



PHYSICIAN PARTNERS

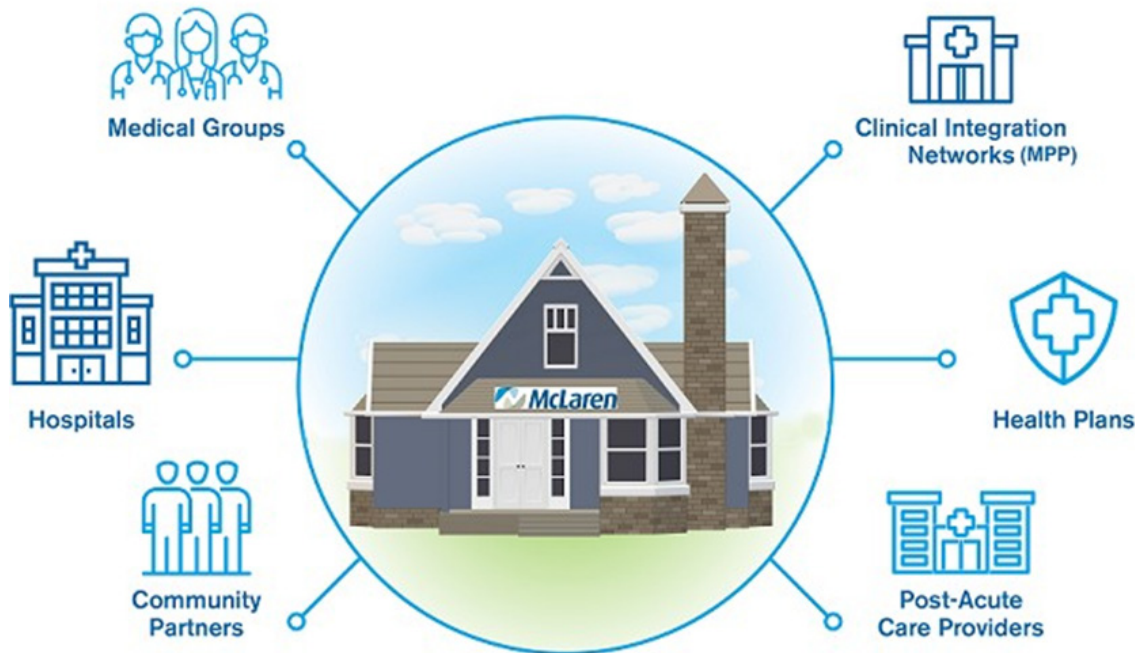
# 2026 Top Ten Quality Metrics Quick Reference

— POWER OUR —

## Population Health Strategy

Population Health Services Organization (PHSO)—an optimized, physician-partnered operations entity that powers a system to improve health outcomes, promote economies of scale and coordination, and reduce variation across the continuum.

### MPP Population Health Services Organization



*McLaren Physician Partners through its members will be the best value in health care as defined by quality outcomes and cost.*





## PHYSICIAN PARTNERS

Dear McLaren Physician Partners Member,

MPP is dedicated to providing the highest value care to our patients and support to our providers and practices.

One of the ways we do this is through success in Population Health Management. The ultimate goal is to improve the quality of care while reducing costs.

Essential components of our strategy include:

- Use of communication technologies to deliver care like portals, secure texting, enhanced outreach to patients and providers, telehealth, and remote patient monitoring
- Continuously improving performance on HEDIS Quality metrics, meeting or exceeding the 90th percentile in performance
- Providing Patient-Centric care consistent with the Patient Centered Medical Home (PCMH) model
- Delivery of coordinated patient care through Transitional Care Management (TCM) and Chronic Disease Management services and addressing social determinants of health
- Adoption and use of evidence-based guidelines

To assist with Population Health Management and HEDIS performance we are pleased to present the 2026 MPP Top Ten Quick Reference Guide. We have made some updates throughout the book, including new coding tips, updates to metrics such as the addition of Plan All-Cause Readmission, Lead Screening for Children, and continue to enhance our section on Team Based Care. Working together with a multidisciplinary team of clinicians provides the most patient-centered model for population health.

As patient centric care continues to evolve, MPP has incorporated several focused strategies into our Clinical Integration (CI) Program and MPP Payment Distribution Methodology. Providers will continue to be rewarded on integration and performance in these metrics. Additional success in payer value-based revenue programs will also be realized with high performance on these metrics because it is no longer about just participation in a program but individual and group performance in a program.

We have identified five main activities that are common among MPP top performing providers and ensure success with Top Ten metric performance and other revenue metrics. These activities include:

- Patient outreach for annual and/or chronic disease management visits
- Pre-visit planning
- Use of a point of care tool to identify patient care gaps (i.e., Persivia Population Health registry or CareTrak)
- Applying evidence-based screening guidelines at all visit types, not just those designated for health maintenance
- Continuous interaction with the MPP Quality Performance Staff

One common comment we receive is the variation of recommendations among differing medical/surgical societies. High value care is one of the many concepts MPP endorses to promote conversations between providers and patients on high value care. Throughout this guide you will find that the HEDIS metrics do not always reflect current cancer screening or professional organization guidelines in terms of age groups or frequency of testing. We have provided you with the HEDIS specifications needed to meet the measure requirements. We have also provided you with professional and societal recommendations so that you can make the best choices with your patients.

If you have any questions regarding the content of this guide, please feel free to contact any one of us. Your MPP Quality Performance Specialist and Practice Coach (field team) are also available to assist you with practice transformation to ensure success in this year's program.

Michael J. Ziccardi, Jr., D.O.  
Chief Medical Officer

Lawrence J. Cowsill, D.O., F.A.C.O.I.  
Senior Medical Director

Preston Thomas, M.D.  
Associate Medical Director

Sara Liter-Kuester, D.O., F.A.C.O.I.  
Chairperson, Quality & CI Subcommittee

**In 2025, MPP Recognized Their Top  
Performing Physicians In Population Health.**

**Individual Awardees:**

Melody Angel, MD (Lansing)	Julia Mueller, MD (Northern)
Richard Cohen, DO (Oakland)	Kathleen Perkins, DO (Lapeer)
Michael DiGiovanni, MD (Lapeer)	David Pohl, DO (Lansing)
Anu Duvoor, MD (Macomb)	John Pradko, DO (Macomb)
Grace Escamilla, MD (Lansing)	Behzod Rostam, MD (Thumb)
Kelly Flynn, DO (Northern)	Neena Sharma, MD (Lapeer)
Habtamu Handro, MD (Lansing)	Richard Shoskey, MD (Northern)
Gary Holloway, DO (Oakland)	Randall Sturm, MD (Flint)
Laura Lucio-Reincke, MD (Port Huron)	Edward Swisher, MD (Lansing)
Brian Mahany, DO (Lansing)	Sanjay Vora, DO (Macomb)
Shaheen Mohammed, MD (Flint)	Jason Whateley, DO (Port Huron)

**Practice Level Awardees:**

Albert A. Przybylski, DO PC (Macomb)  
McLaren Macomb Multi-Specialty Clinic (Macomb)  
McLaren Macomb Family First Medical Center (Macomb)  
McLaren Macomb Family Medicine Anchor Bay (Macomb)  
Partners In Family Medicine, PLLC (Macomb)

## MPP Offers A Variety Of Care Management Programs To Meet The Needs Of Your Patients

Our programs cover all McLaren regions for Transitional and Comprehensive Care Management services, and we accept referrals from practices, providers, hospitals, and patient self-referrals, into any of our programs. Patients are also given our department line number at discharge for questions or issues arising after discharge.

**Department Contact:** [Andrea.Phillips1@mcclaren.org](mailto:Andrea.Phillips1@mcclaren.org)

### REFERRING FOR CARE MANAGEMENT SERVICES

Referral forms from hospitals, practices, providers are accepted via Fax to (810) 600-7924 or via **Cerner to: MHC McLaren Physician Partners Care Management**

Patients can self-refer via our Department Referral line at (844) 368-1817. This line is designed to support patients after discharge, and during extended hours, to support patients who may have questions or issues after normal business hours. This line is monitored Monday-Friday, 8:00 am–8:00 pm and Saturdays, 9:00 am–1:00 pm.

All complete referrals are reviewed and processed within one (1) business day of being received.



