



Astrana Health

Patient Screening and Education Guide



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General Reminders

- Patient refusal does not count as measure compliance
- Compliance is as of Dec. 31 of the measurement year except where an event such as fracture is measured.
- Star thresholds are reset annually based on national performance
- 5 Stars is not 100% to account for national average of patients who refuse and/or are not appropriate.
- Consumer assessment of healthcare providers and systems (CAHPS)
 - Patients perception of care over the last 6 months
- Health outcome survey (HOS)
 - Measures if the patients health has been maintained or improved over a 2 year period



Access to Care

- Everyone
- Every Year
- Regularly reviewing your care plan keeps you aligned with your health goals

AWV vs. APE

Annual Wellness Visit	Annual Physical Exam
Healthcare providers focus on preventive care and overall health assessment, discussing health risk factors, updating vaccinations, and creating a personalized prevention plan. Initial Preventative Physical Exam IPPE: "Welcome to Medicare" preventive visit is a review of a patients medical and social health history, includes education. LOB: Medicare & Medicare Advantage Ages: 65+ *Can change depending on family history Frequency: Annually Gap Closes: Claims Only HCPCS: G0402 - Welcome to Medicare G0438 - Initial Visit with Provider G0439 - Subsequent Visit with Provider	Focuses on vitals, general appearance, and examination. LOB: Commercial & Medicaid Age: 18-64yrs. Frequency: Annually Gap Closes: Claims Only ICD-10: Z00.00 - NORMAL Z00.01 - ABNORMAL New Patient: 99385 - 99387 Established Patient: 99395 - 99397 Less than 1: 99391 Age 1 - 4: 99392 Age 5 - 11: 99393 Age 12 - 17: 99394 Age 18 - 39: 99395 Age 40 - 64: 99396 Age 65+ : 99397

Transitions of Care



Notifications of Admission & Discharge

Receipt of admission and transition information
Anytime a patient has transitioned from acute/post acute

Care Management & PCP Contact

Within 1 business day of discharge



Provider Follow-Up Appointment

Within 5 days of discharge

Use CPT Code:
99495 or 99496

Medication Reconciliation Post Discharge

WITHIN 30 DAYS OF DISCHARGE

- By a RN or prescribing provider (MD/DO/ACP) or pharmacist
- Must include current medication list (patient reported or from medical record) and facility DC Medication list
- Within 30 days from date of discharge



Care of Older Adults

Functional Status Assessment

- ☐ ANNUALLY
- ☐ CPT Code: 99483 OR 1170F

Pain Assessment

- ☐ ANNUALLY
- ☐ CPT Code: Pain Present 1125F, No Present Pain 1126F

Advanced Care Planning

- ☐ ANNUALLY
- ☐ Attempt to obtain a copy for the medical record
- ☐ CPT Code: 99497 Adv. Care Present 1157F, Adv. Care Discussed 1158F

Annual Medication Review

- ☐ ANNUALLY
- ☐ CPT Code: List 1159F & Review 1160F

TIP: Medical assistant to check
and sign off in-person by
provider or telephonic by Nurse.
CPT Code: 1111F

Diabetic Care



Eye Exam for Diabetics (EED)

Age: 18-75

Medicare
Medicaid
Commercial

Frequency:

Positive - Annually
Negative - Every 2 Years

CPT Code:

Diabetes: E10, E11, E13
Positive: 2022F, 2024F, 2026F
Negative: 2023F, 2025F, 2033F

Refer patients with a diagnosis of diabetes (Type 1 or Type 2) to optometrist or ophthalmologist for dilated retinal eye exam.

Glycemic Status Assessment/A1C (GSD)

Age: 18-75

Medicare
Medicaid
Commercial

CPT Code:

<7.0% : 3044F
≥7.0% - <8.0% : 3051F
≥8.0% - <9.0% : 3052 F
≥9.0% : 3046F

Frequency: Annually

High Priority Measure:

Double weighted for Medicaid and Commercial
Triple weighted for Medicare patients

Obtain at least one HbA1c value <8% for Medicaid and Commercial patients;
at least one value <9% for Medicare patients.



Kidney Health Evaluation (KED)

Age: 18-85

Medicare
Medicaid
Commercial

CPT Code:

Estimated Glomerular Filtration Rate (eGFR):

80048, 80053, 80069, 82565

Urine Albumin-Creatinine Ratio (uACR):

82043, 82570

Frequency: Annually

Refer patients with a diagnosis of diabetes (Type 1 or Type 2) to lab to receive a kidney health evaluation during the measure year. Follow up with patients who have not completed test.

