

# Quality Provider Program 2024 Performance Measures

ADULT AND PEDIATRIC



Select  
Health

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\* Intake and measurement periods are defined as follows for each measure:

- Intake Period: The time period when a new member can be identified for inclusion in the denominator
- Measurement Period: The time period wherein data is evaluated for compliance to measure

Other online resources include:

- [Primary Care Program Quick Guide](#)
- [Allowable Corrections Guide](#)
- [Frequently Asked Questions \(by Measure\)](#)
- [Best Practice Manual](#)

# Adult Quality Measures



## Annual Wellness Visits

<b>Description</b>	The percentage of eligible Select Health Medicare™ members who have received their Annual Wellness Visit (AWV)
<b>Denominator</b>	Members who have active Select Health Medicare coverage
<b>Numerator</b>	Members in the denominator who have received an AWV during 2024
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	Enrollment in hospice anytime during the measurement year
<b>Preferred Correction Process*</b>	<p>Centers for Medicare and Medicaid Services (CMS) does not allow for corrections at this time. Best practice is to submit an appropriate billing code with the visit, as follows:</p> <ul style="list-style-type: none"> <li>• G0402, G0438-G0439 + 9381-99397 with modifiers 52, 25, OR</li> <li>• 99201-99205 -99212-99215 with modifier 25 (when documentation supports both services according to Select Health Policy)*</li> </ul> <p>For telehealth codes, refer to the Select Health Coding and Reimbursement Policy #85: Telehealth, which was last revised on July 1, 2022, to address the evolving nature of telehealth during the coronavirus (COVID-19) pandemic. Additional interim coding resources can be found online on the Select Health Coronavirus Updates page.</p>

\* Select Health pays for an AWV and a preventive or Evaluation and Management (E&M) exam on the same date of service (frequently referred to as a Comprehensive Wellness Visit or CWV). Copays apply to an AWV billed with an E&M visit. Additionally, coinsurance may apply for some labs performed as part of the visit. Note that no copay applies when an AWV is billed with a preventive exam.

### ABOUT THE BENEFITS OF ANNUAL WELLNESS VISITS

Members value an opportunity to review preventive care, chronic conditions, and functional status issues with their providers.

For providers, a thorough review of a health risk assessment and a member's chronic medical condition(s) helps the primary care provider better coordinate care with secondary providers. In addition, accurate documentation and coding of chronic conditions improves the accuracy of the member's complexity, thereby making comparative outcome data more relevant and actionable.

## Cancer Screening: Breast

<b>Description</b>	The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer*
<b>Denominator</b>	Women ages 52 to 74 during 2024**
<b>Numerator</b>	Women in the denominator who had one or more mammograms any time between October 2022 and December 2024
<b>Intake and Measurement Periods</b>	<b>Intake Period:</b> January 1, 2023, through December 31, 2024 <b>Measurement Period:</b> October 1, 2022, through December 31, 2024
<b>Exclusions</b>	Members enrolled in hospice or palliative care any time during the measurement year Medicare members 66 years and older enrolled in an I-SNP or living in a long-term institution any time during the measurement year Members 66 years and older with claim-based proof of frailty and advanced illness during the measurement year on a dispensed dementia medication A woman with a history of a bilateral mastectomy or both left and right unilateral mastectomies with two different dates of service may be excluded from the denominator.
<b>Corrections Allowed</b>	“Patient had a mammogram.” “Patient is male.” “Patient does not fit age criteria.” “Patient had bilateral mastectomy or two unilateral mastectomies.”

\* Only mammography as recommended by the U.S. Preventive Services Task Force (USPSTF) or digital breast tomosynthesis screenings will satisfy this measure.

\*\* Once a woman turns 50, this difference between the measure description and the denominator description allows two years to complete the mammogram.