[CM Referral Form](#)

### TRANSITIONAL CARE MANAGEMENT (TCM)

Patients discharged from Inpatient, Observation or post-acute settings are most vulnerable the first seven (7) days after discharge. TCM is a best practice that reduces readmissions, improves compliance with follow-up care, and supports a smooth transition “home”.

#### Services:

- Discharge instruction and medication review, risk-stratification, SDOH screening for resource needs.
- Assistance scheduling follow-up appointments with 7-14-days of discharge.
- Patients with chronic disease are referred to care management services (CCMS/CCM) based on need.
- Assist providers/practices with billing.

**Population:** All attributed members (MPP, MHPN) **Contact:** [Jacquelyne.Helgeson@mcclaren.org](mailto:Jacquelyne.Helgeson@mcclaren.org)

### COMPREHENSIVE CARE MANAGEMENT SERVICES (CCMS)

This program offers care coordination and disease management, oversight and organization of care, monitoring conditions, and providing educational activities by health professionals. This program assigns a Care Coordinator (RN/LMSW) to each patient, focusing on serving at-risk populations and maintaining regular contact until patient goals are met or they can effectively self-manage.

#### Services:

- Patient motivational interviewing and developing patient-centered goals.
- Removing barriers to care, providing education and resources based on patient needs.
- Offers MyCare remote patient monitoring to high-risk patients (CHF, COPD, HTN, DM, ESRD, Discharge).
- Offers ED High-Utilizer support services for real-time review of activity, provider notification and patient engagement to educate on appropriate utilization and reduce avoidable ED visits.
- Care Maintenance, Gaps in Care/Preventative care and screening, PDCM outreach, etc.
- Behavioral Health screening and intervention recommendations/service resources
- Discussing disease progression and end-of-life options.

**Population:** Any referred patient from within McLaren health care system **Contact:** [Holly.McLean@mcclaren.org](mailto:Holly.McLean@mcclaren.org)

## MPP Top Ten Quality Metrics 2026

Category	Measure Title	Specifications
<b>Utilization</b>	Plan All-Cause 30-day Readmission* <sup>^</sup> <b>NEW</b>	Percentage of patients 18 years and older who are readmitted to an acute facility for inpatient or observation or any reason within 30 days of hospital discharge.
<b>Screening Measures</b>	Child and Adolescent Well-Care Visit	Patients 3-21 years of age who had a comprehensive Well-Care visit with PCP, Pediatrician or OB/GYN in 2026
	Breast Cancer Screening* <b>REVISED</b>	Women <b>40</b> - 74 years of age who had one or more mammograms any time during current or prior year (October 1, 2024– December 31, 2026) Exclusion: Bilateral mastectomy
	Chlamydia Screening in Women	Women 16-24 years of age identified as sexually active who had at least one chlamydia test during 2026
	Colorectal Cancer Screening*	Patients age 45-75 with one of the following: <ul style="list-style-type: none"> <li>• FOBT during current year (may not use sample from digital rectal exam (2026))</li> <li>• Flexible sigmoidoscopy in last 5 years (2022-2026)</li> <li>• Colonoscopy in the last 10 years (2017-2026)</li> <li>• CT Colonography in last 5 years (2022-2026)</li> <li>• FIT-DNA (Cologuard) in last 3 years (2024, 2025, 2026)</li> </ul> Exclusion: colorectal cancer, total colectomy
	Cervical Cancer Screening	Women 21-64 years of age who were screened for cervical cancer using either of the following: <ul style="list-style-type: none"> <li>• 21-64 who had a pap smear in the last 3 years (2024- 2026)</li> <li>• 30-64 who had PAP and HPV co-testing during the last 5 years (2022- 2026). (HPV reflex testing results do not count)</li> <li>• 30-64 who had High-risk (hrHPV) testing (without cytology) during the last 5 years (2022-2026)</li> </ul> Exclusion: Hysterectomy with no residual cervix.
<b>Cardiovascular Conditions</b>	Controlling High Blood Pressure*	Patients age 18-85 with a diagnosis of hypertension and whose blood pressure was adequately controlled (139/89 or lower) during measurement year
<b>Comprehensive Diabetes Care</b>	Diabetes Care: Retinal Eye Exam*	Patients age 18-75 who had a diabetic retinal eye exam in current year (may be 2 years if negative)
	Glycemic Status Assessment for Patients with Diabetes*	Patients age 18-75 whose most recent glycemic status (HbA1c) or glucose management indicator (GMI) is less than 8% in 2026
	Diabetes Care: Kidney Health Evaluation for Patients with Diabetes*	Adults ages 18 to 85 of age with diabetes who received a kidney health evaluation during the measurement year as evidenced by both of the following: <ol style="list-style-type: none"> <li>1. eGFR: estimated glomerular filtration rate</li> <li>2. uACR: urine albumin-creatinine ratio</li> </ol>



This symbol identifies metrics that Specialists can close based on their specialty

\*Commercial and Medicare Metrics. (Note: HbA1C value is ≤ 9% for Medicare patients)

<sup>^</sup> Commercial BCBS Metric for 2026 Top Ten

# MPP Pediatrics Top Eight Quality Metrics 2026

Category	Measure Title	Specifications													
<b>Preventative Screenings and Well Child Visit</b>	Adolescent Well Visits	Patients 12-17 years of age who had a comprehensive well-care visit with PCP, Pediatrician or OB/GYN in 2026													
	Well-Child Visits	Patients 3-11 years of age who had at least one well- child visit with a PCP during 2026													
	BMI Percentile	Patients ages 3-17 with a BMI percentile documented annually (either numeric or plotted on a growth chart.) Documentation must include height, weight, and BMI value													
	Chlamydia Screening	Women 16-24 years of age identified as sexually active who has at least one chlamydia test during 2026													
	Counseling for Nutrition	Patients aged 3-17 who have had counseling for nutrition during 2026. Documentation must include a note indicating the date and at least one of the following: discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors), checklist indicating nutrition was addressed, counseling or referral for nutrition education, patient received educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition, weight or obesity counseling. <b>CODE: Z71.3 Dietary Surveillance and Counseling</b>													
Counseling for Physical Activity	Patients aged 3-17 who have had counseling for physical activity during 2026. Documentation must include a note indicating the date and at least one of the following: discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation), checklist indicating physical activity was addressed, counseling or referral for physical activity, member received educational materials on physical activity during a face-to-face visit, anticipatory guidance specific to the child's physical activity, weight or obesity counseling. <b>CODE: Z71.82 Exercise Counseling or Z02.5 Sports Physical</b>														
<b>Behavioral Health</b>	Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase (6-12 Years)	Patients newly prescribed ADHD medication who had one follow-up visit within 30 days of first ADHD medication prescription													
	Depression Screening (ages 12 and older)	Percentage of patients 12 years and older who are screened for depression using a standardized tool. If positive screen (PHQ-9 of 5 or greater) receives follow-up care within 30 days													
	<table border="1"> <thead> <tr> <th colspan="2">Interpreting PHQ-9 Scores</th> <th colspan="2">Actions Based on PHQ-9 Score</th> </tr> </thead> <tbody> <tr> <td>Mild depression</td> <td>5-9</td> <td rowspan="2">&gt;5-14</td> <td rowspan="2">Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment</td> </tr> <tr> <td>Moderate depression</td> <td>10-14</td> </tr> <tr> <td>Moderately severe depression</td> <td>15-19</td> <td>&gt;15</td> <td>Warrants treatment for depression, using antidepressant, psychotherapy, and/or combination of both</td> </tr> </tbody> </table>		Interpreting PHQ-9 Scores		Actions Based on PHQ-9 Score		Mild depression	5-9	>5-14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment	Moderate depression	10-14	Moderately severe depression	15-19	>15
Interpreting PHQ-9 Scores		Actions Based on PHQ-9 Score													
Mild depression	5-9	>5-14	Physician uses clinical judgement about treatment, based on patient's duration of symptoms and functional impairment												
Moderate depression	10-14														
Moderately severe depression	15-19	>15	Warrants treatment for depression, using antidepressant, psychotherapy, and/or combination of both												

**PLAN ALL CAUSE READMISSION (PCR) - NEW****HEDIS Measure Description:**

- Percentage of patients aged 18 years and older who are readmitted to an acute facility for inpatient or observation for any reason within 30 days of hospital discharge.
  - Readmission can be for any reason
  - Inpatient and Observation stays are included
  - Any acute admission to any type of facility, including behavior health facilities