At least 1 eGFR AND at least 1 uACR identified by the following:

1st Option: A quantitative urine albumin test AND a urine creatinine test 4 or less days apart

2nd Option: A Urine Albumin-Creatinine Ratio

MUST be performed in the measurement year to be compliant

Cardiovascular Conditions

Blood Pressure Control (BPD)

Age: 18-75

Frequency: Annually

FOR ALL PATIENTS

Medicaid
Commercial

CPT Code:

Systolic

< 130 mmHg: 3074F

130 - 139 mmHg: 3075F

≥ 140 mmHg: 3077F

Diastolic

< 80 mmHg: 3078F

80 to 89 mmHg: 3079F

≥ 90 mmHg: 3080F



Educate patients to report blood pressure readings via telehealth encounters if they have digital monitors. Or encourage patients to keep a log and report back to their provider at their next in person visit. Reassess patient for compliance and medication regimen while stressing the importance of a healthy diet, exercise, and medication intake if BP readings are compromised.

Behavioral Health

Depression Screening and Follow-Up for Adults (DSF)

Age: 12+yrs.

Medicare
Medicaid
Commercial

Captured Through EHR System:

PHQ-2 LOINC: 55758-7
PHQ-9 LOINC: 44261-6
PHQ-Teens LOINC: 89204-2

Frequency: Annually

Utilize validated tools PHQ9/PHQ2 and ensure that the total score is written clearly on the form with DOS.

Please upload your completed assessment forms of PHQ9/PHQ2 on to the Provider Portal

Record notation of patient refusal on medial record.

Screen for depression and mood changes at every visit using validated tools (i.e., PHQ9/PHQ2)

Educate the patient on the importance of follow-up and adherence to treatment recommendations.

Schedule the next DSF appointment before the patient leaves practice and set reminder calls.

Refer to practitioner who is qualified to diagnose and treat depression, as needed.

Medication Adherence

CURRENT YEAR

MEDICATION ADHERENCE FOR HYPERTENSION (RAS ANTAGONISTS)

MEDICATION ADHERENCE FOR DIABETES MEDICATION

MEDICATION ADHERENCE FOR CHOLESTEROL (STATINS)

- Two medication fills puts the patient in one or more adherence measures
- Patient must have medications on hand at least 80% of the year
- The gap days between refills decreases their portion of days covered
 - In a total of 12 months the goal is to have medications filled at least 330 days
- When possible, prescribe 100 day fills
- Encourage patient to enroll in home delivery (mail order) pharmacy through their health plan

Prevention and Screenings

Breast Cancer Screening (BCS)

Age 40-75 *Speak with your provider if you have a family history

Frequency: EVERY 2 YEARS

CPT Codes:

Mammography: 77065 - 77067

Digital Breast Tomosynthesis: 77061 - 77063

Exclusion - History of Bilateral Mastectomy

ICD-10: Z90.13

Exclusion - History of Two Unilateral Mastectomies

ICD-10: Z90.11 & Z90.12

TIP: When ordering Mammo, order a DEXA

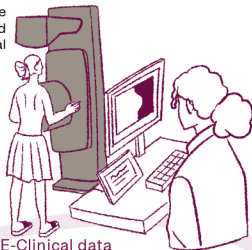
This measure should be collected and reported through the E-Clinical data system. Document the month and year of most recent mammogram with the result and/or mastectomy status in the medical record.

Patient reported mammogram is acceptable by documenting the month & year.

BI-RADS screening, regardless of the result, can close gaps.

Biopsies, breast ultrasounds, or MRIs do not count towards this measure

Medicare
Medicaid
Commercial



Cervical Cancer Screening (CCS)



Pap Smear / Cytology

HCPCS: G0123

HPV Test

HCPCS: G0476

Exclusion - Acquired absence of cervix

ICD-10: Z90.712 (w/ uterus)

ICD-10: Z90.710 (w/o uterus)

Total Abdominal Hysterectomy

CPT: 58150

Age 21-64

Medicaid
Commercial
Every 3 Years

Document the month & year when the cervical cancer screening was performed with specific test names and results in the medical record.

