EmblemHealth®

2022 EmblemHealth Quality Incentive Program

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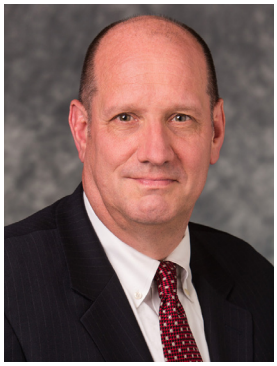


Message from our Chief Medical officer (CMO)

EmblemHealth is committed to helping our Members stay healthy, get well, and live better lives. We do this by giving Members access to high-quality care. Our provider network is an important partner in this effort, and we know you share the same commitment to delivering excellent care to your patients.

As our partner, you have an opportunity to earn incentive payments for the work you do. Our Quality Incentive Program will continue to focus on measures that impact and improve important health outcomes for Members.

Together, we can increase the quality of care for our members and improve their health outcomes.

EmblemHealth's Quality Incentive Program strives to improve the following key outcomes for our shared Members:

1. Engagement in Preventive Care
2. Coordination of Care
3. Chronic Disease Health Outcomes

EmblemHealth values investment in preventive care. Many important measures, including annual well visits, cancer screenings, and immunizations are included in our incentive program to ensure Members get the important care they need to stay healthy.

Coordination of care ensures our Members' needs are being met and improves the efficiency and safety of care delivery. We have included measures to focus on transition of care post-discharge and screening for social determinants of health.

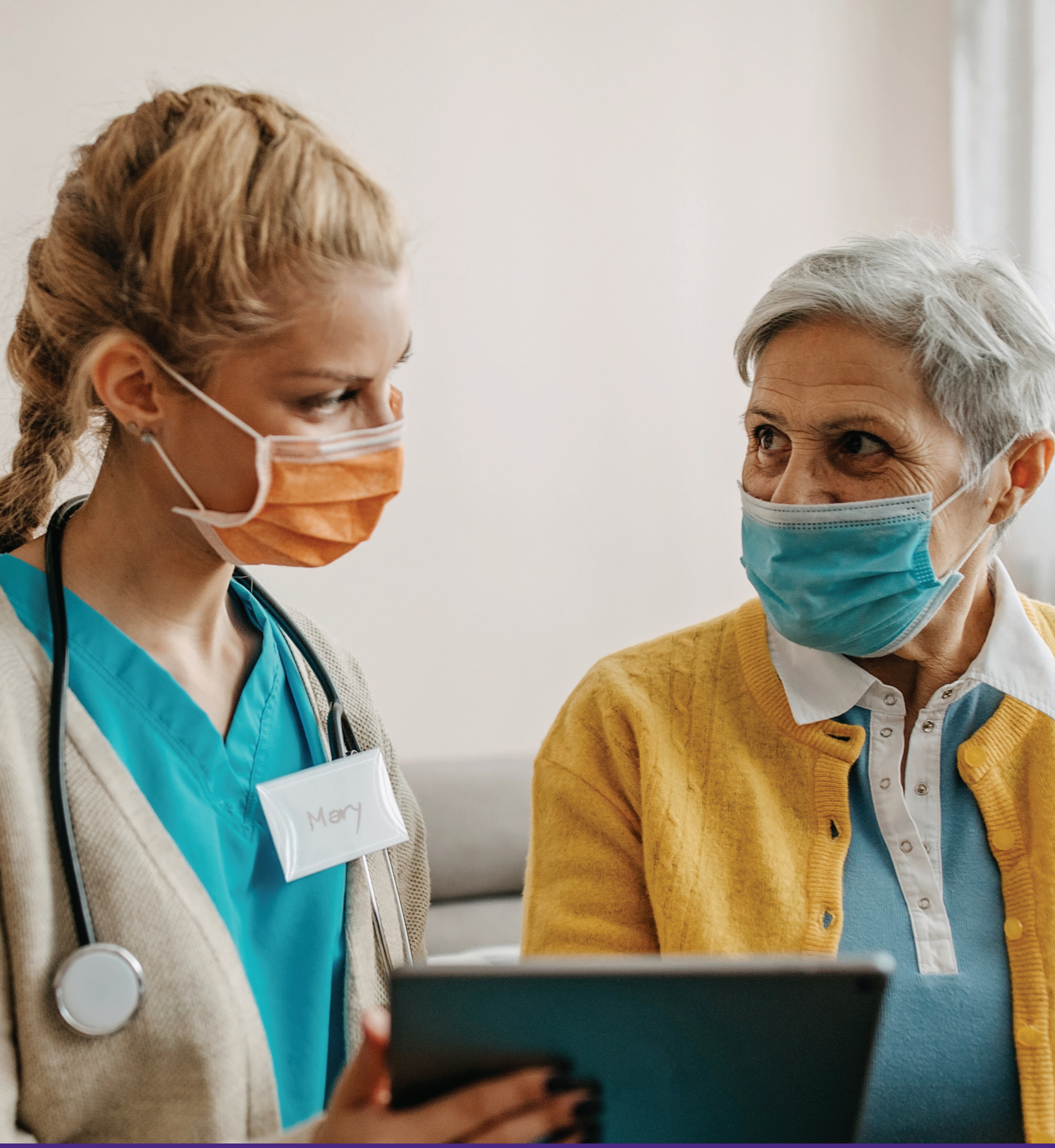
Lastly, it is very important to our health plan that our Members with chronic conditions, such as diabetes and heart disease, get the help and support they need to best manage their conditions. Therefore, we included measures in this program that aid Members with high-risk health conditions in obtaining the assessments and treatments they need to stay well.

While this program will help improve our quality scores, it also allows us to share the savings we gain by improving Member health and achieving quality benchmarks with you. We are grateful for your service and dedication in helping our Members receive the preventive and chronic care needed to keep them healthy. We hope that this program supports you in your efforts.

Sincerely,

Richard Dal Col, MD, MPH

Richard Dal Col, MD, MPH
Enterprise Chief Medical Officer



Program Overview

Measures

Providers will be evaluated on quality measures that are consistent with those published by the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (NYSDOH). For a list of measures that are included in the EmblemHealth Quality Incentive Program, as well as the related payment tiers, please see the charts included in this brochure.

Eligibility and Program Requirements

Primary care providers participate in the Quality Incentive Program at the Group level (indicated as a Med Center by EmblemHealth). Providers participating in a delegated risk arrangement with EmblemHealth are not eligible for the Quality Incentive Program. Additionally, there may be other value-based arrangements that prohibit participation. Please speak to your EmblemHealth Relationship Manager if you have questions about your eligibility for the Quality Incentive Program and existing contracts with EmblemHealth. Eligibility and payout determinations shall be made by EmblemHealth in its sole discretion.

Further qualifications for the EmblemHealth Quality Incentive Program include the following:

1. **Open Panel.** To participate, you must accept new membership.
2. **Membership Eligibility Criteria.** Providers at the Group level (indicated as a Med Center by EmblemHealth) must have at least 50 Members in Medicare or Medicaid/ Child Health Plus/HARP or QHP/Essential to be eligible. Providers must meet this membership threshold to be eligible for each respective Quality Incentive Program. Panel sizes as of Dec. 31, 2022 will be used to determine program eligibility and payout; only panels that meet the membership threshold will be eligible for payout. Additionally, there is now a minimum denominator size requirement in place for each measure (n=15).
3. **Access to EmblemHealth Provider Portal.** The portal will have information on the Quality Incentive Program, gaps in care, and your opportunity for incentive payments. If you do not have an account, you may sign up at **emblemhealth.com/ providers**.
4. **Medical Record Access and Supplemental Data.** You must provide EmblemHealth with access to medical records, at no charge, for quality reviews related to this Quality Incentive Program, as well as for HEDIS® and other regulatory initiatives. Additionally, you must supply supplemental data. Supplemental data should be submitted monthly, using the required format, via secure email to **quality_data@emblemhealth.com**. See additional training material from your EmblemHealth Relationship Manager on supplemental data templates and accepted measures.