## Cancer Screening: Colorectal

<b>Description</b>	The percentage of members ages 45 to 75 who had appropriate screening for colorectal cancer
<b>Denominator</b>	Members ages 46 to 75 during 2024*
<b>Numerator</b>	Members in the denominator who had one of the following: <ul style="list-style-type: none"> <li>• Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) one or more times during 2024</li> <li>• Flexible sigmoidoscopy one or more times from 2020 to 2024</li> <li>• Colonoscopy one or more times from 2015 to 2024</li> <li>• CT colonography one or more times from 2020 to 2024</li> <li>• Fit DNA or Cologuard test one or more times from 2022 to 2024**</li> </ul>
<b>Intake and Measurement Periods</b>	<b>Intake Period:</b> January 1, 2024, through December 31, 2024 <b>Measurement Period:</b> January 1, 2015, through December 31, 2024
<b>Exclusions</b>	Members enrolled in hospice or palliative care any time during the measurement year Medicare members 66 years and older enrolled in an I-SNP or living in a long-term institution any time during the measurement year Members 66 years and older with claim-based proof of frailty and advanced illness during the measurement year on a dispensed dementia medication Members diagnosed with colorectal cancer or who have had a total colectomy at any time Members who died any time during the measurement year
<b>Corrections Allowed</b>	“Patient had appropriate screening.” “Patient has a diagnosis of colorectal cancer.” “Patient does not fit age criteria.” “Patient has a diagnosis of total colectomy.”

\* Once a member turns 45, this difference between the measure description and the denominator description allows one year to complete a colon cancer screening.

\*\* Please note:

- FIT and FIT-DNA (stool DNA with FIT test) are different tests.
- Cologuard test is a covered benefit on Select Health Medicare and Commercial plans.

## Diabetes Care

<p><b>Description</b></p>	<p>The percentage of members ages 18 to 75 with diabetes (type 1 or type 2)* who had:</p> <ul style="list-style-type: none"> <li>• Hemoglobin A1c (HbA1c) testing in control</li> <li>• Retinal eye exam performed</li> </ul> <p><b>Note:</b> Each of the measures listed above is evaluated and scored separately.</p>
<p><b>Denominator</b></p>	<p>Members ages 18 to 75 who have been identified as having diabetes (type 1 or type 2) through the use of claim/encounter data and pharmacy data</p>
<p><b>Numerator</b></p>	<p>Members in the denominator who had one of the following during the current measurement year:</p> <ul style="list-style-type: none"> <li>• Hemoglobin A1c &lt;8% (most recent HbA1c test)</li> <li>• A retinal eye exam performed by an eye care professional** <b>OR</b> a negative retinal eye exam performed in 2023</li> </ul>
<p><b>Intake and Measurement Periods</b></p>	<p><b>January 1</b> through <b>December 31</b> of the measurement year</p>
<p><b>Exclusions</b></p>	<p><b>Members who:</b></p> <ul style="list-style-type: none"> <li>• Are enrolled in hospice or palliative care any time during the measurement year</li> <li>• Have been prescribed dementia medications</li> <li>• Died any time during the measurement year</li> <li>• Have no diagnosis of diabetes in the measurement year or year prior</li> <li>• Have a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes</li> </ul> <p><b>NOTE:</b> Blindness does not remove patient from the measure.</p> <p>Medicare members 66 years and older:</p> <ul style="list-style-type: none"> <li>• Enrolled in an I-SNP or living in a long-term institution any time during the measurement year</li> <li>• With claim-based proof of frailty and advanced illness during the measurement year</li> </ul>
<p><b>Corrections Allowed</b></p>	<p>“A1c results are available.”                  “Patient had a diabetic eye exam.”                  “Patient does not have diabetes.”***</p>

\* A diagnosis of prediabetes does not place the member in the diabetes measure unless there is a diagnosis of R73.03 along with any diabetes medication management, which will then include them in the measure.

\*\* To be compliant, a retinal exam performed during the measurement year must include the result and evidence that result was read or reviewed by an eye care professional; for abnormal retinal eye exams, diabetes eye exams must be repeated annually. An eye exam with result documented as “unknown” does not meet criteria.

\*\*\* This correction can be made with complete documentation signed by MD or DO proving incorrect diagnosis as follows:

- The provider has documented that the member no longer has diabetes in the medical record (must provide complete documentation signed by MD or DO proving incorrect diagnosis).
- The medical record documentation substantiates off-label use of diabetes medications (e.g., diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes), and the health plan can verify the member has no history of diabetes in the billing codes.
- The medical record documentation with a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes without another diagnosis of diabetes.