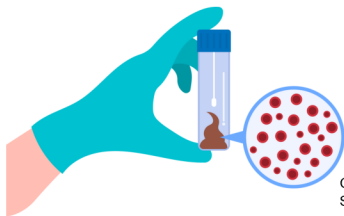
The cervical cytology and HPV test must be from the same data source

Request to have the results of pap tests sent over if completed for OB/GYN

Frequency:

- Patients 21-64 years of age who had cervical cytology in the measurement year or 2 years prior
- Patients 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed in the measurement year or 4 years prior
- Patients 30-64 years of age who had cervical cytology and human papillomavirus (hrHPV) co-testing performed in the measurement year or 4 years prior

Colorectal Cancer Screening (COL)



CT/Colonoscopy
Colonography/Sigmoidoscopy
Upload if gap exists
iFOBT/FIT DNA - Codes
submitted by laboratories

Age 45-75

Medicare
Medicaid
Commercial

Frequency:

Colonoscopy every **10 years** Cologuard every **3 years**
Sigmoidoscopy every **5 years** FIT/FOBT every **1 year**

TIP: Screening colonoscopy until the first time a polyp is removed but thereafter, all colonoscopies would be diagnostic.

Exclusions:

Colorectal Cancer -

ICD-10: C18.0 - C18.9, C19, C20, Z85.038, Z85.048

Colectomy -

CPT: 44150 - 44158, 44210 - 44212

Document the month & year, type, and result of colorectal cancer screening clearly.

Patient reported colonoscopy is acceptable by documenting the date and as much detail as the patient can offer.

Educate and discuss different screening options if the patient is hesitant.
Provide at home FOBT kits if refused other options

Create referral and/or standing order to share with the patient.

Provide a list of locations where colorectal cancer screening can be performed based on the recommendations and patients preference.

Follow Up and discuss the results and findings with the patient

Chlamydia Screening (CHL)

Age 16-24

Medicaid
Commercial

CPT Codes:

87110, 87270, 87320
87490-87492, 87810

Document the month & year and findings of the most recent screening.

Frequency:

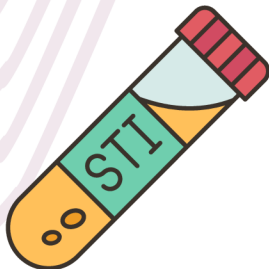
Annually for the patients within age range identified as sexually active.

Educate the patient on the importance of CHL

Conduct chlamydia screening via urine test as part of the annual physical exam

Parental consent is not required

Follow Up and discuss the results and findings with the patient



Bone Density (Dexa) Screening

Osteoporosis in Women After Fracture

Age: 65-85

Determines bone health to reduce the risk of a bone break

BMD Test

CPT: 7078 (CT)	HCPCSII: J0897	J3110 - J3111
77080 (DEXA)	J1740	J3489

Documentation should include Bone Mineral Density (BMD) testing on the day of fracture.

Inpatient BMD test is acceptable

Prescribe medication to treat osteoporosis on the day of fracture or within 180 days of fracture

Document Month & Year

Discuss osteoporosis prevention tips with the female patients within the age range.

Ask if the patient had any recent fractures or falls that the provider is not aware of.

Frequency: 180 days (6months) after the fracture

Osteoporosis Medications

ALENDRONATE

ALENDRONATE - CHOLECALCIFEROL

IBANDRONATE

RISEDRONATE

ZOLEDRONIC ACID

OTHER AGENTS

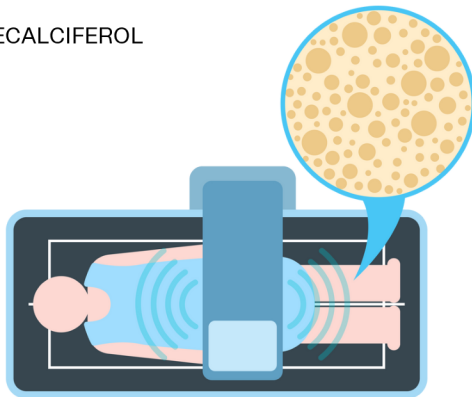
ABALOPARATIDE

DENOSUMAB

RALOXIFENE

ROMOSOZUMAB

TERIPARATIDE



Prenatal and Postpartum Care (PPC)

Prenatal document must include the date of visit and indicate at least one of the following:

- Fetal heart tone auscultation
- Pelvic exam with OB observations
- Fundal height measurement

All Ages
Medicaid
Commercial

Pre-Frequency: First trimester or within 42 days after enrollment postpartum, document must include the date and at least one of the following.