**EXCLUSIONS:**

- Patients receiving Hospice Services
- Patient who died during the admission
- Principal diagnosis of pregnancy or a condition originating during the perinatal period

**Ways to Reduce Readmissions:**

- Offer Open Access Scheduling for patients post discharge.
- Develop a standard office workflow for ensuring patients who have been discharged are seen within 1-2 weeks of discharge (sooner if high risk patient with chronic conditions)
  - Inquire if there are any barriers when scheduling:
    - Medications were able to be filled
    - Home Care or other services such as DME were set up
    - Are there any immediate needs or concerns
- Reconcile all medications from inpatient stay to current home medications, document reconciliation and any changes to the medications
- Encourage patients to respond to MyCare messages (text messages) and participate in Care Coordination of Services
- Review what patients should do if they have issues after hours or on a weekend (contact on-call service, call support line, etc.)
- Utilize Transitional Care Management coding post discharge from an inpatient setting



**LEAD SCREENING IN CHILDREN (LSC) -NEW****HEDIS Measure Description:**

- Percentage of children with one or more capillary or venous blood lead screenings **on or before their second birthday.**
- Can be billed with CPT 83655

**EXCLUSIONS:**

- Patients receiving hospice services

**Documentation and Tips:**

- **All** children should be tested, regardless of exposure risk (older home, etc.), as it may be present in other environments
- Results must be noted in the chart, unknown does not meet the metric specifications
- Document all testing in MCIR
- Utilize in-office capillary testing. If capillary test is greater than 3.5 mcg/dL, confirm with a venous retest as soon as possible
- Parent Education: provide nutritional guidance and recommend a well-balanced diet. Calcium, iron, and vitamin C minimizes the absorption of lead in the body.
- Include lead screening in your office's standing orders
- Michigan Medicaid requires testing at age 12 and 24 months
- If a child is 36-72 months, and has not had lead testing, they should be
- tested once during this time period



## STATIN USE FOR PATIENTS WITH CARDIOVASCULAR DISEASE (SPC) or DIABETES (SUPD)

### HEDIS Measure Descriptions:

- Patients aged 21-75 with Cardiovascular Disease
  - Identified as having clinical atherosclerotic cardiovascular disease
  - Dispensed at least one **moderate or high intensity** statin medication
- Patients aged 40-75 with Diabetes:
  - Dispensed statin medication

NOTE: Only drug claims processed through the patient's pharmacy benefit are counted

### EXCLUSIONS:

- End Stage Renal Disease or Dialysis in previous or current measurement year
- Cirrhosis/Liver Disease in previous or current measurement year
- Female patients who are pregnant, receiving IVF or prescription for clomiphene (estrogen agents) during previous or current measurement year
- Cannot tolerate statin medication, as diagnosed by a claim for myalgia (SPC only), myositis, myopathy or rhabdomyolysis during the measurement year
- Patients receiving Hospice or Palliative Care Services
- Patients with Advanced illness and frailty

Common Exclusion Codes for Statin Metrics	
Myopathy	G72.0
Myositis	M60.9
These two ICD 10 Codes will exclude the patient from CVD and DM Statin Metrics.	

**NOTE:** Exclusions of patients for Statin Therapy **must** be documented and coded every calendar year.



### Tips for Statin Metrics:

Encourage the importance of statin regardless of LDL Levels

Try more hydrophilic statins or reduce the dose/frequency if patient thinks there are adverse effects such as myalgia

Encourage patients to utilize insurance at the pharmacy, discount Rx programs do not go towards deductibles or close gaps

Encourage use of 90-day or 100-day Rx

Document secondary insurances

Forward exclusion documentation to the health plan, *Z78.9 is not an approved exclusion.*

*Repatha alone does not close this gap.*

High Intensity Statin Therapy	
Atorvastatin 40-80 mg	Amlodipine-atorvastatin 40-80 mg
Ezetimibe-simvastatin 80 mg	Rosuvastatin 20-40 mg*
Simvastatin 80 mg	
Moderate Intensity Statin Therapy	
Atorvastatin 10-20 mg	Amlodipine-atorvastatin 10-20 mg
Ezetimibe-simvastatin 20-40 mg	Fluvastatin 40-80 mg
Lovastatin 40 mg	Pitavastatin 1-4 mg
Pravastatin 40-80 mg*	Rosuvastatin 5-10 mg*
Simvastatin 20-40 mg	
*Hydrophilic (water-soluble) statins	

## CONTROLLING HIGH BLOOD PRESSURE (CBP)

### HEDIS Measure Description:

- The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (139/89 or lower) during the measurement year.

### EXCLUSIONS:

- Patients with evidence of ESRD, dialysis, nephrectomy, or kidney transplant anytime during the member’s history on or prior to Dec. 31 of the measurement year
- Patients who were pregnant during the measurement year
- Patients aged 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

	CPT II CODE	READING
Systolic	3074F	Less Than 130
	3075F	130-139
	3077F	Greater than or equal to 140
Diastolic	3078F	Less than 80
	3079F	80-89
	3080F	Greater than or equal to 90

### Ways to improve Controlling High Blood Pressure rates:

Use CPTII Codes at each visit

Enroll patients with HTN in MPP MyCare Program. Reported BP values will be included in electronic supplemental data.

BP is last reading of the year

Have patient return for nurse/MA visit by the end of the year

Repeat any BP measurement that is 140/90 or above and DOCUMENT all repeat measurements

Establish a protocol for retaking high BPs

Review proper technique for taking a blood pressure

Document patient reading of home BP from digital device during telehealth visit. Ranges will not satisfy the measure

BP can be counted from any visit including specialists. Obtain specialist visit consult notes for manual entry



## GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

**HEDIS Measure Description:**

- Percentage of diabetic patients ages 18-75 whose most recent glycemc status (hemoglobin A1C) or glucose management indicator (GMI) is less than 8% during 2026.

**EXCLUSIONS:**

- Polycystic ovarian syndrome (PCOS), gestational diabetes or steroid-induced diabetes in 2025 or 2026
- Patients aged 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

Description	CPT/CPTII Code for A1C Testing
A1C less than 7%	3044F
A1C greater than equal to 7% to less than 8%	3051F
A1C greater than equal to 8% to less than 9%	3052F
A1C greater than 9%	3046F
Point of Care A1C Test (claim will also need code result)	83036

### Ways to improve A1C < 8% rates:

Utilize MPP gaps in care reporting to identify patients with A1C < 8% gaps

Ensure diabetes medication compliance

Refer patients for Self-Management or Nutritional Counseling

Utilize Diabetic or Chronic Care Flow sheets to document testing

Utilize test tracking methods to ensure patient compliance and that lab reports are received

For waived testing at the office, ensure testing is documented in the medical record and CPT II codes are included on the claim

Review hospital medical records for lab results

Forward exclusion documentation to the health plan

GMI is a calculation derived from continuous glucose monitoring (CGM) that assesses average blood sugar values. This is a recognized surrogate for A1C when used for ≥ 14 days, 70% CQM use.

(BIMAL V. PATEL, GABRIEL ALENCAR, SHARON M. WANG, SCOTT LEAS, LAUREL H. MESSER, JORDAN E. PINSKER; 154-LB: HEDIS Glycemic Goals Achieved by Control-IQ Technology Users across All Payer Types. Diabetes 20 June 2023; 72 (Supplement\_1): 154-LB. <https://doi.org/10.2337/db23-154-LB>)



**COMPREHENSIVE DIABETES CARE: KIDNEY HEALTH EVALUATION (KED)****HEDIS Measure Description:**

- The percentage of adults 18–85 years of age with diabetes who received a Kidney Health Evaluation during 2026 on the same or different dates of service.

A Kidney Health Evaluation is defined by completion of both:

1. An estimated glomerular filtration rate (eGFR) *and*
2. A urine albumin-creatinine ratio (uACR)
  - a. Quantitative urine albumin CPT 82043 *and* Urine creatinine CPT 82570. Must be from same specimen.

