Cigarette Smoking Prevalence (Bundled Measure)

Measure Basic Information

Name and date of specifications used: OHA developed these specifications based on the Meaningful Use standards required for electronic health records, as well as cessation benefits guidance with URLs listed below.

URL of Specifications:

- Meaningful Use standards for recording tobacco use status: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/9_Record_Smoking_Status.pdf
- Health Evidence Review Commission (HERC) Prioritized List and Guidelines Notes: http://www.oregon.gov/OHA/HPA/CSI-HERC/Pages/Searchable-List.aspx ("tobacco" in search tool)
- OHA Public Health Division, Tobacco Cessation Coverage Standards: http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/tob_cessation_coverage_standards.pdf
- US Preventive Services Task Force, Final Recommendation – Tobacco Smoking Cessation in Adults: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1
- Treating Tobacco Use and Dependence, 2008 Update: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html
- Departments of Health and Human Services, Labor and Treasury FAQ regarding implementation of various provisions of the Affordable Care Act, May 2, 2014: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf

Measure Type:

HEDIS ☐ PQI ☐ Survey ☐ Other ■ Specify: OHA-developed, bundled measure / Meaningful Use.

Measure Utility:

CCO Incentive ■ State Quality Measure ☐ CMS Adult Core Set ☐ CMS Child Core Set ☐
Other ☐ Specify:

Data Source: Electronic Health Records, cessation benefits survey

Measurement Period: Calendar year 2018

2016 Benchmark: 25%, goal established in 1115 demonstration waiver for Medicaid tobacco prevalence
2017 Benchmark: 25%, Metrics and Scoring Committee consensus and alignment with 1115 waiver goals
2018 Benchmark: 25%, Metrics and Scoring Committee consensus and alignment with 1115 waiver goals

Changes in Specifications from 2017 to 2018

- In 2017, CCOs must meet the minimum benefit requirement and meet a threshold score of 75% to "meet" the measure.

- The Cessation Benefits Floor section was reorganized to improve readability and clarifying language was added regarding quit line benefits. These are clarifications, not a change in the intent.
- The Cessation Benefits Floor includes nicotine lozenges without prior authorization.
- In the EHR Prevalence section, a diagram was added to illustrate the relationship between the smoking rate and the tobacco use rate. This diagram is copied from an existing FAQ.
- Added clarifying language in Data Elements for Reporting to emphasize that the data to be reported is for CCO Medicaid members only. Open card Medicaid members are not counted in this measure. This is a clarification of the specifications, not a change in the intent of the measure.
- Under continuous enrollment criteria, removed reference to eligibility rule of "eligible as of last date of the reporting period" and added reference to alignment with CMS specifications.
- For those using components of NQF0028/CMS138, updated list of value sets as outlined in the Technical Release Notes available here: https://ecqi.healthit.gov/ecqm/measures/cms138v6
- Updated hyperlinks where URLs have changed.

Measure Details

Measure Components and Scoring

This bundled measure is intended to address both cessation benefits offered by coordinated care organizations and cigarette smoking prevalence. The bundled measure has three components:

1) Meeting minimum cessation benefit requirements ('cessation benefit floor');
2) Submitting EHR-based cigarette smoking and tobacco prevalence data according to data submission requirements;
3) Meeting benchmark or improvement target established by the Metrics & Scoring Committee.

Each component is worth a certain percentage. To meet the measure, CCOs must achieve a specified total. The scoring changes over the years, to allow CCOs time to phase in efforts to reduce prevalence.

Measure Components	2016		2017		2018	
For meeting cessation benefit requirement (pass / fail) If CCO does not meet this component, they cannot meet the measure.	40%	60%	33%	66%	25%	75%
For reporting EHR-based prevalence data	40%		33%		25%	
For reducing prevalence (meeting benchmark / improvement target)	20%		33%		50%	

In 2018, if a CCO meets the cessation benefit requirement, they earn 25% toward their total score. If they also report their EHR-based prevalence data, they earn an additional 25%, for a total score of 50%. Because the threshold score in 2018 increases to 75%, a CCO also must meet the benchmark or improvement target for reducing prevalence (worth 50% of the total score) to meet the measure.