- Pelvic Exam
- Evaluation of - Weight, BP, Breast, and Abdomen
- Notion of Postpartum Care
- Depression Screening and Follow Up

Post-Frequency: On or before 7 - 84 days (1-12 Weeks After Delivery)

Timeliness of Prenatal Care

ICD-10: Z34.90

Primary diagnosis codes for pregnancy must be present

CPTII:

0500F - Initial

0502F - Subsequent

Postpartum Care

ICD-10: Z01.411

CPTII: 0503F

Encourage and stress the importance of prenatal visits.

Refer the patient to an OB/GYN for continued prenatal care.

Schedule the next visit before the patient leaves the office. Utilizing telehealth visits if the patient cannot make it to the office.

Encourage a postpartum visit between 7-84 days of delivery.



Pediatric Care

*Refer to Pediatrician as needed

Well-Child Visits (W15/W30)

Age: First 30 months Frequency: **Children 0-15 months old 6+ visits; 15- 30 months old 2+ visits during measurement year**

Medicaid
Commercial

ICD-10:

Z00.121 - Abnormal
Z00.129 - Normal

Well-child visits in the first 15 months

Six (6) or more visits CPT:
99381 (Initial) 99391 (Periodic)
***Before the 15th month**

Well-child visits for age 15 - 30 months

Two (2) or more visits CPT:
99382 (Initial) 99392 (Periodic)
***After 15th month, before 30th month**

Document office visit notes with dated growth chart with the evidence of the following: Health history; Physical development history; Mental development history; Physical exam; Health education/ anticipatory guidance.

Schedule timely visits within the recommended timeframe and educate parents on the importance of preventive care visits.

Utilize every visit, including sick visits, to capture the components of this measure.

Schedule the next well child visit appointment before patient leaves practice and set reminder calls.

Child and Adolescent Well Care Visits (WCV)

Age: 3-21 yrs. Medicaid Commercial ICD-10: Z00.121 - Abnormal Z00.129 - Normal CPT: 99382 - 99385 (New) 99392 - 99395 (Established) Frequency: **Annually**

Document office visit notes with dated growth chart with the evidence of the following: Health history; Physical development history; Mental development history; Physical exam; Health education/ anticipatory guidance.

Educate parents and patients on the importance of preventive care visits.

Take advantage of every visit, including sick visits for both evaluation and management to capture this measure.

Utilize telehealth visits when possible.

Schedule the next well child visit appointment before patient leaves practice

Weight Assessment & Counseling for Nutrition & Physical Activity (WCC)

Age: Less than 18 yrs.

Medicaid
Commercial

Nutrition:
ICD-10: Z71.3

Physical Activity:
ICD-10: Z71.82

BMI Percentile
ICD-10:
Z68.51 (<5%)
Z68.52 (5% to <85%)
Z68.53 (85% to <95%)
Z68.54 (≥95%)

Frequency: **Annually**

BMI percentile documentation MUST include height, weight, and BMI%.

Counseling of Nutrition documentation MUST include a checklist of items discussed (eating habits, dieting behaviors) and nutritional educational materials provided.

Documentation MUST include a checklist of items discussed (exercise routine, daily physical activity, sports participation) and educational materials provided such as a referral for physical activity.

Educate patients and parents on the importance of preventive care visits.

Provide instructions and educational materials on weight management. Anticipatory guidance for nutrition and/or physical activity.

Utilize telehealth visits, when possible, to communicate with the patient.

Schedule follow-up visits.

Lead Screening in Children (LSC)

Age: **After 1st birthday, before 2nd birthday**

CPT:
83655

Medicaid

Documentation must include the date of LSC performed with the results or findings.

Schedule timely appointments that must occur between the 1st and 2nd birthdays.

Communicate with parents about your findings and educate them on the prevention of LSC.

**** Modifier 25 should be appended to a problem-oriented visit when reported in conjunction with the (WCV, W15, W30) visit on the same day.**

Developmental Screening (DEV)

Age: 1-3 yrs.

Medicaid

CPT: 96110 Developmental Screening (i.e., developmental milestone survey, speech, and language delay screen)

Frequency: **Annually**

Utilize validated Developmental Screening tools and ensure that the result of the screening is documented with DOS.

Educate parents on the importance of assessment for developmental delays.

Encourage parents to monitor developmental milestones such as smiling, waving, crawling, first steps, etc.

Refer the child to the appropriate specialist as needed.

Depression Screening and Follow-Up for Adolescents and Adults (DSF)

Age: 12+ yrs.

Medicare

Medicaid

Commercial

Frequency: **Annually**

Captured Through EHR System:

PHQ-2 LOINC: 55758-7

PHQ-9 LOINC: 44261-6

PHQ-Teens LOINC: 89204-2

Utilize validated tools PHQ9/PHQ2 and ensure that the total score is written clearly on the form with DOS.