**EXCLUSIONS:**

- Patients with evidence of ESRD or dialysis any time during the member's history
- Patients aged 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

**Ways to improve Kidney Health Evaluation rates:**

If possible, order both eGFR and uACR on the same date of service but can be done on separate dates of service within current year

**Urine Albumin Creatinine Ratio Lab Test Value Set is the preferred lab to order Must write out for non-Cerner orders**

Point of Care Strip Albumin tests or semi-quantitative tests **do not** meet metric (CPT 82044)

Utilize the first diabetic exam of the year to order the appropriate testing

Utilize MPP gaps in care reporting to identify patients with kidney health evaluation open gaps

Utilize Diabetic or Chronic Care Flow sheets to document testing

Utilize Test Tracking process to ensure patient completed testing and lab reports are received



## COMPREHENSIVE DIABETES CARE: RETINAL EYE EXAM (EED)

**HEDIS Measure Description:**

- Percentage of diabetic patients aged 18-75 who had a retinal or dilated eye exam during 2026 or a negative retinal eye exam in 2025.
- Patient self-reported exams can be captured in medical record for gap closure (must include result, date, and name of eye care professional)

**EXCLUSIONS:**

- Bilateral eye enucleation
- Patients age 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

**Diabetic Retinopathy:** 26% of patients with diabetes develop diabetic retinopathy, the leading cause of blindness in working-aged adults (5.1%). (Source: Lundeen EA, Burke-Conte Z, Rein DB, et al. Prevalence of Diabetic Retinopathy in the US in 2021. JAMA Ophthalmol. 2023;141(8):747–754. doi:10.1001/jamaophthalmol.2023.2289)

Scan the code below for a list of preferred providers for eye exams:

**Ways to improve Retinal Eye Exam rates:**

Use the MPP preferred network of eye care providers

Remind patients that retinal eye exams are covered under their medical insurance

Utilize a retinal eye exam referral form

Utilize MPP gaps in care reporting to identify patients with retinal eye exam gaps

Utilize Diabetic or Chronic Care Flow sheets to document exam results

Utilize referral tracking methods to ensure patient compliance and that specialist reports are received

Forward exclusion documentation to the health plan



# Diabetic Retinopathy Evaluation

Patient Instructions: Please take this form to your eye care professional and have them complete and return.  
 Diabetic Eye exams are covered under medical insurance and may be subject to your specialist co-pay and/or deductible.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Health Plan ID: \_\_\_\_\_

## Primary Care Physician Information

Physician: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### FINDINGS

No diabetic retinopathy is found in either eye. OR

RETINAL EXAM ABNORMALITIES DETECTED, AS FOLLOWS:

Background changes noted in:

Right (*Circle Grade*)            Mild            Moderate            Severe

Clinically significant diabetic macular edema?    Yes    No

Left (*Circle Grade*)            Mild            Moderate            Severe

Clinically significant diabetic macular edema?    Yes    No

Proliferative changes noted in:

Right (*Circle Grade*)            Active            Regressed/Stable

Left (*Circle Grade*)            Active            Regressed/Stable

### FOLLOW UP

Routine follow-up exam is recommended in one year. OR

Follow-up of abnormalities in my office is recommended in \_\_\_\_\_ (timeframe).

Referral to Dr. \_\_\_\_\_ is recommended in \_\_\_\_\_ (timeframe).

Cataracts or Glaucoma detected OR laser treatment is needed. Letter to follow.

### Codes to Indicate HEDIS Compliance:

92004 – Ophthalmological services: Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient, one or more visits.

92014 – Ophthalmological services: Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.

2022F – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed, **with evidence of retinopathy** billed on date of service of exam

2023F – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy** billed on date of service of exam

M1220 – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; **with evidence of retinopathy (Medicare ONLY)**

M1221 - Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy (Medicare ONLY)**

2025F – Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy**

2033F – Eye imaging validated to match diagnosis from seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed **without evidence of retinopathy**

\_\_\_\_\_ Eye Care Professional Signature & Degree

\_\_\_\_\_ Eye Care Professional Printed Name

Office Name: \_\_\_\_\_

## COLORECTAL CANCER SCREENING (COL)

## HEDIS Measure Description:

- Percentage of patients ages 45-75 with one of the following:
  - FOBT (Fecal immunochemical - FIT) during 2026
  - Flexible sigmoidoscopy between 2022 through 2026
  - Colonoscopy between 2017 through 2026
  - CT colonography between 2022 through 2026
  - FIT-DNA (Cologuard) between 2024-2026

## EXCLUSIONS:

- Colon Cancer or Total Colectomy
- Patients age 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

**NOTE: Tests performed on a sample collected via a digital rectal exam do not meet criteria.**

**Colorectal Cancer Screening:**

Michigan's Colorectal Cancer incident rate is around 35.4 cases per 100,000 people (2017-2021), slightly below the national average, but significant disparities exist, with higher rates among Black/African American individuals and a concerning increase in younger adults (under 50)

Source:

**Young-onset Colorectal Cancer (YO-CRC) Facts:**

Since 1994, cases of YO-CRC have increased by 51%. Young adults are the only group with increasing colorectal cancer cases.

Source:

**Ways to improve Colorectal Cancer Screening rates:**

Encourage patients resistant to having a colonoscopy to complete a FOBT or FIT-DNA test at home

For patients preferring FIT-DNA testing, work with MPP quality team to submit bulk orders for subsequent testing

Utilize MPP gaps in care reports to identify patients with Colorectal Cancer Screening gaps

Utilize test and specialist referral tracking methods to ensure compliance

On the patient problem list in the medical record, document test/ surgical history and include date

A pathology report that indicates the type of screening (eg, colonoscopy) and the date when the screening was performed meets criteria

For pathology reports that

do not indicate the type of screening and for incomplete procedures, evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy

Document the date of total colectomy in the medical record

Forward exclusion documentation to the health plan

Send reminders or call patients due for screenings



## BREAST CANCER SCREENING (BCS) – REVISED


### HEDIS Measure Description:

- Percentage of Women ages 40 to 74 who had a mammogram between October 1, 2024, and December 31, 2026. All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) will qualify.

### EXCLUSIONS:

- Bilateral mastectomy
- Patients age 66 and older living in skilled nursing facility
- Patients receiving hospice or palliative care services
- Advanced illness and frailty

### Screening Recommendations

Breast cancer screening recommendations for women at average risk		
<b>American Cancer Society</b>	 <b>National Comprehensive Cancer Network</b>	<b>U.S. Preventive Services Task Force</b>
Annual screening for women 45-54 (women should have the option to begin annual screening between 40 – 44) Women 55 and older can switch to every 2 years (or every year if a woman chooses to do so), for as long as a woman is in good health and is expected to live at least 10 more years.	Women should have a screening mammogram annually starting at 40 and continue as long as they are in good health  Consider tomosynthesis (3-D mammography)	Every 2 years For women aged 40-74

### Ways to improve breast cancer screening rates:

Document date of mastectomy in the medical record and code history of bilateral mastectomy (Z9013)

Educate female patients about the importance of early detection and screening

Breast cancer awareness activities during the month of October

Utilize MPP gaps in care reporting to identify patients with breast cancer screening gaps

Utilize test tracking methods to ensure compliance

Use standing orders for mammograms

Partner with McLaren Regional Breast Centers, which offer free or discounted screening and other services such as transportation and reminder programs

Forward exclusion documentation to the health plan

Send reminders or call patients due for mammograms

**Breast Cancer Screening:** Among Michigan women, breast cancer is the most diagnosed cancer and the second leading cause of cancer death. Black females have the lowest five-year survival rate at 79.5% (National average is 98.7%). Factors that may contribute to the higher death rate include lack of medical coverage, barriers to early detection and screening, unequal access to clinical trials and more likely to be diagnosed with a more aggressive form of cancer

The breast cancer incidence rate in women under 50 has risen faster than in women over 50 with a rate of 1.4 % each year. Women under 40 are nearly 40 percent more likely to die from breast cancer than women over 40.  
**Source:**

Facts About Breast Cancer in Young Women | Breast Cancer Research Foundation



The Michigan Breast and Cervical Cancer Navigation Program provides low-income women access to breast and cervical cancer screening services and follow-up care.