Please note that even if a CCO meets the benchmark or improvement target on the measure, depending on their total score on the other components of the measure, they may not meet the measure. CCOs **must** meet the cessation benefit requirement to meet the measure, regardless of their total score.

Cessation Benefits Floor

OHA will assess each CCO's cessation benefits annually via an online survey to determine if CCOs meet the minimum requirements, or floor. The floor has been established by OHA, based on the materials listed in the URL of specifications section above.

OHA will assess the cessation benefit each CCO has in place as of July 1, 2018. The timing of the 2018 survey is to be determined. Information will be shared with the CCO Metrics Technical Advisory Workgroup (TAG) and posted to http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx. In the meantime, a PDF copy of the 2017 cessation benefit survey will be posted online. Please note that OHA may modify that survey for 2018, based on experience in 2017.

A "covered benefit" is defined here as a benefit that the CCO would pay for if a member receives that service. Sometimes, a service that a CCO would pay for may not actually be available in each community; for example, although a CCO would pay for group counseling, no group counseling is offered in the town where a CCO member lives. In such cases, the CCO would nonetheless receive credit for offering the benefit. In other cases, a CCO member may have access to a service that the CCO does not pay for ("does not cover") – in this situation, the CCO does not receive credit for that benefit.

To meet the cessation benefit floor, CCOs must cover the following components:

The cessation benefit must cover at least two quit attempts per year for both counseling services *and* FDA-approved cessation medications. For cessation medications, minimum quantities of each pharmacotherapy product are listed in Appendix 1.

Counseling (per quit attempt)	FDA-approved cessation medications (per quit attempt)	Access to cessation benefit
✓ Individual counseling – at least 4 sessions of at least 10 minutes each ✓ Group counseling ✓ Telephone counseling – a multi-call benefit (that is, more than one telephone counseling call)*	✓ Nicotine gum ✓ Nicotine patch ✓ Nicotine lozenge ✓ Nicotine nasal spray ✓ Nicotine inhaler ✓ Bupropion SR[1] ✓ Varenicline	✓ No prior authorization to access nicotine gum, patches, or lozenges ✓ No copayments, coinsurance, or deductibles ✓ No annual or lifetime dollar limits ✓ Must offer at least two quit attempts per year

* As part of the counseling requirement, CCOs must cover telephone counseling as a benefit. Telephone counseling can be provided by in-house staff or through a contract with a quit line vendor. The Oregon Tobacco Quit Line services that are funded by OHA's Public Health Division, however, are not a *CCO-covered* benefit. In addition, if an insurer (such as a CCO) does not contract with the Quit Line to provide benefits to its members, then the telephone counseling available through the Quit Line is limited to a single call rather than a multi-call service. For these reasons, use of the Public Health Division-provided Quit Line services does not meet this benefit requirement.

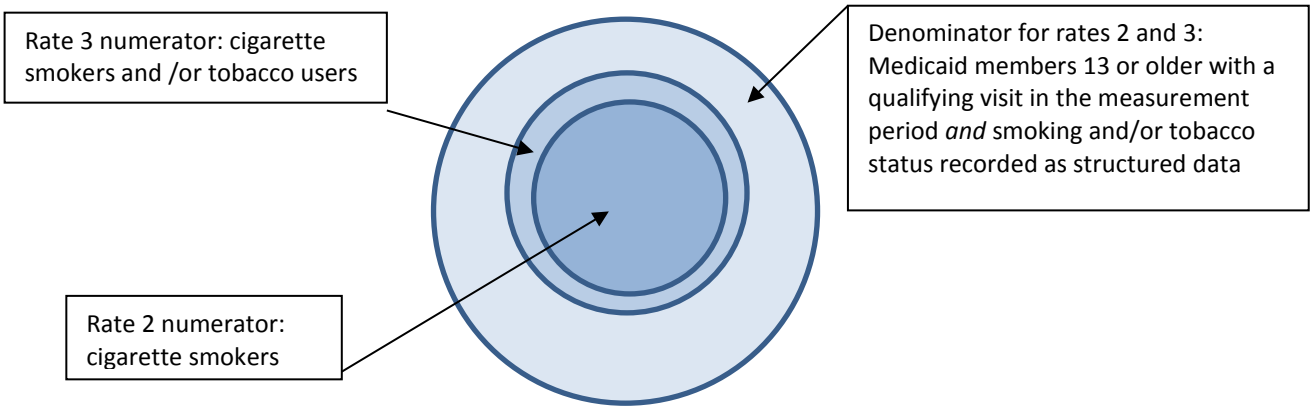
[1] See Appendix 1 for additional details on coverage for bupropion SR.