## Diabetes Care: Kidney Health Evaluation

<b>Description</b>	The percentage of members ages 18-85 with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR)
<b>Denominator</b>	Members 18 to 85 who have been identified as having diabetes (type 1 or type 2) through the use of claim/encounter data and pharmacy data
<b>Numerator</b>	Members who received both of the following during the measurement year on the same or different dates of service: <ul style="list-style-type: none"> <li>At least one eGFR (blood test)</li> <li>At least one uACR* (urine test)</li> </ul>
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	<p><b>Members who:</b></p> <ul style="list-style-type: none"> <li>Have had ESRD or dialysis by the end of the measurement year</li> <li>Enrolled in hospice or palliative care any time during the measurement year</li> <li>Have been prescribed dementia medications</li> <li>Died any time during the measurement year</li> <li>Have no diagnosis of diabetes in the measurement year or year prior</li> <li>Have a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes</li> </ul> <p><b>Medicare members:</b></p> <ul style="list-style-type: none"> <li><b>(For those 66 years and older)</b> Enrolled in an I-SNP or living in a long-term institution any time during the measurement year</li> <li><b>(For those 66 to 80 years of age)</b> With claim-based proof of frailty and advanced illness during the measurement year</li> <li><b>(For those 81 years of age and older by the end of the measurement year)</b> With at least two indications of frailty during the measurement year on different dates of service</li> </ul>
<b>Corrections Allowed</b>	<p>“Patient does not have diabetes.”**</p> <p>“Patient completed an eGFR, urine albumin, and urine creatinine.”***</p>

\* uACR is identified by the uACR LOINC codes or by billing LOINC codes for both a quantitative urine albumin and a urine creatinine test with service dates four or less dates apart

\*\* This correction can be made with complete documentation signed by MD or DO proving incorrect diagnosis as follows:

- The provider has documented that the member no longer has diabetes in the medical record (must provide complete documentation signed by MD or DO proving incorrect diagnosis).
- The medical record documentation substantiates off-label use of diabetes medications (e.g., diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes), and the health plan can verify the member has no history of diabetes in the billing codes.
- The medical record documentation substantiates a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes without another diagnosis of diabetes.

\*\*\* Each missing component must be entered as a separate correction. If both the urine albumin and urine creatinine is missing, only one uACR correction is required.



## Medication Adherence: Cholesterol\*

<b>Description</b>	The percentage of Select Health Medicare members ages 18 and older with a prescription for a cholesterol medication (statin drug) who filled their prescription 80% or more of the time they are supposed to be taking the medication**
<b>Denominator</b>	Members ages 18 and older with at least two fills of cholesterol medication on two separate dates during the measurement year
<b>Numerator</b>	Adults in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	Enrollment in hospice care, diagnosis of end-stage renal disease (ESRD), or dialysis coverage dates anytime during the measurement year
<b>Corrections</b>	CMS does not allow for corrections at this time.

\* The Select Health pharmacy department conducts outreach phone calls to Select Health Medicare members at risk for noncompliance, as identified through pharmacy claims data.

\*\* Statins and statin combination therapies will enter a member into the Medication Adherence: Cholesterol measure. There is no consideration for an off-label use of a cholesterol medication listed within the methodology of this measure. If a cholesterol medication is filled twice in the measurement year, the member will be included in the measure.

## Medication Adherence: Diabetes\*

<b>Description</b>	The percentage of Select Health Medicare members ages 18 and older with a prescription for non-insulin diabetes medication who filled their prescription 80% or more of the time they are supposed to be taking the medication**
<b>Denominator</b>	Members ages 18 and older with at least two fills of non-insulin diabetes medication on two separate dates during the measurement year
<b>Numerator</b>	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	Enrollment in hospice care, diagnosis of end-stage renal disease (ESRD), or dialysis coverage dates anytime during the measurement year All insulin users regardless of whether they are prescribed oral diabetes medications
<b>Corrections</b>	CMS does not allow for corrections at this time.

- \* The Select Health pharmacy department conducts outreach phone calls to Select Health Medicare members at risk for noncompliance, as identified through pharmacy claims data.
- \*\* Non-insulin diabetes and non-insulin diabetes combination therapy will enter a member into the Medication Adherence: Diabetes measure. There is no consideration for an off-label use of a non-insulin diabetes medication within the methodology of this measure. If a diabetes medication is filled twice in the measurement year, the member will be included in the measure.