**Source/Resources:**



## CERVICAL CANCER SCREENING (CCS)

**HEDIS Measure Description:**

- Women aged 21-64 years who were screened for cervical cancer using either of the following:
  - 21-64 who had a pap smear in the last 3 years (2024, 2025, 2026)
  - 30-64 who had PAP and HPV co-testing during the last 5 years (2022, 2023, 2024, 2025, 2026)
  - 30-64 who had High-risk HPV (hrHPV) testing (without cytology) during the last 5 years (2022, 2023, 2024, 2025, 2026)

NOTE: HPV reflex testing results do not satisfy the measure for 5 years

**EXCLUSIONS:**

- Hysterectomy with no residual cervix. Document: Total, Complete, Radical abdominal or Vaginal hysterectomy and the year of the surgery
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening will also meet this measure
- Patients receiving hospice or palliative care services

**Ways to improve Cervical Cancer Screening rates:**

Document date of hysterectomy in the medical record and code absence of cervix and uterus (Z90710)

For Pap and HPV co-testing, do not order “Reflex” testing as the lab will only run the HPV test if the PAP test is abnormal

Educate female patients about the importance of early detection and screening

Utilize MPP gaps in care reporting to identify patients with cervical cancer screening gaps

For patients who have testing done by their OB/GYN, request a copy of the test results from the specialist’s office (see OB/GYN Services Referral Form)

Suggestion is for OB/GYN's to use Z01411 or Z01419 encounter codes instead of Z0000 or Z0001 to prevent billing issues for family practice

Forward exclusion documentation to the health plan

**Cervical Cancer Screening:** Cervical cancer rates have risen by an average of 2.5% each year among women 30-34 years old.

Source: Shahmoradi Z, Damgacioglu H, Clarke MA, et al. Cervical Cancer Incidence Among US Women, 2001-2019. JAMA. 2022;328(22):2267–2269. doi:10.1001/jama.2022.17806

The Michigan Breast and Cervical Cancer Navigation Program provides low-income women access to breast and cervical cancer screening services and follow-up care.

Source/Resources:



# OB/GYN Services

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Health Plan ID: \_\_\_\_\_

## Primary Care Physician Information

Physician: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: MI Zip: \_\_\_\_\_

## FINDINGS

	<b>Date of service</b>	<b>Result</b>
Cervical Cancer Screening	_____	_____
Primary HPV Testing	_____	_____
HPV Co-Testing	_____	_____
Chlamydia Screening	_____	_____
Breast Cancer Screening	_____	_____

### **Please check any that apply:**

- Hysterectomy with no residual cervix  
Date of procedure: \_\_\_\_\_
- Pregnancy Test performed in current measurement year to screen for pregnancy before X-ray or Isotretinoin prescription
- Bilateral Mastectomy  
Date of procedure: \_\_\_\_\_

***Please return with a copy of the test results/reports to the fax number above***

**OB/Gyn Signature** \_\_\_\_\_

**OB/Gyn Printed Name Office Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**CHLAMYDIA SCREENING (CL)****Ways to improve  
Chlamydia Screening  
rates:**

Utilize MPP gaps in care reports to identify patients with chlamydia screening gaps

Perform chlamydia urine test for patients aged 16-24 when they present for pregnancy testing, dysuria, or birth control prescription/refill

Utilize test tracking methods to ensure compliance

Forward exclusion documentation to the health plan

Use EMR to flag patients due for screening

Normalize language about sexual health during office visits

**HEDIS Measure Description:**

- Percentage of women ages 16-24 who were identified as sexually active (through claims for birth control pills, STD testing, or pregnancy testing) who has at least one chlamydia test during 2026.

NOTE: screening may be performed by swab or urine

**EXCLUSIONS:** Women who were included in the measure based on pregnancy test alone and the member had a prescription for Isotretinoin or an X-ray on the date of the pregnancy test or the 6 days after the pregnancy test.

**Talking points:**

- All women who are prescribed birth control are considered sexually active according to the healthcare payers even if prescribed for acne or menses
- This exam is recommended for women between the ages of 16-24 because the rates of infection are very high Chlamydia is the most reported bacterial sexually transmitted disease in the United States
- This test can be as simple as a urine test
- If left untreated, infected women that do not receive treatment can experience future complications including Pelvic Inflammatory Disease, Infertility or Ectopic pregnancy

## CHILD AND ADOLESCENT WELL-CARE VISITS (WV)

### HEDIS Measure Description:

- Percentage of patients ages 3 to 17 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN during 2026.
- NOTE: Services specific to the assessment or treatment of an acute or chronic condition do not count towards this measure

### Documentation:

Documentation in the medical record must include a note indicating a visit to a PCP, Pediatrician or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all the following: (elements may be combined from multiple visits)

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance
- Counseling for nutrition & physical activity; ICD10 codes Z71.3 & Z71.82
- BMI Percentile ICD10 codes Z68.51, Z68.51, Z68.53, Z68.54, Z68.55 or Z68.56
- Chlamydia screening for 16 and older
- Depression screening (PHQ2 & PHQ9); ICD10 code Z13.31,
- CPT Code 96127

Description	Codes for Well-care Visits
Child and Adolescent Well-care Visits	CPT: 99382-4, 99392-4
	ICD-10: Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.82

**NOTE:** ICD 10 Codes for BMI Percentile, Counseling for Physical Activity, Counseling for Nutrition, Depression Screening **MUST** be billed on claims annually.

### Ways to improve Child and Adolescent Well-care visits:

Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a Well Care Visit, immunizations, and BMI value/ percentile calculations

Encourage parents to book next appointment before leaving the office

Use pre-visit planning to ensure correct well care visit template document is used

Convert sports/day care physicals into well-care visits by performing the required services and submitting appropriate codes

Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities

A sick visit and well-child visit can be performed on the same day by adding a modifier 25 to the sick visit, and billing for the appropriate preventive visit

Utilize MPP gaps in care reporting to identify patients with gaps to call patients who are due

**CHILDHOOD AND ADOLESCENT IMMUNIZATIONS (CIS & IMA)****Childhood Immunization Series Combo 10 HEDIS Measure Description:**

- Percentage of children who receive the following vaccines **before age 2 years**

**Immunizations included in Combo 10:**

- 4 DTaP (diphtheria, tetanus, acellular pertussis)
- 3 IPV (polio)
- 1 MMR (measles, mumps, rubella)
- 3 HiB (haemophilus influenza type B)
- 3 HepB (hepatitis B)
- 1 VZV (chicken pox)
- 4 PCV (pneumococcal conjugate)
- 1 HepA (hepatitis A)
- 2 or 3 RV (rotavirus)
- 2 Flu (influenza)

**Immunizations for Adolescents Combo 2 HEDIS Measure Description:**

- Percentage of adolescents who receive the following vaccines **before age 13 years**

**Immunizations included in Combo 2:**

- 1 meningococcal vaccine, administered between 11-13 years
- 1 TDaP (tetanus, diphtheria, pertussis), administered between 10-13 years
- Complete HPV (human papillomavirus) series, administered between 9-13 years

***These two HEDIS metrics have strict age requirements (before 2 years and before 13 years). After those dates, the metric is not met, but it is still important to complete immunization series.***

For more resources visit the McLaren Physician Partners webpage using the QR code:

**Ways to improve Vaccine Series Completion:**

Recommend and encourage vaccines at all appointments, not just well-visits

Utilize MCIR to run reports, review for completion, and to make sure vaccines you administered were uploaded

**Schedule next appointment at current appointment to stay on schedule**

Have a standardized approach throughout your office Each team member from front desk to back office to check out has the same pro-vaccine stance and is aware of schedules

Start HPV at age 9 and Flu at six months to help with metric completion

**Outreach before age 2 and 13 to catch patients who have fallen behind**

Use personal touches and stories, “I vaccinated my child” Or “I just got my own flu shot for this year”

For patients who go to the health department for vaccines, add them into your test tracking

**Never stop recommending vaccines, even if a parent declines today**

## MEDICATION ADHERENCE: PROPORTION OF DAYS COVERED

### HEDIS Measure Description:

- Patients who were dispensed and remained on medication during the measurement year for 80% of the treatment period. Patients enter the measure after the second fill of the medication class below.

### Measures Included:

Proportion of Days Covered Diabetes (All Class) – Patients 18 years or older with a prescription for a diabetes medication (e.g.-non-insulin antidiabetics) who were dispensed and remained on the medication during the measurement year for at least 80% of the treatment period.

Proportion of Days Covered RAS Antagonists (ACE/ARB) - Patients 18 years and older with a prescription for blood pressure medication who were dispensed and remained on an ACE/ARB during the measurement year for at least 80% of the treatment period.

Proportion of Days Covered Statins – Patients 18 years and older with a prescription for a statin who were dispensed and remained on the medication during the measurement year for at least 80% of the treatment period.