EHR-based Prevalence

Cigarette Smoking or Tobacco Use Prevalence

The intent of the measure is to address tobacco prevalence (including cigarette smoking and other tobacco products, such as chew, snuff, and cigars, and excluding e-cigarettes, marijuana, and those using nicotine replacement products such as patches).

However, due to variation in how EHRs capture smoking and tobacco use data and to ensure comparability of prevalence across EHRs and CCOs, the measure first looks for (1) the rate of screening for smoking and/or tobacco use and then looks for separate rates for (2) cigarette smoking and (3) tobacco use, including cigarettes and other tobacco products. The following diagram shows the relationship of the second and third rates.



As not all EHRs will be able to report on tobacco use, only the cigarette smoking prevalence will be used for comparison to the benchmark or improvement target. Although complete reporting is preferred, OHA will accept data submissions that include the cigarette smoking prevalence rate without tobacco use prevalence rate. If a practice is able to report the tobacco use prevalence rate but not the smoking prevalence rate, the CCO must seek OHA approval to include the practice in the CCO's data submission. For more information, see Cigarette Smoking Prevalence – Additional FAQ at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

Data Elements for Reporting

CCOs must meet reporting requirements as set out in the Year Six (2018) Guidance Documentation, which will be published no later than October 2018.

This prevalence measure is determined through three separate rates. Each rate will be reported separately.

1) Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded?
2) Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers?
3) Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers *and/or* tobacco users?

Please note that these rates are to be reported for CCO Medicaid members only. Open card Medicaid members are not counted in this measure.

Rate 1:

Data elements required denominator: Unique Medicaid members 13 years old or older by the beginning of the measurement year, who had a qualifying visit with the provider during the measurement period. See Appendix 2 for identifying qualifying visits.

If a patient is seen by the provider more than once during the measurement period, for the purposes of measurement, the patient is only counted once in the denominator.

Data elements required numerator: Unique members age 13 years or older who had a qualifying visit with the provider during the measurement period, who have their smoking and/or tobacco use status recorded as structured data.

Rate 2:

Data elements required denominator: Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Data elements required numerator: Of patients in the Rate 2 denominator, those who are cigarette smokers. See below for additional information on identifying cigarette smoking in the numerator.

Rate 3:

Data elements required denominator: Unique Medicaid members age 13 years or older who had a qualifying visit with the provider during the measurement period and who have their smoking and/or tobacco use status recorded as structured data (Rate 1 numerator).

Data elements required numerator: Of patients in the Rate 3 denominator, those who are cigarette smokers *and/or* tobacco users. See below for additional information on identifying tobacco use in the numerator.

Identifying Cigarette Smokers & Tobacco Users

Ideally, smoking and/or tobacco use status of the patient is recorded as structured data in the EHR in accordance with the certification criteria §170.207(h).[2] Smoking and/or tobacco use status noted as free text narrative in a patient's chart is unlikely to be recorded as structured data. The intent of this bundled measure is to utilize the EHR functionality to extract structured data via custom query, rather than manually conducting a chart review of the electronic records to identify tobacco users.

Numerator data must be submitted in two separate rates: cigarette smoking only, and broader tobacco use.