Claims, encounter data, and supplemental data files for 2022 dates of service will be accepted until Feb. 28, 2023. Standard supplemental data files will also be accepted until Feb. 28, 2023 if a prior submission was received by Dec. 31, 2022. Non-standard data (medical records) may be submitted as proof of historical services, or services rendered by partnering or specialty providers only, to supplement compliance outside of claims and the standard supplemental file. The due date for non-standard data is December 31, 2022.

Measurement Period

Provider groups will be paid based on their panel membership as of Dec. 31, 2022. Payment is based on each eligible Member receiving services, or claims received for services rendered. Incentive payments will be made in July 2023. Payments will be sent to the IPA/managing entity to disburse and not to individual providers.

Benchmark Targets

EmblemHealth evaluates and updates our program, methodology, measurement sets, and benchmarks annually. In addition, we ensure that our various programs align with the quality of care standards defined by the National Committee for Quality Assurance (NCQA), NYSDOH's requirements, and EmblemHealth's quality improvement priorities.

EmblemHealth utilizes a benchmark methodology that uses a combination of the official NCQA/CMS industry-standard benchmarks for individual lines of business (LOBs), the historical performance of our plan, and clustering of our network performance. Those industry-standard benchmarks follow a clustering methodology where the benchmarks are created based on the results of the entire industry (every health plan). In some instances, EmblemHealth may adjust the industry-standard benchmarks to account for the plan and New York state performance. For example, EmblemHealth may slightly reduce the benchmark if we are currently below the 50th percentile. Similarly, if the plan is above the 75th percentile, we may slightly increase the benchmark to support continuous quality improvement while keeping our targets as achievable as possible. This methodology is used to define our benchmarks for each LOB.

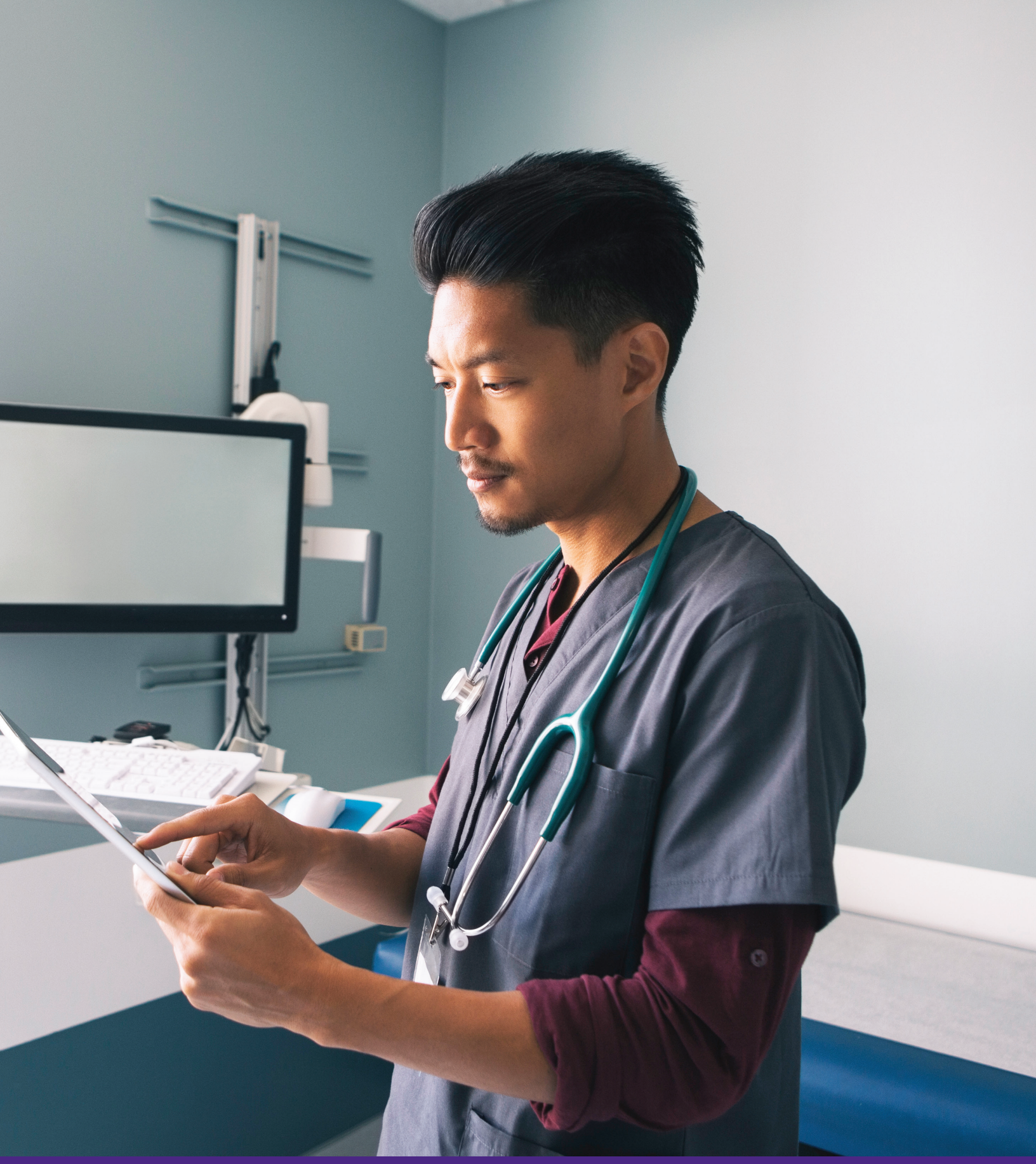
Additional Incentive Opportunities

1. **Access to Electronic Medical Records (EMRs)**
   EmblemHealth will offer an additional incentive for provider groups that grant remote access to their EMRs. Allowing this access can help increase your rates, as it will assist us in capturing services that are not typically billed for, or historically have trouble showing up through claims. Each EMR system access granted to EmblemHealth will result in a payment of $2,000. Please note this is a one-time incentive for new access only.

2. **Risk Adjustment Reimbursements**
   EmblemHealth is committed to assisting our providers in identifying and managing our Members' chronic conditions. This is also an area where providers can earn additional reimbursements.

   Through a web-based tool on our portal, providers can view Member alerts that show emerging chronic conditions and existing conditions that need to be treated. Providers can respond to the alert online and attach required progress notes and documentation. Providers who participate can receive a reimbursement for each compliant completed alert, and additional reimbursements if the compliant alerts are completed prior to July 1, 2022.

Reimbursement for each completed alert with attached progress notes
$150 per Medicare member, $40 per Medicaid member, $100 per NYSOH Marketplace member.