Please upload your completed assessment forms of PHQ9/PHQ2 on to the Provider Portal

Record notation of patient refusal on medial record.

Screen for depression and mood changes at every visit using validated tools (i.e., PHQ9/PHQ2)

Educate the patient on the importance of follow-up and adherence to treatment recommendations.

Schedule the next DSF appointment before the patient leaves practice and set reminder calls.

Refer to a practitioner who is qualified to diagnose and treat as needed.

Childhood Immunizations Status (CIS)

Age: Less than 2 yrs.

Medicaid

Commercial

IPV – 3 doses

CPT: 90697, 90698, 90713, 90723

Varicella Zoster – 1 dose

CPT: 90710, 90716

Pneumococcal Conjugate – 4 doses

CPT: 90670

Hepatitis A – 1 dose

CPT: 90633

Rotavirus – 2 or 3 doses

CPT: 90681 - 2 doses, 90680 - 3 doses

Hepatitis B – 3 doses

CPT: 90697, 90723, 90740, 90744, 90747, 90748

HIB – 3 doses

CPT: 90644, 90647, 90648, 90697, 90698, 90748

Influenza – 2 doses

CPT: 90655, 90657, 90661, 90673, 90685-90688

Document the current and/or historical date and type of each immunization administered to CAIR2. **All immunizations must be captured to close this measure.**

Time sensitive measure!

Schedule newborns for vaccines as soon patient turns six weeks old to prevent them from falling behind.

Educate parents on the importance of completing each vaccine series. Administer vaccinations during patients' office visits.

Schedule visits within the guideline timeframes. Contact and follow up with parents on their child's vaccination appointments.

Immunizations for Adolescents (IMA)

Age: By 13th birthday

Medicaid

Commercial

Tdap

CPT: 90649- 90651 (between 10th and 13th birthday)

CPT: 90715 HPV (2 or 3 times; 2 doses between 9th and 13th birthday)

Document the current and/or historical date and type of each immunization administered to CAIR2. **All immunizations must be captured to close this measure.**

Time sensitive measure!

Educate parents on the importance of completing each vaccine series. Administer vaccinations during patients' office visits.

Schedule visits within the guideline timeframes.

Contact and follow up with parents on their child's vaccination appointments.

**** Modifier 25 should be appended to a problem-oriented visit when reported in conjunction with the (WCV, W15, W30) visit on the same day.**

Documentation Tips

- **Diagnoses must be definitive**
 - Otherwise, document the signs and symptoms
- **All diagnoses reported in the assessment**
 - Must be supported in the progress note with status, plan and treatment
- **For the diagnosis to be considered valid, it must be supported by Monitor, Evaluate, Assessment, and Treatment (M.E.A.T.)**
 - Each assessed diagnosis in the assessment should include appropriate plan and treatment
- **Generally, conditions being managed, maintained, or controlled by medications are considered current and active.**
 - “Congestive Heart Failure, continue with Lasix”
- **Do not document “history of” for an active condition or assign an active code when the condition no longer exists.**
 - Can result in inaccurate documentation of conditions and impact quality of care
- **Be Specific:**
 - Use adjectives, e.g., chronic, recurrent, mild, intermittent, etc.
 - Include laterality, severity/stage, etiology
 - If in your clinical judgment a potential condition cannot be diagnosed definitively, please code signs and symptoms instead.
- **Linkage:**
 - Link meds/lab results to corresponding diagnoses (eGFR for CKD; Spirometry for COPD)
 - Document the status and treatment plan in the progress note for the conditions that are being evaluated
 - Causal Relationships: “CKD secondary to DM”
- **“Possible”, “Probable”, and “Likely”:**
 - In ICD-10-CM those terms mean the patient may or may not have the condition or it is **unconfirmed**
 - Only document condition(s) that have been confirmed and are supported with plan

Care Coordination

DID YOU KNOW?

When and who to refer to in our care coordination department for behavioral health, social services, and house calls.