[2] The standard for recording smoking status is part of the Common Clinical Data Set, and it remains the same in both the 2014 Edition and 2015 Edition certification criteria.
https://www.healthit.gov/sites/default/files/commonclinicaldataset_ml_11-4-15.pdf

Rate 2 (see above): those who are current cigarette smokers

Those Medicaid members ages 13 years and older who have their cigarette smoking status recorded as structured data within the EHR who are current cigarette smokers. The current cigarette smoker rate includes all of the following categories:

- Current every day smoker
- Current some day smoker
- Smoker, current status unknown
- Heavy tobacco smoker
- Light tobacco smoker

Additionally, any combination of "yes" responses based on the individual EHR's functionality for recording cigarette smoking status as structured data that identifies cigarette smokers also qualifies as a positive numerator event.

Rate 3 (see above): those who are current tobacco users

Those Medicaid members ages 13 years and older, who had their tobacco use status recorded as structured data within the EHR who are current tobacco users.

The current tobacco user rate should include all of the above cigarette smoking categories and any other use of tobacco products, as documented in the individual EHR's functionality. For example, any other categories within the EHR that identify patients who use cigars, snuff, chew, strips, sticks, gum, etc.

Note: Cigarette smoking and/or tobacco use status must be recorded during the measurement year or the year prior to the measurement year. It does not need to be recorded on the date of the qualifying visit, but the recorded status cannot be older than 24 months. For the 2018 measurement year, this means any status recorded prior to January 1, 2017, should not be included.

Required exclusions for numerator:

- Members with missing smoking or tobacco use status will be excluded from rates 2 and 3. Data on members with missing smoking or tobacco use status will be collected separately to be reviewed in the future to determine whether this exclusion is potentially incentivizing providers to not record smoking status, particularly of known tobacco users, as this will result in an artificially lowered prevalence rate (and lower is better for this measure). See Rate 1 above.

  For additional information on this exclusion, please see the January 28, 2016, slides and notes from the Metrics Technical Advisory Group (TAG) meeting at http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Metrics-Technical-Advisory-Group.aspx

- Note that e-cigarettes and marijuana (medical or recreational) should be excluded from both the cigarette smoking rate and the broader tobacco use rate; the measure is focused on cigarettes and other tobacco products.

  Additional clarification may be needed with providers or modifications made to EHRs to ensure that providers and systems are asking about and documenting cigarette smoking and/or tobacco use separately from e-cigarette and marijuana use.

- In addition, the measure is focused on cigarette and tobacco use, not nicotine use. Patients who are using nicotine replacement therapy (NRT) should also be excluded from the numerator (unless they are also still using cigarettes and/or other tobacco products).

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria:
There are no continuous enrollment criteria required for this measure. OHA's intention is to maintain alignment with CMS electronic clinical quality measure (eCQM) specifications for reporting the supplemental data element for "Patient Characteristic Payer: Payer."

What are allowable gaps in enrollment: N/A

Define Anchor Date (if applicable): N/A

Appendix 1: Minimum Quantities Table for Cessation Medications

Medication, quantity, and dosage are based on the *Public Health Service -Treating Tobacco Use and Dependence: 2008 Update—Clinical Practice Guidelines,* online at www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html

Medication	**Bupropion SR***	**Varenicline**	**Nicotine Gum** 2mg and 4mg	**Nicotine Lozenge**	**Nicotine Inhaler** 10 mg	**Nicotine Nasal Spray**	**Nicotine Patch** 7mg, 14 mg, 21 mg, 42 mg
Quantity for one quit attempt.	150 mg, 1 box of 60 tablets = 30 day supply x 3 (90 days) = 3 boxes (180) per quit attempt	0.5 mg: 11 tablets per quit attempt 1 mg: One box contains 56 tablets = 30 day supply x 3 (90 days) = 3 boxes (168) per quit attempt	24 maximum per day x 90 days = 2,160 pieces per quit attempt Number of boxes depends on quantity per box: 2 mg (packaged in different amounts), boxes of 100–190 pieces) 4 mg (packaged in different amounts), boxes of 100–190 pieces)	20 Maximum per day x 12 weeks = 1,800 lozenges per quit attempt 2 mg, 72-168 lozenges per box 4 mg, 72-168 lozenges per box	16 cartridge maximum per day x 180 days = 2,880 cartridges per quit attempt 17 boxes (1 box has 168 10-mg cartridges)	Maximum 40 doses per day (80 sprays). 100 doses per bottle (200 sprays). 1 bottle will last at least 2.5 days. 36 bottle supply for 90 days per quit attempt	1 patch per day x 90 days = 90 patches per quit attempt