2022 Measures and Targets

Medicare:

MEASURES	INCENTIVE TARGETS[1]			INCENTIVE PAYMENT[2]		
	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
Prevention						
1. Annual Wellness Visit	55%	60%	65%	$50	$75	$100
2. Breast Cancer Screening	61%	69%	76%	$25	$50	$75
3. Colorectal Cancer Screening	62%	66%	71%	$25	$50	$75
4. Social Determinants of Health Screening	2%	5%	8%	$25	$50	$75
Chronic Disease Care						
5. Eye Exam for Patients with Diabetes	62%	66%	71%	$25	$50	$75
6. Blood Sugar Control for Patients with Diabetes	60%	66%	72%	$25	$50	$75
7. Controlling High Blood Pressure	40%	50%	59%	$25	$50	$75
Medication Adherence						
8. Medication Adherence for Diabetes	85%	87%	91%	$25	$50	$75
9. Medication Adherence for Hypertension	82%	87%	90%	$25	$50	$75
10. Medication Adherence for Cholesterol	83%	87%	91%	$25	$50	$75
Utilization						
11. All Cause Readmission	8%	6%	4%	$25	$50	$75
12. Transition of Care – Patient Engagement after Inpatient Discharge	75%	78%	83%	$25	$50	$75

[1] Targets are based on Medicare Cut Points published by CMS, historical performance data, and additional industry-standard benchmarks.

[2] Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

Medicaid/Child Health Plus/HARP:

MEASURES	INCENTIVE TARGETS[1]			INCENTIVE PAYMENTS[2]		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Adult Prevention						
1. Annual Wellness Visit	55%	60%	65%	$25	$50	$75
2. Breast Cancer Screening	70%	72%	73%	$25	$50	$75
3. Colorectal Cancer Screening	59%	64%	67%	$25	$50	$75
4. Social Determinants of Health Screening	2%	5%	8%	$25	$50	$75
5. Cervical Cancer Screening	73%	75%	77%	$25	$50	$75
6. Chlamydia Screening	72%	80%	82%	$25	$50	$75
Adult Chronic Disease Care						
7. Blood Sugar Control for Patients with Diabetes	70%	74%	75%	$25	$50	$75
8. Controlling High Blood Pressure	66%	69%	75%	$25	$50	$75
9. Asthma Medication Ratio	61%	63%	67%	$25	$50	$75
Pediatric Care						
10. Annual Dental Visit	64%	66%	69%	$25	$50	$75
11. Childhood Immunization Status (Combo 3)	80%	83%	85%	$25	$50	$75
12. Immunizations for Adolescents (Combo 2)	40%	44%	56%	$25	$50	$75
13. Lead Screening in Children	89%	92%	94%	$25	$50	$75
14. Well-Child Visits in the First 30 Months of Life — 6 or More Visits in the First 15 Months	71%	74%	77%	$50	$75	$100
15. Well-Child Visits in the First 30 Months of Life — 2 or More Visits in Months 15-30	75%	80%	85%	$25	$50	$75
16. Child and Adolescent Well-Care Visits	73%	79%	81%	$50	$75	$100
Behavioral Health						
17. Follow-up After Emergency Department Visit for Mental Illness – 7 day	61%	67%	78%	$25	$50	$75
Utilization						
18. All Cause Readmission	8%	6%	4%	$25	$50	$75
19. Transition of Care – Patient Engagement after Inpatient Discharge	65%	68%	73%	$25	$50	$75

[1] Targets are based on benchmarks published by NYSDOH, historical performance data, and additional industry-standard benchmarks.

[2] Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

Essential/QHP:

MEASURES	INCENTIVE TARGETS[1]			INCENTIVE PAYMENTS[2]		
	TIER 1	TIER 2	TIER 3	TIER 1	TIER 2	TIER 3
Adult Prevention						
1. Annual Wellness Visit	55%	60%	65%	$50	$75	$100
2. Breast Cancer Screening	69%	73%	77%	$25	$50	$75
3. Colorectal Cancer Screening	58%	66%	73%	$25	$50	$75
4. Cervical Cancer Screening	71%	76%	80%	$25	$50	$75
5. Chlamydia Screening	41%	49%	62%	$25	$50	$75
Adult Chronic Disease Care						
6. Blood Sugar Control for Patients with Diabetes	59%	69%	75%	$25	$50	$75
7. Eye Exam for Patients with Diabetes	43%	53%	63%	$25	$50	$75
8. Controlling High Blood Pressure	47%	60%	68%	$25	$50	$75
9. Asthma Medication Ratio	79%	83%	87%	$25	$50	$75

[1] Targets are based on Quality Compass benchmarks published by NCQA, historical performance data, and additional industry-standard benchmarks.

[2] Once the Tier 1, Tier 2, or Tier 3 target is achieved, the provider will earn the respective incentive payment for each eligible member who received appropriate treatment.

Summary of Changes from 2021 Program

EmblemHealth has made changes to enhance and simplify the overall structure of the Quality Incentive Program. New metrics that focus on key priorities for our Plan and Providers, such as utilization of care and social determinants of health, are now included in the program. We are focused on supporting our Provider relationships through ongoing reporting, targeted quality improvement efforts, and increased incentive opportunities.

Updated Eligibility Criteria

- Provider groups are now required to have an open panel with EmblemHealth.
- Panel size eligibility and payments will occur at the Group level instead of TIN level.
- Provided clarity around who can participate in the Quality Incentive Program.
- Minimum denominator size requirement now in place for each measure (n=15).

Added Incentive Opportunities:

- Granting EMR access is now an additional incentive opportunity.
- Added an Incentive Program for Essential/QHP Plan.

New Measures

Medicare

- Social Determinants of Health Screening
- All Cause Readmission
- Transition of Care – Patient Engagement After Inpatient Discharge

Medicaid

- Social Determinants of Health Screening
- All Cause Readmission
- Transition of Care – Patient Engagement After Inpatient Discharge
- Annual Wellness Visit
- Well-Child Visits in the First 30 Months of Life – 2 or more Visits in Months 15-30
- Follow-up After Emergency Department Visit for Mental Illness – 7 day