## Medication Adherence: Hypertension\*

<b>Description</b>	The percentage of Select Health Medicare members ages 18 and older with a prescription for a blood pressure medication who filled their prescription 80% or more of the time they are supposed to be taking the medication**
<b>Denominator</b>	Members ages 18 and older with at least two fills of hypertension medication on two separate dates during the measurement year
<b>Numerator</b>	Members in the denominator who filled their prescription 80% or more of the time they are supposed to be taking the medication
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	Enrollment in hospice care, diagnosis of end-stage renal disease (ESRD), or dialysis coverage dates anytime during the measurement year One or more prescriptions for sacubitril/valsartan
<b>Corrections</b>	CMS does not allow for corrections at this time.

\* The Select Health pharmacy department conducts outreach phone calls to Select Health Medicare members at risk for noncompliance, as identified through pharmacy claims data.

\*\* ACE inhibitors, ACE inhibitors combination therapy, ARB, and ARB combination therapy will enter a member into the Medication Adherence: Hypertension measure. There is no consideration for an off-label use of a blood pressure medication within the methodology of this measure. If a hypertension medication is filled twice in the measurement year, the member will be included in the measure.

## Statin Therapy: Diabetes\*

<b>Description</b>	The percentage of Select Health Medicare members ages 40 to 75 with diabetes who were dispensed at least two diabetes medication fills and received a statin medication fill during the measurement period**
<b>Denominator</b>	Members ages 40 to 75 who have been identified as having diabetes by claims/encounter data
<b>Numerator</b>	Members in the denominator who were dispensed at least one statin medication of any intensity in 2024
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	<p>Enrollment in hospice any time during the measurement year</p> <p>Adverse effects of antihyperlipidemic and antiarteriosclerotic drugs</p> <p>Pregnancy, lactation, or fertility in the measurement year</p> <p>Any of the following diagnoses:</p> <ul style="list-style-type: none"> <li>• Liver disease, PCOS, or prediabetes in the measurement year or year prior</li> <li>• ESRD, dialysis coverage dates, or cirrhosis in the measurement year or year prior</li> <li>• Myositis, myopathy, or rhabdomyolysis in the measurement year</li> </ul>
<b>Preferred Correction Process</b>	<p>Do NOT complete a correction submission. Best practice is to submit an appropriate exclusion code with the visit for the following:</p> <ul style="list-style-type: none"> <li>• “Patient has diagnosis of myositis.” (Statin Myositis, Drug-induced Myositis, Muscle Inflammation, General inflammation, Inflammation): M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879, M60.9 codes</li> <li>• “Patient has diagnosis of myopathy.” (Statin Myopathy, Drug-induced Myopathy, Muscle weakness, General Weakness): G72.0, G72.89, G72.9 codes</li> <li>• “Patient has diagnosis of rhabdomyolysis.” (Statin Rhabdomyolysis, Drug-induced Rhabdomyolysis, Elevated CK): M62.82 code</li> <li>• “Patient has diagnosis of lactation.” (Associations with lactation: Infection, Abscess, Nonpurenlent Mastitis, Retracted or Cracked Nipple, Unspecified Disorders): O91.03, O91.13, O91.23, O92.5, O92.70, O92.79, Z39.1 codes</li> <li>• “Patient has diagnosis of polycystic ovarian syndrome (PCOS).”: E28.2 code</li> <li>• “Patient has diagnosis of cirrhosis.”: K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69 codes</li> <li>• “Patient has diagnosis of ERSD.”: I12.0, I13.11, I13.2, N18.5, N18.6, N19, Z91.15, Z99.2 codes</li> <li>• “Patient has diagnosis of adverse effects of antihyperlipidemic and antiarteriosclerotic drugs.”: T46.6X5A code</li> </ul>

\* This measure is based on the Medicare Statin Use in Persons with Diabetes (SUPD) criteria.

\*\* For members who cannot tolerate statin therapy, a trial of as little as 7 days, if appropriate, would count for compliance.