Medication	**Bupropion SR***	**Varenicline**	**Nicotine Gum** 2mg and 4mg	**Nicotine Lozenge**	**Nicotine Inhaler** 10 mg	**Nicotine Nasal Spray**	**Nicotine Patch** 7mg, 14 mg, 21 mg, 42 mg
Recommended Dosage for one quit attempt	**Recommended dose**: Patients should begin bupropion SR treatment 1–2 weeks before they quit smoking. Patients should begin with a dose of 150 mg every morning for 3 days, then increase to 150 mg twice daily. **Maximum dose:** Dosage should not exceed 300 mg per day. **Duration:** Dosing at 150 mg twice daily should continue for 7–12 weeks.	**Recommended Dose:** Start varenicline 1 week before the quit date at 0.5 mg once daily for 3 days, followed by 0.5 mg twice daily for 4 days, followed by 1 mg twice daily. **Duration:** Continue 1 mg twice daily for 3 months. Maintenance at 0.5 mg twice daily is also an option for those with dose-related side-effects (pg 114 of Clinical Practice Guidelines)	**Recommended Dose:** Various recommendations, including 2 mg gum for those smoking ≥30 minutes after waking up, or <25 cigarettes per day; 4 mg gum for those smoking <30 minutes after waking up, or ≥25 cigarettes per day. **Recommended Frequency:** One piece every 1 to 2 hours for the first 6 weeks. **Minimum Recommended Daily Frequency:** At least 9 pieces per day for the first 6 weeks. **Maximum Daily Frequency:** Up to 24 pieces per day.	**Recommended Dose:** The 2-mg lozenge is recommended for patients who smoke their first cigarette ≥30 minutes after waking, and the 4-mg lozenge is recommended for patients who smoke their first cigarette <30 minutes after waking. **Recommended Frequency:** One piece every 1 to 2 hours for the first 6 weeks. **Minimum Recommended Daily Frequency:** At least 9 lozenges per day for the first 6 weeks.	**Recommended dose:** A dose from the nicotine inhaler consists of a puff or inhalation. Each cartridge delivers a total of 4 mg of nicotine over 80 inhalations. **Minimum Recommended Daily Frequency**: 6 cartridges per day. **Maximum Daily Frequency**: 16 cartridges per day. **Duration:** Recommended duration of therapy is up to 6 months. Instruct patient to taper dosage during the final 3	**Recommended Dose:** Each dose (2 sprays, one in each nostril) contains 1 mg of nicotine. Initial dosing should be 1-2 sprays per hour, increasing as needed for symptom relief. **Minimum Recommended Daily Frequency:** 8 doses (16 spays) per day. **Maximum Frequency:** Up to 5 doses (10 sprays) per hour; up to 40 doses (80 sprays) per day. **Duration:** Recommended duration of therapy is 3 months.	**Recommended Dose:** Treatment of 8 weeks or less has been shown to be as efficacious as longer treatment periods. Patches of different doses sometimes are available as well as different recommended dosing regimens. The dose and duration recommendations in this table are examples. Clinicians should consider individualizing treatment based on specific patient characteristics, such as previous experience with the patch, amount smoked,

Medication	Bupropion SR*	Varenicline	Nicotine Gum 2mg and 4mg	Nicotine Lozenge	Nicotine Inhaler 10 mg	Nicotine Nasal Spray	Nicotine Patch 7mg, 14 mg, 21 mg, 42 mg
			Duration: The gum should be used for up to 12 weeks.	**Maximum Daily Frequency:** Up to 20 lozenges per day. **Duration:** The lozenge should be used for up to 12 weeks.	months of treatment.		degree of dependence, etc.