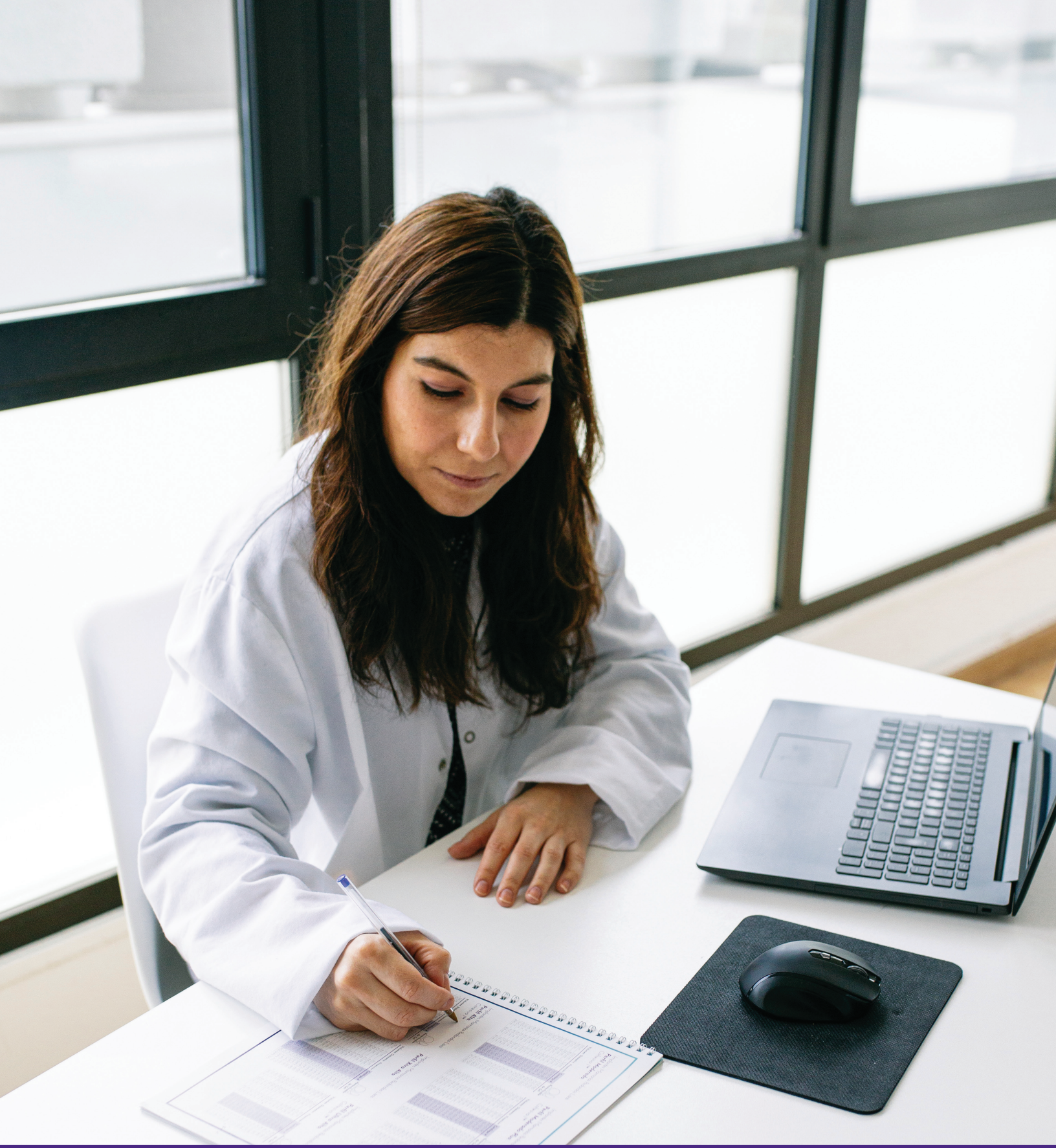
Removed Measures

Medicare

- Osteoporosis Management in Women Who Had a Fracture
- Statin Use in Persons with Diabetes

Medicaid

- Comprehensive Diabetes Care – Eye Exam
- Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%
- Use of Spirometry Testing in the Assessment of COPD
- Antidepressant Medication Management – Continuation Phase
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications
- Follow-up for Children Prescribed ADHD Medication – Initiation Phase
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing



Measure Specification and Tips

All Cause Readmission (PCR)

Percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Numerator/Denominator

Numerator: Acute inpatient or observation stay followed by an unplanned acute inpatient or observation readmission for any diagnosis within 30 days after discharge.

Denominator: Acute inpatient or observation stay with a discharge on or between 1/1 and 12/1 of the measurement period.

Exclusion Criteria:

- Died during the stay.
- Received hospice care at any time during the measurement period.
- Have a primary diagnosis of pregnancy.
- Had a primary diagnosis of a condition that originated in the perinatal period.

Additional Measure Information

- Post-discharge planning and care coordination are essential in preventing unplanned readmissions. This measure is based on discharge events.

Documentation Requirements

- Document medication reconciliation (discharge medications reconciled with current medication list) in the Member's medical record.

Telehealth

- Medication reconciliation may be done over the phone.

HELPFUL TIPS

- **Identify high utilizers and populations at risk.**
- **Partner with facility to improve care coordination upon discharge.**
- **Keep open appointments so patients can be seen promptly upon discharge.**
- **Work with Members and caregivers to ensure they understand discharge care plan.**
- **Obtain hospital discharge summary and use to schedule post-discharge appointments.**

Annual Dental Visit (ADV)

Percentage of Members ages 2-20 who have had at least one dental visit during the measurement year.

Numerator/Denominator

Numerator: Members in the denominator with one or more visits with a dental provider during the measurement year.

Denominator: Members ages 2-20 as of 12/31 of the measurement year.

Exclusion Criteria:

Received hospice care at any time during the measurement period.

Codes/Medications for Compliance

Applicable Codes
• CPT: 99188, 96152, 96154 • HCPCS: KO2.9

Applicable Codes
Telehealth CDT: • D1330: Oral Hygiene Instructions • D1310: Nutritional Counseling for control and prevention of oral disease • D1320: Tobacco Cessation

Documentation Requirements

- Any preventive service or procedure.

Telehealth

- Telehealth can be used for compliance. (D1330, D1310)

HELPFUL TIPS

- **Inform family of link of oral health to overall health.**
- **Encourage early routine visits, beginning at age 1 or first tooth eruption.**
- **Services must be performed by a dental practitioner (DDS, DMD, and certified and licensed dental hygienists).**
- **For many one-year-olds, visits will be counted because the specification includes children whose second birthday occurs during the measurement year.**
- **Teledentistry services utilized for dental emergencies will satisfy the ADV measure.**

Annual Wellness Visit (AWV)

The percentage of Members ages 18 and older who had an annual physical exam in the measurement year.

Numerator/Denominator

Numerator: Members in the denominator who had an annual wellness exam in the measurement year.

Denominator: Members ages 18 and older.

Additional Measure Information

Visit includes:

- Physical assessment
- Physical exam
- Laboratory tests
- Immunizations
- Preventive screening
- Referrals
- Counseling

Codes/Medications for Compliance

Applicable Codes
• HCPCS code of G0438- G0439, G0468
• CPT codes of 99402-99404, 99381-99387, 99391-99397

Documentation Requirements

- For Medicare, when billing an Annual Wellness Visit and Annual Physical Exam on the same day, use a modifier code of 25 for the Annual Physical Exam.

Telehealth

- Telehealth can be utilized.

HELPFUL TIPS

- **Send reminders prior to the scheduled appointment date.**
- **Consider expanding early morning, evening, and weekend hours.**
- **Utilize visit to address behavioral health needs and social determinants of health.**
- **Provide Members with personalized health advice.**
- **Can be done annually based on calendar year in conjunction with an Annual Physical Exam.**

Asthma Medication Ratio (AMR)

The percentage of Members ages 5-64 with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Numerator/Denominator

Numerator: Members in the denominator who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Denominator: Members ages 5-64 who have persistent asthma during both the measurement year and the year prior.

Exclusion Criteria:

Certain Members are excluded, e.g., if they have emphysema, COPD, or other respiratory conditions.

Codes/Medications for Compliance

Codes
• EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.

Medications (as applicable)
• Dyphylline-guaifenesin, Omalizumab, Dupilumab, Benralizumab, Mepolizumab, Reslizumab, Budesonide-formoterol, Fluticasone- salmeterol, Fluticasone-vilanterol, Formoterol-mometasone, Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone, Montelukast, Zafirlukast, Zileuton, Theophylline

Documentation Requirements

- Use all the medication lists in the Asthma Controller Medications table to identify asthma controller medications.

Telehealth

- *Note:* Members can get into denominator with telehealth visits. Use telehealth visits to review, document, and prescribe medication, when appropriate.

HELPFUL TIPS

- **Emphasize the important role of controller medications in managing symptoms.**
- **Demonstrate the correct way to use inhaled agents.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Consider more frequent visits until the patient is compliant.**
- **Encourage patients to receive their annual flu shot.**

Blood Sugar Control for Patients with Diabetes (HBD)

Percentage of Members ages 18-75 with Diabetes whose Hemoglobin A1c (HbA1c) was in control.