### EXCLUSIONS:

- Received hospice services anytime during the measurement year.
- Patients with end-stage renal disease diagnosis
- Diabetes measure only: Prescription for insulin
- Hypertension measure only: Prescription for sacubitril/valsartan

### Ways to improve medication adherence:

Encourage patients to submit insurance information when using RX discount programs

#### Encourage use of 90-day Rx fills and/or mail order with auto-refill

Forward exclusion documentation to the health plan

Patients must fill the RX, for it to count towards the 80%

If a patient has a preexisting prescription going into a new year the 80% adherence would be 80% of the entire year (Example: 80% of 365 days = 292 days)

If a patient is starting a new medication, the treatment period starts on the first day the patient picks up the prescription

MEDICATIONS INCLUDED IN EACH MEASURE		
Diabetes	Hypertension	Cholesterol
<ul style="list-style-type: none"> <li>• Biguanides</li> <li>• Sulfonylureas</li> <li>• Thiazolidinediones</li> <li>• Dipeptidyl peptidase (DPP)-IV inhibitors</li> <li>• Incretin mimetics</li> <li>• Meglitinides</li> <li>• Sodium glucose cotransporter 2 (SGLT2) inhibitors</li> </ul>	Renin-angiotensin system (RAS) antagonists: <ul style="list-style-type: none"> <li>• Angiotensin converting enzyme (ACE) inhibitors</li> <li>• Angiotensin II receptor blockers (ARBs)</li> <li>• Direct renin inhibitors</li> </ul>	Statins



## NON-MEDICAL DRIVERS OF HEALTH

**Non-Medical Drivers of Health** are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Purpose:** Standardized approach to screening for, documenting and coding social needs enabling healthcare systems to:

- Track the social needs that impact their patients, allowing for personalized care that addressed patients medical and social needs
- Aggregate data across patients to determine how to focus a non-medical driver strategy
- Identify population health trends and guide community partnerships

Use this QR code for a complete list of SDOH Codes



**Who can screen?** Clinicians including, but not limited to, social workers, community health workers, case managers, or nurses.

**Required Documentation:** use of standardized screening tool documented in the patient’s medical record with evidence of review. Must minimally include these five categories: Food, transportation, utility, living situation, and safety (refer to screening form or Cerner screening tool)



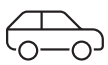




Refer patient to Care Management for positive screenings : **1-844-368-1817**

ICD-10 Code	Category	Description	Z-Code
<b>Z59: Problems related to housing and economic circumstances:</b>	Housing	Homelessness Unspecified	Z59.00
	Housing	Homeless, stays in shelter	Z59.01
	Safety	Inadequate Housing; includes feeling unsafe in home/ household/neighborhood	Z59.1
	Utilities	Inadequate housing utilities	Z59.12
	Food	Food Insecurity	Z59.14
	Living Situation	Extreme Poverty	Z59.5
	Transportation	Transportation Insecurity	Z59.82
<b>Z91: Problems related to personal risk factors</b>	Safety	Personal history of adult physical and sexual abuse	Z91.410
	Safety	Person history of adult intimate partner abuse	Z91.414



**NON-MEDICAL DRIVERS OF HEALTH SCREENING TOOL**

<b>Today's Date:</b>		<b>Physician/Provider Name:</b>	
<b>Patient Name:</b>		<b>Date of Birth:</b>	
<b>Address:</b>		<b>Zip Code:</b>	<b>Phone Number:</b>
<b>Office use only:</b> Referral sent to: <input type="checkbox"/> MPP Care Coordination <input type="checkbox"/> Community Resource <input type="checkbox"/> Other_____			

Patient Screening Questions		
	<b>What is your living situation today?</b>	<input type="checkbox"/> I have a steady place to live. <input type="checkbox"/> I have a place to live today, but I am worried about losing it in the future. <input type="checkbox"/> I do not have a steady place to live
	<b>In the past 12 months, have you ever eaten less than you feel you should because there is not enough food?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already shut off
	<b>Do you have a history of or are you currently in an abusive or neglectful situation?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Would you like to speak to a member of our Care Management department to assist you with any resources or needs indicated above?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>Are any of your needs urgent?</b> <i>For example: I do not have food today, I don't have a place to sleep tonight.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Declined to answer screening questions.

## ADDITIONAL HEDIS MEASURES AT A GLANCE

Category	Measure Title	Specifications
Respiratory Conditions	Appropriate Testing for Pharyngitis*	Patients ages 3 years and older diagnosed with pharyngitis and dispensed an antibiotic should have received a strep test within 3 days prior to diagnosis through 3 days after diagnosis. POC strep test completed in your office, you can bill <b>CPT 87880</b> .
	Appropriate Treatment for Upper Respiratory Infection*	Patients ages 3 months and older diagnosed with URI who were NOT dispensed an antibiotic 30 days prior through 3 days after the diagnosis.
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*	Patients ages 3 months and older diagnosed with acute bronchitis who were NOT dispensed an antibiotic.
	Medication management for people with Asthma	Patients 5-64 years of age, dispensed controller medication and remained on for at least 50% of the time during 2026.
Behavioral Health	Antidepressant Medication Management: Acute Phase	Patients ages 18 and older diagnosed with new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).
	Antidepressant Medication Management: Continuation Phase	Patients ages 18 and older diagnosed with new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).
	Follow-up Care for Children Prescribed ADHD Medication: Continuation and Maintenance (C&M) Phase (6-12 years)	Patients newly prescribed ADHD medication who remained on the medication for at least 210 days and who in addition to the visit in the initiation phase, had at least 2 follow-up visits within 270 days (9 months) after the initiation phase ended.
Transition of Care	Post Hospital Follow-up	Post hospital follow-up visit within 7 or 14 calendar days of discharge. Higher risk patients may need to be seen sooner.
Prevention Screening	Medical assistance with smoking cessation	Patients 18 years and older who are screened and are identified to use tobacco; receive face-to-face cessation advice, information on medication and strategies to help them quit.
	Influenza Immunization	Patients aged 6 months and older with a visit between August 1, 2025 and March 31, 2026 who received an influenza immunization OR who reported previous receipt of an influenza immunization. Document refusal.
Utilization	Imaging for Low Back	Patients aged 18 to 75 (not including palliative care or hospice) with a primary diagnosis of low back pain who did not have imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.
Pharmacy	Risk of Continued Opioid Use-15 days	Patients 18 years and older with >15 days of a NEW opioid Rx in a 30-day period, or 31 or more days of Rx in a 62-day period. Measurement period: Nov 1, 2025-Oct 31, 2026. Tramadol is considered an opioid in this metric.
Diabetes	Blood Pressure Control for Patients with Diabetes	Patients 18-75 years of age with diabetes whose blood pressure was adequately controlled less than 140/90 during the measurement year.

\*Metric is attributed to primary care provider even if ordered by another provider. Episodes are excluded if there is a history of a competing diagnosis or positive antibiotic history in the prior 30 days.

## MEDICATION RECONCILIATION POST DISCHARGE

**Purpose:**

- Medication Reconciliation helps patients understand any medication changes that occurred as a result of the hospitalization and helps prevent adverse drug events and other medication issues that may arise after discharge.

**Measure Description:**

- Patients 18 years and older whose hospital discharge medications were reconciled with the most recent medication list in the outpatient medical record on the date of discharge through 30 days after discharge.
- Emergency room or Urgent Care visits do not count as a hospital discharge.

**Documentation**

- Documentation must include evidence of medication reconciliation within the outpatient medical record.
- Performed by the prescribing practitioner, registered nurse or clinical pharmacist.
- May be performed during a telehealth visit.