*About Bupropion SR

Bupropion SR is an FDA-approved, evidence-based product for cessation, marketed as Zyban. However, bupropion SR is also the generic product for Wellbutrin, for depression. Wellbutrin / bupropion SR for depression is currently on the 7/11 carve out list of mental health drugs, rather than on CCOs' formularies.[3] Given that the generic product is the same drug, there can be confusion regarding what CCOs are expected to cover as part of the minimum cessation benefit. This section provides clarification on the expectations for bupropion SR coverage as part of the minimum cessation benefit.

Specific codes for generic products can be used to differentiate between generic bupropion SR for Zyban (cessation) and generic bupropion SR for Wellbutrin (depression). See table below. To meet the minimum cessation benefit requirement for bupropion SR, CCOs must cover Zyban and/or generic bupropion SR that is therapeutically equivalent to Zyban (i.e., AB2). The availability of Wellbutrin/ generic bupropion SR that is therapeutically equivalent to Wellbutrin (i.e., AB1) on the 7/11 carve out list will not meet minimum cessation benefit criteria.

[3] http://www.oregon.gov/oha/HSD/OHP/Pages/Plan-Tools.aspx (Scroll down to the section labeled "7-11 Drug Carveout List")

Purpose	Product	Generic	Brand	FDA's Orange Book Therapeutic Equivalence[4]	Generic Code Number[5]
Major Depression Disorder	Bupropion HC1 extended-release (SR) tablets 100 mg, 150 mg, 200 mg	Buproprion HCL SR 150 mg	*Wellbutrin SR*	AB1	FDB GCN 46238
Smoking Cessation	Bupropion HC1 sustained release tablets 150 mg	Bupropion HCL SR 150 mg	*Zyban*	AB2	FBD GCN 31439

In practice, which product is dispensed to a member at the pharmacy depends on both how the doctor writes the prescription and which products the pharmacy stocks:

- If the prescription is written specifically for Zyban, the pharmacy will either dispense Zyban or the generic bupropion SR therapeutically equivalent to Zyban. The pharmacy would then know that the prescription is for cessation purposes and would bill the CCO.

  If the prescription is written specifically for Wellbutrin, the pharmacy will either dispense Wellbutrin or the generic bupropion SR therapeutically equivalent to Wellbutrin. The pharmacy would then know that the prescription is for mental health purposes and would bill the state under the 7/11 carve out.

  If the prescription is written for bupropion SR, but also includes purpose of diagnosis (e.g., "bupropion SR for depression"), pharmacists are directed by Oregon law to provide the therapeutically equivalent form of the generic for the stated purpose.[6]

- If the prescription is written for bupropion SR without any other clarification or diagnosis (e.g., "bupropion SR for depression"), the pharmacy will not know if the product is for cessation or mental health, and will likely dispense the cheapest generic form of bupropion SR available (which currently is bupropion SR affiliated with depression). See cost table below.

  Oregon law allows pharmacists to dispense or administer the lowest retail cost, effective brand which is in stock when the practitioner prescribes a drug by its generic name.

[4] http://www.fda.gov/Drugs/InformationOnDrugs/ucm129662.htm

[5] This number is the unique identifier created by FirstDataBank, Oregon's vendor for loading drug information into MMIS.

[6] See ORS 689.515 http://www.oregonlaws.org/ors/2007/689.515

Average Actual Acquisition Cost (AAAC) by product[7]	Generic bupropion SR	Brand
Depression	17 cents / tablet. 60 tablets / month. 3 month course = ~$30.	$5.38 / tablet
Cessation	45 cents / pill 60 pills / month 3 month course = ~$81	$3.41 / tablet* *No AAAC available; wholesale price listed*

OHA anticipates that pharmacies will continue to dispense the generic bupropion SR for depression and bill the state under the 7/11 carve out, unless otherwise directed, given the cost differential. As long as the CCO also covers Zyban or generic bupropion SR for cessation on their formulary, this is acceptable.

CCOs may need to work with their pharmacy benefit managers to ensure that Zyban or generic bupropion SR for cessation is added to their formularies.