# Pediatric Quality Measures



## Immunizations: Adolescence

<b>Description</b>	<p>The percentage of members 13 years of age who have completed the following vaccines by their 13th birthday:*</p> <ul style="list-style-type: none"> <li>• Meningococcal conjugate: one dose</li> <li>• Human papillomavirus (HPV): Either the two dose or three dose series**</li> <li>• Tetanus, diphtheria toxoids, and acellular pertussis (Tdap): one dose</li> </ul>
<b>Denominator</b>	Adolescents who turn 13 years of age during the measurement year
<b>Numerator</b>	Adolescents in the denominator who have completed the vaccinations listed in the “Description” above by their 13th birthday
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Data Source</b>	Data for this measure comes from Select Health claims, the Utah Statewide Immunization Information System (USIIS), and corrections made in the QDC tool.
<b>Exclusions</b>	Enrollment in hospice at any time during the measurement year
<b>Preferred Correction Process</b>	<p>Enter the immunization into USIIS using valid vaccine codes and avoiding unspecified codes when possible.***</p> <p>For the Quality Provider Program correction, include one of the following required forms of documentation from the medical record:</p> <ul style="list-style-type: none"> <li>• A note indicating the name of the specific antigen and the date of service</li> <li>• A certificate of immunization prepared by an authorized healthcare provider or agency that includes the specific dates and types of immunization administered</li> </ul>

\* The measure includes all adolescents who fit the criteria.

\*\* To meet the requirement for compliance, the two-dose series of HPV vaccine must be administered at a minimum of 146 days apart and prior to the member’s 13th birthday.

\*\*\* Intermountain Medical Group clinics should enter into iCentra, while affiliate clinics should enter into USIIS.

## Immunizations: Childhood

<p><b>Description</b></p>	<p>The percentage of members who have completed the following by their 2nd birthday:</p> <ul style="list-style-type: none"> <li>• Diphtheria, tetanus, and acellular pertussis (DTaP): four doses</li> <li>• Polio (IPV): three doses</li> <li>• Measles, mumps, and rubella (MMR): one dose</li> <li>• Haemophilus influenza type B (HiB): three doses</li> <li>• Hepatitis B (HepB): three doses</li> <li>• Chicken pox (VZV): one dose</li> <li>• Pneumococcal conjugate (PCV): four doses</li> <li>• Hepatitis A (HepA): one dose</li> <li>• Rotavirus (RV) vaccinations*: two or three doses</li> </ul>
<p><b>Denominator</b></p>	<p>Children who turn two years of age during the measurement year</p>
<p><b>Numerator</b></p>	<p>Children in the denominator who have completed the vaccinations listed in the “Description” above on or prior to their 2nd birthday</p>
<p><b>Intake and Measurement Periods</b></p>	<p><b>January 1</b> through <b>December 31</b> of the measurement year</p>
<p><b>Data Source</b></p>	<p>Data for this measure comes from Select Health claims, the Utah Statewide Immunization Information System (USIIS), and corrections entered in the QDC tool.</p>
<p><b>Exclusions</b></p>	<p>Enrollment in hospice anytime during the measurement year</p> <p>One of the following contraindications for a specific vaccine documented prior to the 2nd birthday:</p> <ul style="list-style-type: none"> <li>• <b>Any Vaccine:</b> Severe combined immunodeficiency, immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma, leukemia, or intussusception</li> <li>• <b>DTaP:</b> Encephalitis with a vaccine-adverse effect code</li> <li>• <b>Rotavirus, IPV, HiB, PCV:</b> Anaphylactic reaction to vaccine</li> <li>• <b>MMR:</b> Anaphylactic reaction to the vaccine or history of measles, mumps, or rubella</li> <li>• <b>VZV:</b> Anaphylactic reaction to vaccine or history of varicella zoster</li> <li>• <b>Hepatitis A:</b> Anaphylactic reaction to vaccine or history of Hep A</li> <li>• <b>Hepatitis B:</b> Anaphylactic reaction to common baker’s yeast or history of Hep B</li> </ul>
<p><b>Preferred Correction Process</b></p>	<p>Enter the immunization into USIIS using valid vaccine codes and avoiding unspecified codes when possible.**</p> <p>For the Quality Provider Program correction, include one of the following required forms of documentation from the medical record:***</p> <ul style="list-style-type: none"> <li>• A note indicating the name of the specific antigen and the date of service</li> <li>• A certificate of immunization prepared by an authorized healthcare provider or agency that includes the specific dates and types of immunization administered</li> </ul>

\* Depending on the brand used

\*\* Intermountain Medical Group clinics should enter into iCentra, while Utah affiliate clinics should enter into USIIS. For Idaho, Nevada, and Colorado clinics, Select Health does not receive data feeds from the state immunization records and would require data correction submissions using the QDC Tool.