**Acceptable Documentation Examples: Must include a phrase indicating reconciliation was completed.**

- Documentation of current medications with a notation that references the discharge medications eg no changes in meds since discharge, same meds at discharge, discontinue all discharge meds
- Documentation of the patient’s current medications with a notation that the discharge medications were reviewed
- Documentation that the provider “reconciled the current and discharge meds”
- Document of the current medication list, discharge medication list and notation that the appropriate practitioner reviewed both lists on the same date of service
- Notation that no medications were prescribed or ordered upon discharge
- Documentation that patient was seen for post-discharge follow-up with evidence of medication reconciliation or review
- Documentation in the discharge summary that the discharge medications were reconciled with the current medications; the discharge summary must be in the outpatient chart

Codes for Medication Reconciliation	Description
1111F	Discharge medications reconciled with current medication list in the outpatient medical record within 30 days of discharge. Does not need to be billed with 99495 or 99496, it is included in these codes.
99495	Transitional Care Management; communication with a patient/caregiver within two business days of discharge and a decision- making at least moderate-complexity within 14 days
99496	Transitional Care Management; communication with a patient/caregiver within two business days of discharge and a decision-making of at least high complexity within 7 days
99212-99215 + 1111F	If you do not have TCM documentation to bill TCM codes, please add 1111F with Office Visit E&M codes 99212-99215. During the 30 days post hospital discharge- bill 1111F Medication Reconciliation code with Office Visit E&M 99212-99215.

**NOTE: Codes listed above cannot be billed simultaneously or on the date of discharge.**

## ANNUAL WELLNESS VISIT

**Purpose:** Yearly personalized structured preventive appointment providing primary care providers the ability to create age-appropriate plans with their patients that can lead to identifying risk factors, and offering recommended evidence-based referrals.

### Ways to improve AWW rates:

Utilize MPP list to identify patients needing AWWs

Increase communication efforts through a pro-active approach using forms/letters, in-office or phone staff scripting including appointment reminders

Utilize Health risk assessment forms or documentation templates to ensure compliance

Schedule future appointments as an AWW with appropriate time allotted

Convert annual physical exam to AWWs in schedule

Conduct AWW during a Telehealth Visit

### Benefits

- \*No patient co-pay
- \*National reimbursement rate is \$174.35 for the initial year and \$137.61 for subsequent years.
- \*Identifies coding opportunities for chronic conditions to improve HCC diagnosis coding
- \*Attributes patient to provider
- \*Ancillary revenue opportunities for screenings or treatment of chronic conditions within McLaren network
- \*Supports Quality Measure Gap Closure
- \*Supports Patient engagement

### CODING

**G0402 – Initial Preventive Physical Examination** (“Welcome to Medicare” visit) for new Medicare enrollees within the first 12 months of Part B enrollment.

**G0438 – Initial Annual Wellness Visit** (if past the IPPE/Welcome visit timeframe, or after initial enrollment period).

**G0439 – Subsequent Annual Wellness Visits** (after the initial AWW).

### Codes that can accompany AWWs

The Annual Wellness Visit (AWV) is a preventive service and does not include evaluation or treatment of acute or chronic medical conditions. If management of medical conditions occurs on the same date of service, an E/M code (99202–99205 or 99211–99215) may be billed in addition to the AWW when documentation supports a separate and significant service. Modifier –25 must be appended to the E/M code.

**99497 – Advance Care Planning** (30 minutes, face-to-face) can be billed on the same day as an AWW (co-pay waived under Medicare when done at the time of the AWW).

**HCPCS G2211 - “Office or other outpatient evaluation and management visit complexity add-on”.** You can report HCPCS G2211 when performed on the same day as an AWW (codes G0438/G0439). That means if during a scheduled AWW you also address complexity beyond the usual preventive visit (e.g., moderate complexity E/M work), you can append G2211 with the appropriate E/M code billed with modifier -25.

**G0513 / G0514 – Prolonged preventive service codes** (30 extra minutes / 60+ extra minutes beyond the usual AWW) — useful if the AWW is more in-depth.

**G0442 / G0443 – Annual alcohol misuse screening** (G0442) and 15 min counseling (G0443). These may be performed during an AWW if eligible.

**G0447 – Obesity counseling** (15 minutes) when BMI meets criteria, may be done with IPPE or AWW.


**99406/99407 – Tobacco Cessation counseling.** 99406 (3-10 minutes) counseling, 99407 (≥ 10 minutes) counseling.

### Who can perform AWW?

Doctor of Medicine or Osteopathy, physician assistant (PA), nurse practitioner, certified clinical nurse specialist, or medical professional, including a health educator, registered dietician, nutrition professional or other licensed practitioner, or a team of medical professionals working under the direct supervision of a physician. (source: Medicare Processing Manual - Chapter 18 - Preventive and Screening Services)



## MEDICARE MEASURES

Category	Measure Title	Specifications
Adult Prevention and Screening Measures	Breast Cancer Screening (A)	Reference Page #15
	Colorectal Cancer Screening (A)	Reference Page # 14
	Falls: Screening for Future Fall Risk (A)  Use this QR code for a Fall Risk Assessment Tool that may be used during a telehealth visit: 	Patients 65 years of age and older who were screened for future fall risk during 2026. <b>Screening for Future Fall Risk:</b> Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure (Example screening tool: Get-Up-And-Go test.) <ul style="list-style-type: none"> <li>• Documentation of "no falls" is sufficient</li> <li>• Medical record must include documentation of screening performed</li> <li>• Any history of falls screening during the measurement period is acceptable</li> <li>• A gait or balance assessment meets the intent of the measure</li> </ul>
	Tobacco Use: Screening and Cessation Intervention (A)	Patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. <b>Tobacco Use</b> – Includes any type of tobacco, including smokeless/e-cigs/vaping <b>Tobacco Cessation Intervention</b> – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Written self-help materials (eg, brochures, pamphlets) and complementary/alternative therapies <b>do not</b> qualify for the numerator.
	Screening for Depression and Follow-Up Plan (A)	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool (examples: PHQ-2, PHQ-9) AND if positive, a follow-up plan is documented on the date of the eligible encounter. <b>A follow-up plan must</b> include one of the following: referral to a provider for additional evaluation and assessment, pharmacologic interventions, or other interventions or follow up for the diagnosis or treatment of depression. Codes: Administration of Screen: <b>G0444</b> , Positive PHQ-9 (5 or greater) AND a follow-up plan is documented <b>G8431</b> , Negative PHQ-9 (4 or less): <b>G8510</b>
Mental Health	Depression Remission at Twelve Months (A)	Patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event date. <b>Index Event Date:</b> The date in which the first instance of elevated PHQ-9 greater than nine <b>AND</b> diagnosis of depression or dysthymia occurs. <b>Remission:</b> defined as a PHQ-9 score of less than five. <b>Exclusions:</b> Patients with an active diagnosis of bipolar disorder, personality disorder, schizophrenia or psychotic disorder, pervasive developmental disorder any time prior to the end of the measurement period, patients who died, patients who received hospice or palliative care, or who were permanent nursing home residents any time during the denominator identification period or the measure assessment period.
Comprehensive Diabetes Care	Diabetes Care: Retinal Eye Exam	Reference Page # 12
	Glycemic Status Assessment for Patient with Diabetes (GSD) (A) NOTE: For ACO, can not use results from continuous glucose monitoring system	Percentage of diabetic patients ages 18-75 whose most recent glycemic status (hemoglobin A1c) or glucose management indicator (GMI) is <b>less than or equal to 9%</b> during 2026. Exclusion: Patients receiving hospice or palliative care services, in a long term care facility, or advanced illness & frailty
	Diabetes Care: Kidney Health Evaluation for Patient with Diabetes	Reference Page # 11
Transitions of Care	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