Numerator/Denominator

Numerator: HbA1c control (<9.0%): Members in the denominator who have an HbA1c level < 9.0% in the measurement year (most recent HbA1c level is used).

Denominator: Members between ages 18-75 who have diabetes.

Exclusion Criteria:

- Members receiving palliative/hospice care services or taking dementia medications.
- Members ages 66 and older with frailty and advanced illness; or enrolled in an Institutional Special Needs Plan or living long-term in an institution.

Codes/Medications for Compliance

Applicable Codes
• **HbA1c Lab Test:** • CPT: 83036, 83037 • HbA1c Test Results • CPT II: 3044F, 3046F, 3051F, 3052

Medications (as applicable)
• An extensive list of eligible medications can be found in the HEDIS MY 2020 & MY 2021 Vol.2 Technical Specifications for Health Plans document

Documentation Requirements

- Documentation must include screening results and date of service.

Telehealth

- Members can get into denominator with telehealth visits. Telehealth not sufficient to complete screening. Collect and document history of diabetes care.

HELPFUL TIPS

- **Emphasize importance of medication and insulin adherence in managing blood glucose.**
- **Adjust therapies to improve levels and recommend follow-up visits to monitor results.**
- **Create a diabetes checklist in your EMR/patient chart to monitor if patients are up to date with recommended screenings.**
- **The date of the latest A1c of the added "measurement" should be submitted. Identify early in the year who may need A1c testing, if results are high you have time for adjustments. Repeat to see if A1c improves.**

Breast Cancer Screening (BCS)

The percentage of women ages 50-74 years who have had a mammogram to screen for breast cancer.

Numerator/Denominator

Numerator: Members in the denominator who have had one or more mammograms between 10/1 two years prior to the measurement year and 12/31 of the measurement year.

Denominator: Women ages 52-74.

Exclusion Criteria:

Members with bilateral mastectomy and those receiving palliative care are excluded from the measure. Do not count MRIs, ultrasounds, or biopsies toward the numerator: Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

Codes/Medications for Compliance

Codes
• CPT: 77055-77057, 77061-77063, 77065-77067 • HCPCS: G0202, G0204, G0206
Exclusion Codes
• Z90.13, All palliative care codes
Medications (as applicable)
• N/A

Documentation Requirements

- Date of screening and results in medical record.

Telehealth

- Telehealth not sufficient to complete screening.
- Review and document history of screenings only.

HELPFUL TIPS

- **Highlight the importance of early detection.**
- **Discuss common fears about testing.**
- **Place a reminder in the patient's chart for when the next screening is due.**
- **Create "Standing Order" for ease of access.**
- **Share list of mammogram facilities.**

Cervical Cancer Screening (CCS)

The percentage of women ages 21-64 who had an appropriate screening for cervical cancer in the required time frame.

Numerator/Denominator

Numerator: Members in the denominator who have had one or more cervical cancer screenings in the time frame (depends on age).

Denominator: Women ages 24-64.

Exclusion Criteria:

- Members with hysterectomy with no residual cervix, cervical agenesis, or acquired absence of the cervix.
- Members receiving palliative care are not included in the measure.
- Members in hospice are excluded from the eligible population.

Codes/Medications for Compliance

Applicable Codes
Cervical Cytology
• CPT: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175
• HCPCS: G0123, G0124, G0141, G0143, G0144, G0147, G0148, P3000, P3001, Q0091
HPV Test Cw
• PT: 87620, 87621, 87622, 87624, 87625
• HCPCS: G0476w

Exclusion Codes
• Z90.710, Z90.712
• Palliative Care codes
• Hospice codes

Documentation Requirements

- Date cervical cytology was performed.
- Result or finding.

Additional Measure Information

- Women ages 21-64: Cervical cytology during the current year or two years prior to the current year (every three years).
- Women ages 30-64: Cervical cytology/HPV co-testing during the current year or four years prior to the current year (every five years).
- Optional Exclusion: Members with hysterectomy with no residual cervix, cervical agenesis, or acquired absence of the cervix and Members receiving palliative care are not included in the measure. Documentation of "vaginal hysterectomy" meets criteria for documentation of hysterectomy with no residual cervix.

Telehealth

- Telehealth not sufficient to complete screening.
- Review and document history of screenings only.

HELPFUL TIPS

- **Highlight the importance of early detection.**
- **Place a reminder in the patient's chart for when the next screening is due.**
- **Conduct test at other visits, e.g., sick visits if opportunity presents.**
- **If patient has had hysterectomy, document and code for this condition.**
- **Flag charts of patients after screening is performed to ensure timely follow-up of results and data capture for compliance.**

Child and Adolescent Well-Care Visits (WCV)

The percentage of Members ages 3-21 who had at least one comprehensive well-care visit with a PCP or OB/GYN provider during the measurement year.

Numerator/Denominator

Numerator: Members in the denominator with one or more well-care visits during the measurement year.

Denominator: Members ages 3-21 as of 12/31 of the measurement year.

Exclusion Criteria:

Received hospice care at any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
Well-Care Visit • CPT: 99381-99385, 99391-99395, 99461 • HCPCS: G0438, G0439, S0302 ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Additional Measure Information

- Replaces W34 measure.

Telehealth

- Telehealth can be used for compliance. (Appropriate CPT needs to be submitted with GT modifier.)

Documentation Requirements

- Well-child visits must occur with PCP but does not have to be the PCP assigned.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (**https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**).

HELPFUL TIPS

- **Conduct or schedule well-care visits when patients present for illnesses, or other events– add modifier for separate and distinct services.**
- **Document all the required elements of a well-child visit.**
- **Pre-schedule the next well-visit before the patient leaves the office. Relay the importance of returning even if the child is doing fine.**
- **Provide health education/ anticipatory guidance.**
- **Take an opportunity to check and administer vaccines that are due at every visit.**

Childhood Immunization Status (CIS) — Combo 3

The percentage of children who have received all recommended vaccines by their 2nd birthday.

Numerator/Denominator

Numerator: Members in the denominator who have had the following vaccines by their 2nd birthday:

- 4 diphtheria/tetanus/acellular pertussis (DTaP) vaccines.
- 3 polio (IPV) vaccines.
- 1 measles/mumps/rubella (MMR) vaccine†
- 3 haemophilus influenza type B (HiB) vaccines
- 3 hepatitis B (HepB) vaccines
- 1 chicken pox (VZV) vaccine†
- 4 pneumococcal conjugate (PCV) vaccines

†Must occur between the child's 1st and 2nd birthday.

Denominator: Children turning age 2 during the measurement year.

Exclusion Criteria:

- Members using hospice services any time during the measurement year.
- Members who had a severe combined immunodeficiency, severe disorder of the immune system, HIV, malignant neoplasm of lymphatic tissue, or intussusception on or before their 2nd birthday.

Codes/Medications for Compliance

Applicable Codes
• DTaP: CPT: 90698, 90700, 90723 • IPV: CPT: 90698, 90713, 90723 • MMR: CPT: 90707, 90710 • HIB: CPT: 90644, 90647, 90648, 90698, 90748 • Hep B: CPT: 90723, 90740, 90744, 90747, 90748; • HCPCS: G0010 • VZV: CPT: 90710, 90716 • Pneumococcal: CPT: 90670; HCPCS: G0009

Documentation Requirements

- Collect and document history of immunizations. Documentation must include vaccine name and date administered.
- Children who had a contraindication for a specific vaccine (Ex.: anaphylactic reaction, immunodeficiency) are excluded.

