds the specialty average	3 points
Offers weekly non-traditional hours	2 points
Total Possible Points	**5 Points**

Measurement Period

Accessibility is measured quarterly. Specialty averages are derived at the start of each calendar year.

Measurement Method

The number of office hours that a practice is available to see patients is derived from an internal database containing information reported by each practice. The table on the following pages shows how office hours are calculated for solo and group practices.

Specialty Average

The practice is compared to other practices in the same specialty to ensure equivalent measurement. The specialty averages are derived at the start of each calendar year.

Definition: Non-traditional Hours

Non-traditional hours are those hours offered:

- Before 9 am, Monday through Friday
- After 5 pm, Monday through Friday
- Anytime on Saturday or Sunday

Member Access (continued)

Points Earned for Non-traditional Hours

The opportunity to earn points for offering non-traditional office hours differs according to whether you are a solo or group practice.

- Group practices must offer 6 or more non-traditional office hours
- Solo practices must offer 4 or more non-traditional office hours

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Important!

Our data is based on information that you provide, so if your practice office hours change, it's important to update Highmark. Mail or fax your information to Highmark on practice letterhead. Include the following information:

- Practice billing number
- Previous office hours at all locations
- New office hours at all locations

Fax to:
1-800-236-8641

or

Mail to:
Provider Data Services
PO Box 898842
Camp Hill, PA 17089-8842

or

Update your information via NaviNet

Note: Please contact your Provider Relations Representative in addition to sending the new information.

Member Access (continued)

Calculating Member Access This table shows how to determine office hours for solo and group practices.

Solo practice	Group practice
Add the number of office hours reported at all of the solo practitioner's offices each week to determine the weekly total. If any practice location's office hours overlap with another location, only the non-overlapping hours will be counted. Any locations with the same office hours will not be counted twice. If the solo practice has more than four non-traditional hours within a week, the practice will receive additional points.	Add the number of office hours reported at all of the group's offices each week to determine the weekly total. If any practice location's office hours overlap with another location, only the non-overlapping hours will be counted. Any locations with the same office hours will not be counted twice. If the group practice has more than six non-traditional hours within a week, the practice will receive additional points.
Example: *Dr. X - solo practitioner* Dr. X's Elm Street location is open Monday through Friday from 9 am to 4 pm and is closed one hour for lunch. (6 hrs/day x 5 days) = 30 hrs Dr. X's Oak Street location is open Monday through Friday from 5:30 pm to 7 pm. (1.5 hrs/day x 5 days) = 7.5 hrs Dr. X offers a total of 37.5 weekly hours that include 7.5 non-traditional hours.	Example: *Doctors Inc. - group practice* Doctors Inc.'s Maple Avenue location is open Monday through Thursday from 9 am to 5 pm. Doctors Inc.'s Aspen Avenue location is open Monday through Thursday from 12 pm to 8 pm and Friday from 9 am to 7 pm. Maple Ave- (8 hrs/day x 4 days) = 32 hrs Aspen Ave- (3 hrs/day x 4 days) = 12 hrs* (10 hrs/day x 1 day) = 10 hrs* *Only non-overlapping hours are counted at the Aspen Avenue location. Doctors Inc. offers a total of 54 weekly hours that include 14 non-traditional hours.

Best Practice – Office Based Initiative

Description

The Best Practice indicator awards points to practices that have created a clinical quality initiative to improve care offered in the office setting. The initiative must be different than the clinical quality indicators in the QualityBLUE program. A work plan must be submitted to Highmark for approval prior to implementation. A Highmark Medical Management Consultant or Provider Relations Representative can assist you with the process.

Highmark may also accept professional organization based certification or recognition activities as meeting the Best Practice requirement. A practice may complete either an office based or professional organization based activity.

Maximum Quality Score

The maximum quality score for this indicator is 5 points.

Criteria – Workplan Activity

All work plans submitted must include the following elements:

1. Definition of the specific problem addressed, describes the scope of the problem, the impact on patient care and why this specific problem was chosen as a quality initiative.

2. A baseline measurement of performance, which includes the method of calculation, the source of performance data and the time frame that applies to the baseline measurement.

3. A specific goal and outcome measure, targeted performance level and timeline/target date to reach targeted performance level.

4. A detailed descriptive list of action items/interventions. Each action item should have a target date for implementation and a person responsible for implementation.

5. Specific results or outcome measures relative to the targeted performance level as stated in item 3 above. A cost impact analysis of the change in performance may also be included.

Best Practice (continued)

Criteria-Workplan Activity (cnt)

6. Documentation of the overall clinical initiative, which includes all components above as well as a description of issues identified, lessons learned and an analysis on the impact the initiative had on patient care. the summary should indicate how the improvements will be sustained over time .

Measurement Method -Work Plan Initiative

Less than 4 work plan elements deemed complete earns 0 points.

Elements 1-4 above deemed complete earns 3 points
Elements 1-5 above deemed complete earns 4 points
Elements 1-6 above deemed complete earns 5 points

The Best Practice work plan must be completed within one year from the date of the first payment.