(A) – This measure is reported for ACO/MIPS Quality performance

Category	Measure Title	Specifications
<b>Care for Older Adults</b>  The percentage of adults 66 years of age and older who had each of the following during the measurement year	Medication Review	A review of all a patient’s medications, including prescription medications, OTC medications and herbal or supplemental therapies.
	Pain Assessment	At least one pain assessment is documented each year. Documentation must include either: <ul style="list-style-type: none"> <li>that the patient was assessed for pain (positive or negative findings) or</li> <li>patient was assessed for pain using a standardized assessment tool. For example, the Numeric Pain Rating Scale (NPRS) or the Wong-Baker FACES Pain Rating Scale.</li> </ul>
	Functional Assessment	At least one functional assessment is documented each year. Documentation must include one of the following: <ul style="list-style-type: none"> <li>Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking</li> <li>Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances</li> <li>Result of assessment using a standardized functional status assessment tool</li> </ul>
<b>Transitions of Care</b>	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.
<b>Cardiovascular Conditions</b>	Controlling High Blood Pressure (A)  The BP value in this measure meets the HEDIS specifications to close the gap. According to NCQA, for a member's BP to be controlled the systolic and diastolic BP must be <140/90mm Hg (adequate control).	Patients ages 18 – 85 with diagnosis of hypertension and whose blood pressure is adequately controlled, ≤139/89 (if hypertension is treated by a specialist, may obtain BP from their record). Blood pressure should be last one of the calendar year. Repeat any BP measurement that is 140/90 or higher. Blood pressure may be patient-reported taken with a digital device and documented. Claim date and date for compliant BP have to match.  Systolic Blood Pressure CPT II codes: - <b>3074F</b> SBP less than 130 - <b>3075F</b> SBP 130-139 - <b>3077F</b> SBP greater than or equal to 140  Diastolic Blood Pressure CPT II codes: - <b>3078F</b> DBP less than 80 - <b>3079F</b> DBP 80-89BP - <b>3080F</b> DBP greater than or equal to 90  Exclusions: ESRD, kidney transplant, dialysis, pregnancy during 2026, non-acute inpatient admission during 2026, hospice or palliative care services, or living in a skilled nursing facility, advanced illness or frailty.
<b>Patient Experience</b>  Patient experience (satisfaction) is being measured by the insurance companies. This is an example of the questions on the survey.  Visit the MPP.org website to view our Patient Experience Training:	Getting Needed Care (A)	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
	Getting Care Quickly (A)	<ul style="list-style-type: none"> <li>In the last 6 months, when you contacted this provider’s office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?</li> <li>In the last 6 months, when you made an appointment for a checkup or routine care with this provider, how often did you get an appointment as soon as you needed?</li> </ul> Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
	Care Coordination (A)	<ul style="list-style-type: none"> <li>In the last 6 months, how often did this provider seem to know the important information about your medical history?</li> <li>In the last 6 months, when this provider ordered a blood test, X-ray, or other test for you, how often did someone from this provider’s office follow up to give you those results?</li> <li>In the last 6 months, how often did you and someone from this provider’s office talk about all the prescription medicines that you were taking?</li> </ul> In the last 6 months, did you get the help you needed from this provider’s office to manage your care among these different providers and services?

(A) – This measure is reported for ACO/MIPS Quality performance

Category	Measure Title	Specifications
Pharmacy	Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults	Percentage of patients 65 and older with concurrent use of 2 or more unique anticholinergic medications. Concurrent use means overlapping prescriptions for anticholinergic medications adding up to at least 30 cumulative days during measurement period. <b>Lower rates mean better performance.</b> Exclusions: Patients who were admitted into hospice care any time during the measurement year.
	Concurrent Use of Opioids and Benzodiazepines (COB)	Percentage of patients 18 years and older with concurrent use of prescription opioids and benzodiazepines. This means two or more prescription claims for opioids filled on 2 or more different dates of service with a cumulative day supply of 15 or more days during the measurement year. <b>Lower rates mean better performance.</b> Exclusions: Cancer diagnosis, sickle cell disease, hospice care during the measurement year.
	Influenza Immunization	Patients aged 6 months and older with a visit between August 1, 2025 and March 31, 2026 who received an influenza immunization OR who reported previous receipt of an influenza immunization. Document refusal.
	Statin Therapy for Patients with Cardiovascular Disease	Percentage of patients 21-75 identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high-intensity or moderate-intensity statin medication during the year Also includes patients: - 20 years and older who have ever had a LDL level greater that equal to 190 or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR - Patients aged 40-75 with a diagnosis of diabetes Exclusions/Exceptions: pregnancy, IVF, breastfeeding, prescription for clomiphene, diagnosis of myalgia, myositis, myopathy, or rhabdomyolysis; patients with cirrhosis; patients with end-stage renal disease (ESRD); hospice or palliative care, living in a skilled nursing facility; advanced illness or frailty.
	Statin Therapy for Patients with Diabetes	Patients aged 40-75 with diabetes who do not have clinical atherosclerotic cardiovascular disease and were dispensed a statin medication during the year. Exclusions: Myocardial Infarction, CABG, PCI or other revascularization, IVD, pregnancy, IVF, prescription for clomiphene, ESRD, cirrhosis, myalgia, myositis, myopathy or rhabdomyolysis, hospice or palliative care, enrolled in long term facility, advanced illness and frailty.
	Osteoporosis Management in Women Who Had a Fracture	The percentage of women ages 67-85 years of age and older who suffered a fracture and who had either a bone density test or a prescription or a drug to treat or prevent osteoporosis six months after the date of the fracture. Code: 4005F (pharmacologic therapy [other than vitamins/minerals] for osteoporosis prescribed) Exclusions: Patients who had a bone mineral test, encounter for osteoporosis therapy, received a prescription to treat osteoporosis, use of hospice or palliative care, enrolled in long term care, or advanced illness and frailty. <b>Osteoporosis Medications</b>

Description	Prescription
Bisphosphonates	<ul style="list-style-type: none"> <li>• Alendronate</li> <li>• Alendronate-cholecalciferol</li> <li>• Ibandronate</li> <li>• Risedronate</li> <li>• Zoledronic acid</li> </ul>
Other Agents	<ul style="list-style-type: none"> <li>• Abaloparatide</li> <li>• Denosumab</li> <li>• Raloxifene</li> <li>• Romosozumab</li> <li>• Teriparatide</li> </ul>

(A) – This measure is reported for ACO/MIPS Quality performance

## ASSESSMENT

# Timed Up & Go (TUG)

**Purpose:** To assess mobility

**Equipment:** A stopwatch

**Directions:** Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

### ① Instruct the patient:

#### When I say “Go,” I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

#### NOTE:

Always stay by the patient for safety.

### ② On the word “Go,” begin timing.

### ③ Stop timing after patient sits back down.

### ④ Record time.

#### Time in Seconds: \_\_\_\_\_

An older adult who takes  $\geq 12$  seconds to complete the TUG is at risk for falling.

CDC’s STEADI tools and resources can help you screen, assess, and intervene to reduce your patient’s fall risk. For more information, visit [www.cdc.gov/steady](http://www.cdc.gov/steady)

Patient \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_  AM  PM

## OBSERVATIONS

Observe the patient’s postural stability, gait, stride length, and sway.

### Check all that apply:

- Slow tentative pace
- Loss of balance
- Short strides
- Little or no arm swing
- Steadying self on walls
- Shuffling
- En bloc turning
- Not using assistive device properly

These changes may signify neurological problems that require further evaluation.



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING   0   +        +        +         
=Total Score:       

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

**For PHQ screening tools in different languages; please go to [www.phqscreeners.com](http://www.phqscreeners.com)**

# MPP QUALITY REGIONS - 2026



## 1. McLaren Bay Region

MPP Providers in Arenac, Bay, Crawford, Iosco, Ogemaw, Roscommon, Saginaw counties

## 2. McLaren Caro Region

MPP Providers in Huron, Sanilac, Tuscola counties

## 3. McLaren Central Michigan

MPP Providers in Clare, Gladwin, Isabella, Midland counties

## 4. McLaren Flint

MPP Providers in Genesee county

## 5. McLaren Greater Lansing

MPP Providers in Calhoun, Clinton, Eaton, Ionia, Ingham, Livingston, Shiawassee counties

## 6. McLaren Lapeer Region

MPP Providers in Lapeer county

## 7. McLaren Macomb

MPP Providers in Macomb county

## 8. McLaren Northern Michigan

MPP Providers in Alpena, Antrim, Charlevoix, Cheboygan, Emmet, Grand Traverse, Otsego, Presque Isle counties

## 9. McLaren Oakland

MPP Providers in Oakland county

## 10. McLaren Port Huron

MPP Providers in St. Clair county

## 11. McLaren Thumb Region

MPP Providers in Huron, Sanilac, Tuscola counties

## 12. Karmanos Cancer Center

Providers throughout the regions with main site in Wayne County

### McLaren Physician Partners Medical Leadership

Michael Ziccardi, DO - Chief Medical Officer

michael.ziccardi@mclaren.org | 248-484-4923

Lawrence Cowsill, DO - Senior Medical Director

lawrence.cowsill@mclaren.org | 248-484-4925

**Director of Quality - Tiffany Francis, MPH**  
tiffany.francis@mclaren.org | 248-484-4931

**For General Quality Team Inquiries**

**MPPQuality@mclaren.org**





---

2701 Cambridge Ct., Ste 200 | Auburn Hills, MI 48326  
Phone: 248.484.4928 | Fax: 248.484.4999  
[McLarenPP.org](http://McLarenPP.org)

---