Telehealth

- Telehealth not sufficient to complete immunizations.

HELPFUL TIPS

- **Begin vaccination conversations as early as prenatal appointments.**
- **Present vaccination as the default option, presuming parents will immunize.**
- **Provide parents with records of their children's immunizations and ask them to bring the record to each visit.**
- **Schedule the next appointment at time of checkout and use every office visit as an opportunity to vaccinate.**

Chlamydia Screening (CHL)

The percentage of women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia during the current year.

Numerator/Denominator

Numerator: Members in the denominator who have had a chlamydia screening in the current year.

Denominator: Women ages 16-24 identified as sexually active.

Exclusion Criteria:

- Members in hospice are excluded from the eligible population.
- Exclude Members who qualified for the denominator based on a pregnancy test alone and who meet either of the following: pregnancy test and a prescription for Isotretinoin or pregnancy test and an x-ray on the date of pregnancy test or six days after.

Codes/Medications for Compliance

Applicable Codes
Chlamydia Culture • CPT: 87110, 87270, 87320, 87490-87492, 87810, 87491

Exclusion Codes
All Hospice codes • CPT: 81025, 84702, 84703 • Diagnostic Radiology
Medications (as applicable)
• Contraceptive Medications as indicated in the HEDIS Medications list.

Additional Measure Information

- Women are identified as sexually active through claims/encounter and pharmacy data.

Documentation Requirements

- Date of test and results.

Telehealth

- Telehealth not sufficient to complete screening.
- Review and document history of screenings (must include screening result) only.

HELPFUL TIPS

- **Discuss safe sex practices and sexually transmitted diseases with patients.**
- **Highlight the importance of early detection.**
- **Review/confirm all preventive health screenings at each visit.**
- **Consider universal urine screening approach as a method to help prevent gaps in test and unidentified sexually active women.**

Colorectal Cancer Screening (COL)

The percentage of Members ages 50-75 who have had an appropriate screening for colorectal cancer in required time frame (depends on screening type).

Numerator/Denominator

Numerator: Members in the denominator with colorectal cancer screening in required time frame (varies by type of screening).

Additional Numerator Specifications:

- Fecal occult blood test (FOBT): current year.
- Flexible sigmoidoscopy: current year or 4 years prior (5 years).
- Colonoscopy: current year or 9 years prior (10 years).
- CT colonography: current year or 4 years prior (5 years).
- FIT-DNA: current year or 2 years prior (3 years).

Denominator: Members between ages 50-75.

Exclusion Criteria:

- Members with evidence of colorectal cancer or total colectomy and Members receiving palliative care are not included in the measure.

Codes/Medications for Compliance

Applicable Codes
Flexible Sigmoidoscopy:
• CPT: 45330-45335, 45337-45338, 45340- 45342, 45346-45347, 45349-45350; HCPCS: G0104; ICD9: 45.24

Applicable Codes
Colonoscopy:
• CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121 ICD9: 45.22, 45.23, 45.25, 45.42, 45.43
CT Colonography:
• CPT: 74261-74263
FIT-DNA:
• CPT: 81528; HCPCS: G0464
FOBT:
• CPT: 82270, 82274; HCPCS: G0328

Documentation Requirements

- Test name
- Date of test
- Result

Telehealth

- Telehealth not sufficient to complete screening. Collect and document history of screenings.

HELPFUL TIPS

- **Ensure that the Member's history is updated annually regarding prior colorectal cancer screening test(s).**
- **Discuss all options for screening including FOBT for Members who may not want colonoscopy.**
- **Provide order for testing.**
- **Highlight the importance of early detection.**
- **Review Review/ confirm all preventive health screenings at each visit.**
- **Place a reminder in the patient's chart for when the next screening is due.**

Controlling High Blood Pressure (CBP)

The percentage of Members ages 18-85 diagnosed with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator/Denominator

Numerator: Members in the denominator with a blood pressure reading of <140/90 Hg during the measurement year.

Denominator: Members ages 18-85 diagnosed with hypertension at two or more visits between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Exclusion Criteria:

- Members in hospice or receiving palliative care are excluded from the measure.

Codes/Medications for Compliance

Applicable Codes
Diastolic Blood Pressure: • CPT II: 3078F, 3079F, 3080F **Systolic Blood Pressure:** • CPT II: 3074F, 3075F, 3077F

Additional Measure Information

- Blood pressure readings that are Member-reported and/or taken with remote digital monitoring device are reportable.

Documentation Requirements

- Utilize the most recent blood pressure (BP) reading during the measurement year, which must be taken on or after second diagnosis of hypertension

Telehealth

- Members can get into denominator with telehealth type visits. Automatic BP readings taken during a telehealth visit, telephone visit, e-visit, or virtual check-in can be used for compliance.

HELPFUL TIPS

- **If blood pressure reading is high when the patient arrives, recheck at the end of the visit.**
- **If patient is hypertensive during visit, review medication history and consider modifying treatment plan.**
- **Schedule a follow-up visit once treatment plan has been initiated.**
- **Record exact systolic and diastolic values; do not round a result.**

Eye Exam for Patient with Diabetes (EED)

The percentage of Members ages 18-75 with diabetes (type 1 or 2) who had a retinal eye exam.

Numerator/Denominator

Numerator: Members in the denominator who had a retinal or dilated eye exam during the measurement year or a negative retinal eye or dilated eye exam (negative for retinopathy) in the measurement year or year prior.

Denominator: Members between ages 18-75 who have diabetes.

Exclusion Criteria:

- Members who do not have a diagnosis of diabetes.
- Members in hospice or using hospice services any time during the measurement year.
- Members receiving palliative care.

Codes/Medications for Compliance

Applicable Codes
Diabetic Retinal Screening: • CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213, 99215, 99242-99245. • HCPCS: S0620, S0621, S3000

Applicable Codes
Eye Exam with Retinopathy: • CPT II: 2022F, 2024F, 2026F **Eye Exam Without Retinopathy:** • CPT II: 2023F, 2025F, 2033F **Diabetic Retinal Screening Negative:** • CPT II: 3072F

Documentation Requirements

- Documentation must include screening results and date of service.
- Eye exams can be performed by an optometrist or ophthalmologist.
- A bilateral eye enucleation counts for numerator compliance.
- Eye exams read by artificial intelligence system count for compliance.

Telehealth

- Members can get into denominator with telehealth visits. Telehealth not sufficient to complete screening. Collect and document history of diabetes care.

HELPFUL TIPS

- **Explain the risk of impaired vision caused by diabetes and the importance of retinal eye exams.**
- **Ensure results are read by optometrist or ophthalmologist.**
- **Create a diabetes checklist in your EMR/ patient chart to monitor if patients are up to date with recommended screenings.**

Follow-up After Emergency Department Visit for Mental Illness (FUM)

The percentage of emergency department (ED) visits for Members ages 6 or older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness.

Numerator/Denominator

Numerator: 7-Day Follow Up: Members in the denominator with a follow-up visit with any provider, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit.

Denominator: Emergency room visit with a principal diagnosis of mental illness or intentional self-harm.

Exclusion Criteria:

- Members receiving hospice or palliative care are excluded from the measure.