\*\*\* Each missing date of service must be entered in as a separate correction.

## Immunizations: Childhood Influenza

<b>Description</b>	The percentage of members who have had two influenza vaccinations by their 2nd birthday
<b>Denominator</b>	Children two years of age during the measurement year
<b>Numerator</b>	Children in the denominator who have two doses of influenza vaccine, with different dates of service, on or prior to their 2nd birthday*
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Data Source</b>	Data for this measure comes from Select Health claims and the Utah Statewide Immunization Information System (USIIS).
<b>Exclusions</b>	<p>Enrollment in hospice anytime during the measurement year</p> <p>One of the following contraindications documented prior to the 2nd birthday:</p> <ul style="list-style-type: none"> <li>• Immunodeficiency</li> <li>• Human immunodeficiency virus (HIV)</li> <li>• Lymphoreticular cancer, multiple myeloma, or leukemia</li> <li>• Anaphylactic reaction to neomycin</li> </ul>
<b>Preferred Correction Process</b>	<p>Enter the immunization into USIIS using valid vaccine codes and avoiding unspecified codes when possible.**</p> <p>For the Quality Provider Program correction, include one of the following required forms of documentation from the medical record:</p> <ul style="list-style-type: none"> <li>• A note indicating the name of the specific antigen and the date of service</li> <li>• A certificate of immunization prepared by an authorized healthcare provider or agency that includes the specific dates and types of immunization administered</li> </ul>

\* Vaccinations administered prior to 6 months (180 days) of age do not count.

\*\* Intermountain Medical Group clinics should enter into iCentra, while Utah affiliate clinics should enter into USIIS. For Idaho, Nevada, and Colorado clinics, Select Health does not receive data feeds from the state immunization records and would require data correction submissions using the QDC Tool.



## Well-Care Visits: 0 to 15 Months\*

<b>Description</b>	The percentage of members who turned age 15 months during the measurement year and had six well-care visits with a primary care provider during their first 15 months of life**
<b>Denominator</b>	Children who turned age 15 months during the measurement year
<b>Numerator</b>	Children in the denominator who had at least six well-care visits on or before the day the child turned 15 months old. The 15 month birthday is calculated by using the child's first birthday plus 90 days. (Note that the date by which the visits must be completed is in the Measure Instructions column on the gaps list.)
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusion</b>	Enrollment in hospice anytime during the measurement year Members who died any time during the measurement year
<b>Corrections Allowed</b>	"Patient had at least six well-care visits before age 15 months old."***

\* 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/) (<https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/>)

\*\* Members with Select Health as a secondary insurance provider are also included in this measure. To count toward the measure, visits:

- Must occur on or before the member's 15-month birth date.
- Can include newborn or two-week visits. Note that all outpatient well-care visits with a primary care provider on different dates of service within the first 15 months of life will count toward the six required well-care visits. For an outpatient visit not coded as a well-care visit to count, documentation from the medical record must be submitted as a correction and include evidence that a well-care visit was done. Visits conducted within 2 weeks of each other will count as one visit.

\*\*\* Each missing visit date must be entered as a separate correction. Uploaded documentation of the office encounter must be labeled or identifiable as a well-care or preventive visit. Notation of acute or sick care cannot be the primary focus for the visit.