Criteria-Professional Organization Based Activity

In order for a practice to be eligible to receive five points using this method, all physicians in a practice must participate in and must document completion of the certification/recognition activity. Certification/recognition activities accepted by Highmark for consideration as meeting the Best Practice requirement include the following:

1. Performance in Practice (PIP) modules from the American Board of Family Medicine (ABFM)
2. Performance in Practice (PIP) activities from the American Board of Pediatrics (ABP)
3. Maintenance of Certification Practice Improvement Modules (PIMs) from the American Board of Internal Medicine (ABIM)
4. METRIC modules from the American Academy of Family Physicians (AAFP)
5. National committee for Quality Assurance (NCQA) Physician recognition Programs

Practices cannot receive partial credit for incomplete certification/recognition activities. Submit only final proof documentation from one of the above.

Best Practice (continued)

Measurement Method- Professional Organization Activity

Certification/recognition activities approved as complete earn 5 points for the Best Practice initiative.

Points awarded are retained for one year. To maintain the points for a Best Practice initiative, updated documentation of a new activity completed, must be received and approved prior to the end of the 12 month period for which the previously awarded points were applicable.

Submission Form

The *Best Practice Submission Form for Office-Based Activity* and the *Best Practice Submission From for Professional Organization Activity* can be found on the Highmark Blue Shield Provider Resource Center, under QualityBLUE Program through NaviNet or at www.highmarkblueshield.com.

Measurement Period

Work plans and professional organization activities will be measured quarterly.

The documentation submission deadlines are as follows:

1st Quarter	November 10
2nd Quarter	February 10
3rd Quarter	May 10
4th Quarter	August 10

Electronic Health Record Implementation

Description

The Electronic Health Record Implementation (EHR) indicator awards points to practices that have initiated the implementation of an electronic health record system (EHR). The EHR must include, at a minimum, a point-of-patient-contact, electronic documentation component.

Maximum Quality Score

The maximum quality score for this indicator is 5 points.

Criteria

Acceptable forms of proof include the Commitment to Purchase and Verification of Installation as follows:

- Copy of a signed vendor contract
- Copy of a purchase order
- Copy of a cancelled check
- Vendor letter acknowledging implementation
- Letter from practice verifying implementation by practice site
- Direct observation of the EHR system in place

Submission Form

The *Electronic Health Record Submission Form* can be found on the Highmark Blue Shield Provider Resource Center under QualityBLUE Program through NaviNet or via www.highmarkblueshield.com.

The documentation submission deadlines are as follows:

1st Quarter	November 10
2nd Quarter	February 10
3rd Quarter	May 10
4th Quarter	August 10

Electronic Health Record Implementation (continued)

Measurement Method

If the practice has not initiated any activity relative to the implementation of an EHR, zero points are earned.

If any of the following elements are documented and verified, the practice will earn 3 points:

- Commitment to purchase an EHR.
- Implementation of an EHR in at least one practice site.

If the practice has implemented an EHR in at least 50% of the total number of the practice sites, the practice will earn 5 points.

The implementation activity has two years for completion from the start date, which begins when 3 points are earned.

Measurement Period

Implementation activities will be measured quarterly.

Electronic Prescribing Implementation

Description

The Electronic Prescribing Implementation (eRx) indicator awards points to practices that have initiated the implementation of an electronic prescribing system.

Maximum Quality Score

The maximum quality score for this indicator is 5 points.

Criteria

Practices can earn 5 points if the selected vendor , software and version have been approved by the eHealth Collaborative. A complete listing of approved vendors and software solutions can be found at www.highmarkehealth.org.

If the practice selects a vendor not approved by the eHealth Collaborative, the software must meet all 7 requirements listed below to earn 5 points. If the software meets fewer than the 7 requirements, but meets at least elements 1-4, the practice will be awarded 3 points.

If a vendor other than those listed on the highmarkehealth website is used, verification of functionality is required. The practice must check all functional elements that apply to the existing or purchased eRx system. These include:

1. Electronically order medications from the patient's pharmacy of choice, record and maintain medical history
2. Identify drug-to-drug interactions at the point-of-care
3. Protect confidential patient information
4. Direct electronic connections with majority of pharmacies in the 49-county area to place prescription orders (faxing capabilities acceptable)
5. Communication with the Pharmacy Benefits Manager to show benefits and formulary information at the point-of-care
6. Communication with Pharmacy Benefits Manager to display dispensed medications prescribed by other physicians
7. Bi-direction electronic communications with pharmacies to respond to Pharmacy-initiated refill requests.

Electronic Prescribing (continued)

Acceptable Documentation

Acceptable forms of documentation include:

- A signed contract or purchase order,
- A monthly invoice from the vendor if the system has been long-standing

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Submission Form

The *eRx Data Submission/Review Form* can be found on the Highmark Blue Shield Provider Resource Center under QualityBLUE Program through NaviNet or via www.highmarkblueshield.com.

Measurement Period

The documentation submission deadlines are as follows:

1st Quarter	November 10
2nd Quarter	February 10
3rd Quarter	May 10
4th Quarter	August 10