Codes/Medications for Compliance

Applicable Codes
Visit with Principal Mental Health Diagnosis OR with Principal Intentional Self-Harm Diagnosis:
• CPT: 98960-98962, 99078, 99201-99205,99211-99215, 99241-99245,99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510
• HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013- H2020, T1015
• UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983

Applicable Codes
E-Visit or Virtual Check-In
• CPT: 98969-98972, 99421-99423, 99444, 99457
• HCPCS: G0071, G2010, G2012, G2061-G2063
Telephone Visits:
• CPT: 98966-98968, 99441-99443
† Additional codes qualify. See NCQA HEDIS specifications for additional information.

Documentation Requirements

- Follow-up visit may occur on the date of the ED visit.

Telehealth

- Telehealth visit, telephone visit, e-visit, or virtual check-in with principal diagnosis of mental health disorder count for numerator compliance.

HELPFUL TIPS

- **Help Member schedule a follow-up visit with a health care professional within 7 days to help prevent emergency department readmission.**
- **Make sure the mental health diagnosis is the primary focus of follow-up visit.**
- **Contact Member to confirm they went to follow-up visit.**
- **Help assist in coordination of care for behavioral health services.**

Immunizations for Adolescents — Combo 2 (IMA)

The percentage of Members age 13 who have had all required immunizations.

Numerator/Denominator

Numerator: Members in the denominator who had the following vaccines by their 13th birthday.

- 1 Meningococcal conjugate vaccine
- 1 Tdap vaccine
- 2 or 3 HPV vaccines

Denominator: All adolescents who turn age 13 during the measurement year.

Exclusion Criteria:

- Members in hospice care are excluded from the measure.

Additional Measure Information

- Any of the following on or before the adolescent's 13th birthday meet the optional exclusion criteria: Anaphylactic reaction, encephalopathy.

Codes/Medications for Compliance

Applicable Codes
Meningococcal Vaccine: • CPT: 90734 **Tdap Vaccine:** • CPT: 90715 **HPV Vaccine:** • CPT: 90649, 90650, 90651
Exclusion Codes
Hospice codes: • T80.52XA, T80.52XD, T80.52XS G04.32

Documentation Requirements

- Documentation must include vaccine name and date administered.
- For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

Telehealth

- Telehealth not sufficient to complete immunizations.
- Review and document history of immunizations.

HELPFUL TIPS

- **Present vaccination as the default option, presuming parents will immunize.**
- **Provide parents with records of their children's immunizations and ask them to bring the record to each visit.**
- **Schedule the next appointment at time of checkout and use every office visit as an opportunity to vaccinate.**
- **Use text ap automated reminders to outreach parents for scheduling reminders.**

Lead Screening in Children (LSC)

The percentage of children age 2 who had one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.

Numerator/Denominator

Numerator: Members in the denominator who had at least one lead capillary or venous blood test on or before the child's 2nd birthday.

Denominator: Children who turn age 2 during the measurement year.

Exclusion Criteria:

- Received hospice care at any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
• Lead Test CPT: 83655

Documentation Requirements

- A note indicating the date the test was performed.
- The result or finding.

Telehealth

- Telehealth cannot be used for compliance.

HELPFUL TIPS

- **Educate caregivers about the risks of lead poisoning and the importance of screening.**
- **Identify children at higher risk and screen them earlier when appropriate.**
- **Ask caregivers about potential risk factors for lead poisoning such as the age of their home, caregiver occupations and hobbies, use of foods and spices, and hand-to-mouth activity.**

Medication Adherence for Cholesterol

The percentage of Medicare members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their cholesterol medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with at least two statin cholesterol prescriptions filled (on unique dates of service) during the year.

Exclusion Criteria:

- Members receiving palliative care and members with ESRD are excluded from measure.

Codes/Medications for Compliance

Applicable Codes
• EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Only statin medications qualify.

Medications
• Fluvastatin
• Pitavastatin
• Rosuvastatin
• Pravastatin
• Atorvastatin (+/- Amplodipine)
• Simvastatin (+/- Ezetimibe, Niacin)
• Lovastatin (+/- Niacin)

Documentation Requirements

- Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

- No benefits or inclusions around telehealth.

HELPFUL TIPS

- **Stress the importance of remaining on statin medication to lower blood cholesterol and reduce the risk of cardiovascular disease.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Schedule follow-up visits to check progress.**
- **Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.**

Medication Adherence for Diabetes

The percentage of Medicare members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their diabetes medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with at least two filled prescriptions for diabetes medications (on unique dates of service) during the year.

Exclusion Criteria:

- Members receiving palliative/hospice care services.
- Members with an ESRD diagnosis or dialysis coverage dates.
- Members with one or more prescriptions for insulin.

Codes/Medications for Compliance

Applicable Codes
• EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only RAS antagonists qualify.**
Medications
• ACEI/ARB/direct renin inhibitor • ACEI/ARB/direct renin inhibitor combination

Documentation Requirements

- Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

- No benefits or inclusions around telehealth.

HELPFUL TIPS

- **Stress the importance of remaining on diabetes medication to control blood glucose and reduce the risk of diabetes- related illnesses.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Schedule follow-up visits to check progress.**
- **Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.**

Medication Adherence for Hypertension

The percentage of Medicare members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Members in the denominator who fill their hypertension medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare members with a prescription for a blood pressure medication.

Exclusion Criteria:

- Members receiving palliative/hospice care services.
- Members with an ESRD diagnosis or dialysis coverage dates.
- Members with one or more prescriptions for sacubitril/valsartan.

Codes/Medications for Compliance

Applicable Codes
• EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. **Only RAS antagonists qualify.**
Medications
• ACEI/ARB/direct renin inhibitor • ACEI/ARB/direct renin inhibitor combination

Documentation Requirements

- Data from this measure comes from PDE data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

- No benefits or inclusions around telehealth.

HELPFUL TIPS

- **Stress the importance of remaining on RAS antagonists to treat hypertension and proteinuria and reduce the risk of renal and heart disease.**
- **Consider prescribing a 90-day supply when appropriate and educate patient on pharmacy auto-refill program.**
- **Schedule follow-up visits to check progress.**
- **Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.**

Social Determinants of Health Screening (SDOH)

The percentage of Members ages 18 and over who were screening for social determinants of health in the measurement year.

Numerator/Denominator

Numerator: Members who were screened or social determinants of health in the measurement year.

Denominator: Members ages 18 and older.

Exclusion Criteria:

- N/A

Codes/Medications for Compliance

Applicable Codes
• HCPCS code G9919 – Screening performed and positive. • HCPCS code G9920 – Screening performed and negative. • In conjunction with Z Diagnosis Code (see last pages of Brochure).

Documentation Requirements

- SDOH data can be documented in health assessments, screening tools, EHRs, patient self-reporting, and submitted claims (by anyone on the care team).

Telehealth

- No current benefits or inclusions around telehealth.

HELPFUL TIPS

- **Link Members to behavioral health and/or other social service providers.**
- **Discuss/understand intersection between SDOH and preventive and chronic disease care.**
- **Keep track of and monitor social needs expressed by Members that impact treatment adherence and health outcomes.**
- **Determine screening tool used by providers and/or EmblemHealth to ensure the data is consistent and comprehensive.**

Transitions of Care (TRC)

The percentage of inpatient discharges for Members ages 18 and older who were engaged after inpatient discharge.

Numerator/Denominator

Numerator: Patient engagement after inpatient discharge within 30 days (office visit, telehealth, home visit).

Denominator: Members ages 18 and older who had an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Exclusion Criteria:

- Members in hospice or using hospice services.