Refer to [Bright Futures](https://www.aap.org/en/practice-management/bright-futures) for more information. (<https://www.aap.org/en/practice-management/bright-futures>)

## Well-Care Visits: 15 to 30 Months\*

<b>Description</b>	The percentage of members who turned age 30 months during the measurement year and had two or more well-care visits with a primary care provider between the child's 15-month birthday plus 1 day and the 30-month birthday**
<b>Denominator</b>	Children who turned age 30 months during the measurement year
<b>Numerator</b>	Children in the denominator who had at least two well-care visits between the child's 15-month birthday (plus 1 day) and the 30-month birthday***
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusion</b>	Enrollment in hospice anytime during the measurement year Members who died any time during the measurement year
<b>Corrections Allowed</b>	"Patient had at least two well-care visits before age 30 months +1 day old."****

\* 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 \(https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/\)](https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/)

\*\* Members with Select Health as a secondary insurance provider are also included in this measure. \*\* To count toward the measure, visits:

- Must occur on or before the member's 15-month birth date.
- For an outpatient visit not coded as a well-care visit to count, documentation from the medical record must be submitted as a correction and include evidence that a well-care visit was done.

\*\*\* Children 3 years of age during the measurement year may be in both well-care visit measures: 15 to 30 months and 3 to 11 years.

\*\*\*\* Each missing visit date must be entered as a separate correction. Uploaded documentation of the office encounter must be labeled or identifiable as a well-care or preventive visit. Notation of acute or sick care cannot be the primary focus for the visit.

Refer to [Bright Futures](https://www.aap.org/en/practice-management/bright-futures) for more information. (<https://www.aap.org/en/practice-management/bright-futures>)

## Well-Care Visits: 3 to 21 Years\*

<b>Description</b>	The percentage of members ages 3 to 21 who had one or more comprehensive well-care visits with a primary care provider or OB/GYN during the measurement year**
<b>Denominator</b>	Children and adolescents ages 3 to 21 during the measurement year***
<b>Numerator</b>	Children and adolescents in the denominator who had at least one well-care visit during the measurement year
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusion</b>	Enrollment in hospice anytime during the measurement year Members who died any time during the measurement year
<b>Corrections Allowed</b>	Patient had at least one well-care visit during the measurement year."****

\* 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 \(https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/\)](https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/)

\*\* Members with Select Health as a secondary insurance provider are also included in this measure. All outpatient well-care visits with a primary care or OB/GYN provider between 3 and 21 years of age will count toward the well-care visit measurement. For an outpatient visit not coded as a well-care visit to count, documentation from the medical record must be submitted as a correction and include evidence that a well-care visit was done.

\*\*\* Children 3 years of age during the measurement year may be in both well-care visit measures: 15 to 30 months and 3 to 21 years.

\*\*\*\* Each missing visit date must be entered as a separate correction. Uploaded documentation of the office encounter must be labeled or identifiable as a well-care or preventive visit. Notation of acute or sick care cannot be the primary focus for the visit.

Refer to [Bright Futures](https://www.aap.org/en/practice-management/bright-futures) for more information. (<https://www.aap.org/en/practice-management/bright-futures>)

## Screening: Childhood Lead (Medicaid Only)

<b>Description</b>	The percentage of Select Health Community Care members who had at least one capillary or venous lead blood test for lead poisoning by their second birthday
<b>Denominator</b>	Children two years of age during the measurement year
<b>Numerator</b>	Children who had at least one lead capillary or venous blood test on or before the child's second birthday
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Exclusions</b>	Members in hospice or using hospice services any time during the measurement year Members who died any time during the measurement year
<b>Corrections Allowed</b>	"Patient had lead screening."*

\* For Quality Provider Program corrections, enter lead blood tests into the QDC Tool. Correction must include uploaded documentation of the test date and test result.

## Screening: Maternal Depression

<b>Description</b>	The percentage of postpartum women screened for clinical depression in a pediatric office up to 3 times in a newborn's first year of life
<b>Denominator</b>	The number of postpartum women presenting with their newborn for pediatric care
<b>Numerator</b>	The number of postpartum women screened for clinical depression in a pediatric office, using a standardized tool, up to 3 times in a newborn's first year of life
<b>Intake and Measurement Periods</b>	<b>January 1</b> through <b>December 31</b> of the measurement year
<b>Data Source</b>	Data for this measure comes from Select Health claims.
<b>Exclusions</b>	Deliveries for which members were in hospice or using hospice services any time during the measurement period
<b>Preferred Correction Process</b>	Centers for Medicare and Medicaid Services (CMS) does not allow for corrections at this time. Best practice is to submit an appropriate billing code with the visit, as follows:  <i>CPT 96161 "Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument."</i>

# Notes

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