CCOs may also need to provide updates to pharmacies to clarify coverage for cessation products.

[7] Rates in this table were taken from the AAAC Rate Listing for rates effective as of December 15, 2015. Rates are updated frequently. The most recent rates can be found at http://www.mslc.com/Oregon/AAACArchiveList.aspx.

Appendix 2: Qualifying Visits

CCOs must use one of the following options for identifying the tobacco prevalence denominator and document which denominator option is being used as part of the data submission.

(1) If a Meaningful Use Report is available, use the Denominator Encounter Criteria for the MU Smoking Status Objective:

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include:

(1) Concurrent care or transfer of care visits
(2) Consultant visits, or
(3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health).

A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Notes: Specific E&M codes would need to be defined by those pulling the data. There may be Meaningful Use queries/reports that they could use, but it wouldn't ensure a transparent or standard process (especially for data validation).

(2) If a Meaningful Use Report is unavailable, code sets included in the Denominator Encounter Criteria for the MU Tobacco Cessation clinical quality measure (CQM) may be used:[8]

Denominator Encounter Criteria for Tobacco Use and Cessation Intervention (NQF 0028/ CMS 138)[9]

[8] Value sets can be downloaded from the Value Set Authority Center: https://vsac.nlm.nih.gov/#download-tab

[9] Please note that this list of qualifying visits does include non-primary care provider qualifying visits, particularly mental health treatment. These visits are included because some mental health professionals may participate in Meaningful Use, and we erred on the side of not modifying the MU list of qualifying visits.

However, if a custom query is applied at the practice level for all providers, with no exclusion for non-PCPs applied, it may pull in data from mental health professionals for patients already included in the denominator for their PCP visits. In other words, a patient may have multiple qualifying visits with both provider types that would be picked up.

We do advise applying the custom query only to data for primary care providers, since that is the scope of our reporting here; however, if that is not feasible, we recommend stripping out the non-PCP qualifying visits after the query has been run to avoid duplication.

On a related note, this list of qualifying visits does not include dental visits, although some dental providers may be engaged in addressing cessation and providing interventions. Similarly to the mental health professional denominator duplication issue described, including dental visits in the list of qualifying dental health visits could also lead to duplication of members in the denominator if they have both a qualifying PCP visit and a qualifying dental health visit.

Type of Visit	Code
Annual Wellness Visit	HCPCS (2017) G0438, G0439
Face-to-Face Interaction	SNOMEDCT (2017-03) 12843005, 18170008, 185349003, 185463005, 185465003, 19681004, 207195004, 270427003, 270430005, 308335008, 390906007, 406547006, 439708006, 87790002, 90526000
Health & Behavioral Assessment - Individual	CPT (2017) 96152
Health and Behavioral Assessment - Initial	96150
Health and Behavioral Assessment, Reassessment	96151
Home Healthcare Services	99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
Occupational Therapy Evaluation	97165, 97166, 97167, 97168
Office Visit	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
Ophthalmological Services	92002, 92004, 92012, 92014
Preventive Care Services - Established Office Visit, 18 and Up	99395, 99396, 99397
Preventive Care Services - Group Counseling	99411, 99412
Preventive Care Services - Other	99429
Preventive Care Services-Individual Counseling	99401, 99402, 99403, 99404
Preventive Care Services-Initial Office Visit, 18 and Up	99385, 99386, 99387
Psych Visit - Diagnostic Evaluation	90791, 90792
Psych Visit – Psychotherapy	90832, 90834, 90837
Psychoanalysis	90845
Speech and Hearing Evaluation	92521, 92522, 92523, 92524, 92540, 92557, 92625

OHA does recommend keeping the focus on qualifying PCP / outpatient visits to align with other EHR-based measures, but if there are concerns that some members are *only* being seen in dental settings, there may be rationale to include these dental visits in the denominator to ensure that the members are captured in the prevalence data. Please contact OHA for additional discussion on including dental visits.

Version Control

1/12/18 – Corrected typo on p13 so text refers to CMS 138 (tobacco use: screening and cessation intervention) rather than CMS 136.