Codes/Medications for Compliance

Applicable Codes
For Patient Engagement After Inpatient Discharge
Outpatient Visit:
• CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
Telephone Visit:
• CPT: 98966, 98967, 98968, 99441, 99442, 9944

Applicable Codes
E-Visit or Virtual Check-In:
• CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458
• HCPCS: G2010, G2012, G2061, G2062, G2063, G0071
Transitional Care Management Services:
• CPT: 99495, 99496

Additional Measure Information

- Care coordination is important when transitioning from the hospital setting back to home to ensure clear understanding of follow-up needs.

Documentation Requirements

- Receipt of inpatient admission documented in medical record within 3 days of admission.
- Receipt of discharge summary documented in medical record within 3 days of discharge.

Telehealth

- Telehealth visit, telephone visit, e-visit, or virtual check-in count for compliance in patient engagement after inpatient discharge.

HELPFUL TIPS

- **Document receipt of inpatient admission notification with a date stamp**
- **Ensure patient's discharge information is comprehensive and complete.**
- **Ensure patient has a follow-up visit within 30 days of discharge.**

Well-Child Visits in the First 30 Months of Life (W30)

The percentage of Members who had the following number of well-child visits during the last 15 months:

- Well-child visits in the first 15 months: 6 or more well-child visits.
- Well-child visits for age 15 months-30 months: 2 or more well-child visits.

Numerator/Denominator

Numerator: Well-child visits in the first 15 months: Children who turned 15 months old during the measurement year with 6 or more well-child visits.

Denominator: Well-child visits for age 15 months-30 months: Children who turned 30 months old during the measurement year with 2 or more well-child visits.

Exclusion Criteria:

- Received hospice care at any time during the measurement year.

Codes/Medications for Compliance

Applicable Codes
Well-Care Visit • CPT: 99381-99385, 99391-99395, 99461 • HCPCS: G0438, G0439, S0302 ICD10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2

Additional Measure Information

- Replaces W15 measure.

Telehealth

- Telehealth can be used for compliance. (Appropriate CPT needs to be submitted with GT modifier.)

Documentation Requirements

- Well-child visits must occur with PCP but does not have to be the PCP assigned.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (**https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx**).

HELPFUL TIPS

- **Conduct or schedule well-care visits when patients present for illnesses, or other events like sports physicals, accidental injuries, and colds — add modifier for separate and distinct services.**
- **Document all the required elements of a well-child visit.**
- **Pre-schedule the next well visit before the patient leaves the office. Relay the importance of returning even if the child is doing fine.**
- **Provide health education/ anticipatory guidance.**
- **Take an opportunity to check and administer vaccines that are due at every visit.**

Social Determinants of Health Diagnosis Codes

Code	Category	Description
Z55.0	Education and Literacy	Illiteracy and low-level literacy
Z55.1		Schooling unavailable and unattainable
Z55.2		Failed school examinations
Z55.3		Underachievement in school
Z55.4		Educational maladjustment and discord with teachers and classmates
Z55.8		Other problems related to education and literacy
Z55.9		Problems related to education and literacy, unspecified
Z56.0	Employment/Unemployment	Unemployment, unspecified
Z56.1		Change of job
Z56.2		Threat of job loss
Z56.3		Stressful work schedule
Z56.4		Discord with boss and workmates
Z56.5		Uncongenial work environment
Z56.6		Other physical and mental strain related to work
Z56.9		Unspecified problems related to employment
Z56.81		Sexual harassment on the job
Z56.82		Military deployment status
Z56.89		Other problems related to employment
Z57.0	Occupational Exposure	Occupational exposure to noise
Z57.1		Occupational exposure to radiation
Z57.2		Occupational exposure to dust
Z57.4		Occupational exposure to toxic agents in agriculture
Z57.5		Occupational exposure to toxic agents in other industries
Z57.6		Occupational exposure to extreme temperature
Z57.7		Occupational exposure to vibration
Z57.8		Occupational exposure to other risk factors
Z57.9		Occupational exposure to unspecified risk factor
Z57.31		Occupational exposure to environmental tobacco smoke
Z57.39		Occupational exposure to other air contaminants
Z59.0	Housing	Homelessness
Z59.1		Inadequate housing
Z59.2		Discord with neighbors, lodgers, and landlord
Z59.3		Problems related to living in residential institution
Z59.4		Lack of adequate food and safe drinking water
Z59.5		Extreme poverty (100% FPL or below)
Z59.6		Low income (200% FPL or below)
Z59.7		Insufficient social insurance and welfare support
Z59.8		Other problems related to housing and economic circumstances
Z59.9		Problem related to housing and economic circumstances, unspecified

Code	Category	Description
Z60.0	Social Environment	Problems of adjustment to life-cycle transitions
Z60.2		Problems related to living alone
Z60.3		Acculturation difficulty
Z60.4		Social exclusion and rejection
Z60.5		Target of (perceived) adverse discrimination and persecution
Z60.8		Other problems related to social environment
Z60.9		Problem related to social environment, unspecified
Z62.0	Upbringing	Inadequate parental supervision and control
Z62.1		Parental overprotection
Z62.3		Hostility towards and scapegoating of child
Z62.6		Inappropriate (excessive) parental pressure
Z62.9		Problem related to upbringing, unspecified
Z62.21		Child in welfare custody
Z62.22		Institutional upbringing
Z62.29		Other upbringing away from parents
Z62.810		Personal history of physical and sexual abuse in childhood
Z62.811		Personal history of psychological abuse in childhood
Z62.812		Personal history of neglect in childhood
Z62.813		Personal history of forced labor or sexual exploitation in childhood
Z62.819		Personal history of unspecified abuse in childhood
Z62.820		Parent-biological child conflict
Z62.821		Parent-adopted child conflict
Z62.822		Parent-foster child conflict
Z62.890		Parent-child estrangement not elsewhere classified
Z62.891		Sibling rivalry
Z62.898		Other specified problems related to upbringing
Z63.0	Primary Support group/family circumstances	Problems in relationship with spouse or partner
Z63.1		Problems in relationship with in-laws
Z63.4		Disappearance and death of family member
Z63.5		Disruption of family by separation and divorce
Z63.6		Dependent relative needing care at home
Z63.8		Other specified problems related to primary support group
Z63.9		Problem related to primary support group, unspecified
Z63.31		Absence of family member due to military deployment
Z63.32		Other absence of family member
Z63.71		Stress on family due to return of family member from military deployment
Z63.72		Alcoholism and drug addiction in family
Z63.79		Other stressful life events affecting family and household

Code	Category	Description
Z64.0	Psychosocial	Problems related to unwanted pregnancy
Z64.1		Problems related to multiparity
Z64.4		Discord with counselors
Z65.0		Conviction in civil and criminal proceedings without imprisonment
Z65.1		Imprisonment and other incarceration
Z65.2		Problems related to release from prison
Z65.3		Problems related to other legal circumstances
Z65.4		Victim of crime and terrorism
Z65.5		Exposure to disaster, war, and other hostilities
Z65.8		Other specified problems related to psychosocial circumstances
Z65.9		Problem related to unspecified psychosocial circumstances
Z91.42	Abuse	Personal history of forced labor or sexual exploitation
Z91.410		Personal history of adult physical and sexual abuse
Z91.411		Personal history of adult psychological abuse
Z91.412		Personal history of adult neglect
Z91.419		Personal history of unspecified adult abuse
Z13.9	Other	Encounter for screening, unspecified
Z73.3		Stress not elsewhere classified
Z91.120		Patient's intentional underdosing of medication regimen due to financial hardship

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