Social Services

- Social Security application
- Housing, Authority, and Assistance with placement
 - Assisted Living Facility
 - Group Home
 - Nursing Home
- Immigration Services
- Department of Motor & Vehicle – ID
- Minute Phone
- Welfare
- Medicaid & Medicare applications
- Veterans
- Transportation

Psychiatrist

- Anything psych related
- Supervises Nurse Practitioner

Care Coordination

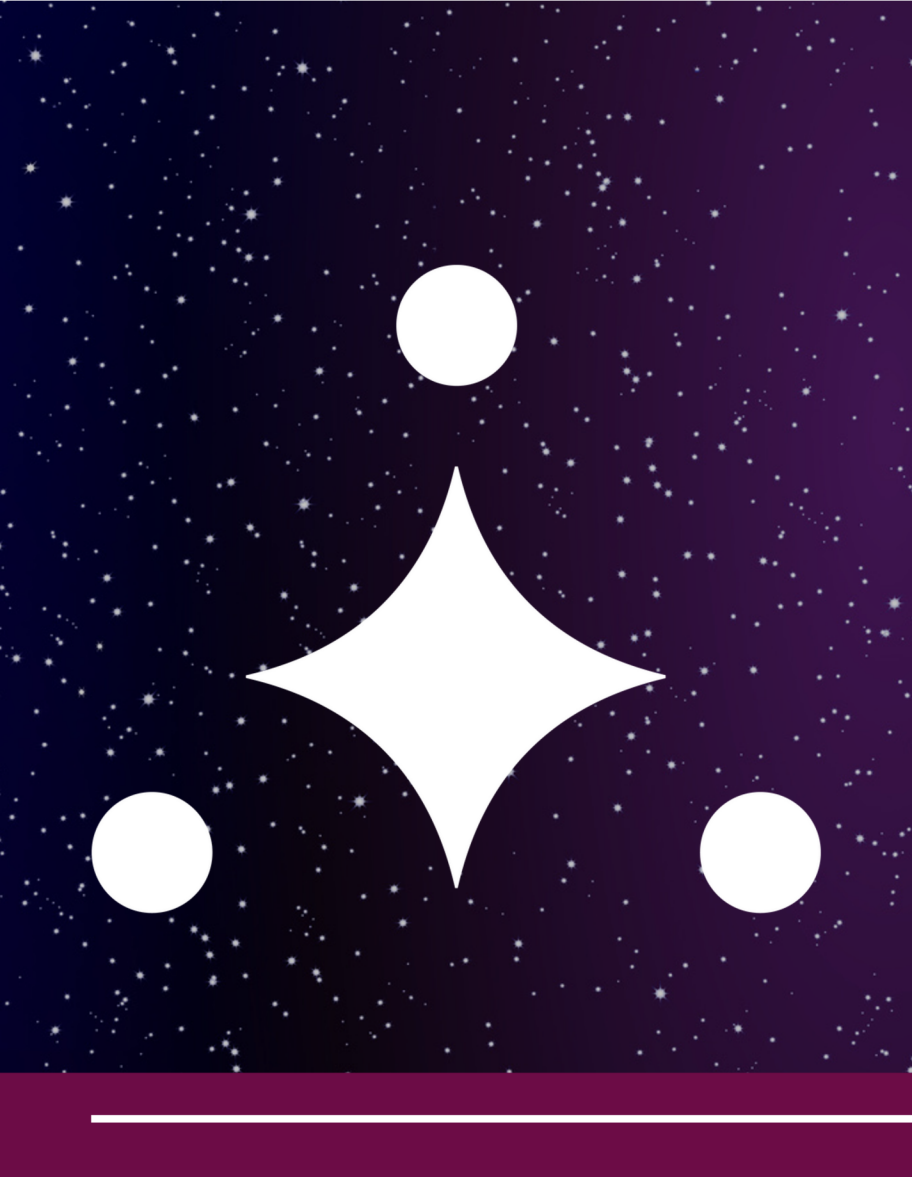
- Hospital High utilizers
- Chronic care coordination-high-utilizers
- Appointments/ referrals to in-network to Behavioral Health providers.
- House calls-as needed
- Transition of Care - Follow up appointments

Psychiatric Nurse Practitioner

Tina Sajadi, APRN, PMHNP
Grace Korir, MSN, PMHNP-BC

- Follow up after visit with psychiatrist
- Can see simple new patients
- Controlled medications





The Patient Screening and Education Guide

This is a practical tool to help clinics improve patient care. It offers guidelines for timely screenings, managing chronic conditions, and ensuring follow-up care, especially for high-risk patients. This guide includes recommendations for preventive services like annual wellness visits, cancer screenings, and diabetes care, along with tips for medication management. It also provides documentation advice to help clinics meet national quality standards. Using this guide will help clinics streamline care, improve patient outcomes, and ensure clear communication with patients. These booklets have been allocated according to each role in the clinic. They are designed for your specific position, so please do not take them home, keep them in office for your ongoing reference.

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