INTERPRETA SUPPLEMENTAL DATA PORTAL REFERENCE GUIDE 2021

Quality Management
qualitymeasures@medpointmanagement.com
818-702-0100, ext. 1353

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

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TABLE OF CONTENTS

Introduction to Supplemental Data

Encounters are always the best way to send HEDIS data; however, there are circumstances where only medical records or data extractions will make the members compliant. There are two ways to submit supplemental data:

1. **Interpreta Supplemental Data Portal**
    - Upload medical records one by one for each member that may have one or multiple HEDIS measures and codes.
    - Full instructions are included in this Guide.
2. **Excel Templates for Medical or Lab**
    - Type 1 – **Standard Data** – EHR extract that require no corrections, additions of data or codes on an Excel template (i.e. blood pressure readings). No medical records are initially required to be sent.
    - Type 2 – **Non-Standard Data** – Data that has been manually entered or altered on an Excel template. Medical records are required to be submitted with the file.
    - Instructions – Each template includes tabs at the bottom that explain what is required for each column (field), a health plan code list and provider specialty code list.
    - **Request Forms** – To request the Excel Supplemental Data template forms, please contact your Quality Specialist or email QIFiles@medpointmanagement.com.
    - **Training** – We are available to help you plan your supplemental data strategies, train you on the spreadsheets and answer your questions. Email us or call at 818-702-0100, x1353.

Most Common Supplemental Data Submitted:

1. BCS and CCS - Exclusions for total hysterectomy and bilateral mastectomy or member reported screenings that are noted on medical records that include date (or year), where it was done and result.
2. Blood Pressure - CPT II codes.
3. Point-of-Care Labs - A1c, Microalbumin, FOBT - with results.
4. COA – Where one component was coded, and others were not.
5. Eye Exams – Negative for retinopathy in 2019 (3072F).
6. Child and Adolescent visits (AWC, W34, W15 and WCC) - Where age-specific CPT codes and codes for child BMI percentile, counseling for nutrition and physical activity were missed.
7. CIS and IMA – Immunizations that are noncompliant in Interpreta but compliant in your records.
8. MRP – When medications were reconciled and not coded (1111F).
9. Services completed at the clinic under a different insurance coverage or program.

Interpreta Supplemental Data Process

Supplemental data is important to capture medical records and data that cannot be submitted through the regular encounter process. This guide will help you navigate the **Interpreta Supplemental Data portal** at https://portal.interpreta.com.

The process to enter data one member at a time is easy and intuitive and medical records can be uploaded. This system will give you a running record of the data you have entered.

Once you hit submit, the record will be in pending status and then reviewed by our quality staff. It will then be approved or rejected. You can correct rejected records and submit them again. Rejected records will have comments stating why they were returned. Please be sure to **check for rejected records** so you can correct them and resubmit.

Before entering a record, please check that the measure is non-compliant. Do not enter data if Interpreta shows the measure is compliant. The supplemental data portal provides a list of due/overdue or compliant measures on the right side of the screen.

Please follow the steps in this guide and let us know if you have any questions.

Thank you for all the work you do to enter supplemental data to improve your HEDIS scores.

TRAINING
If you would like a **training**, please contact
qualitymeasures@medpointmanagement.com
or call 818-702-0100, x1353.

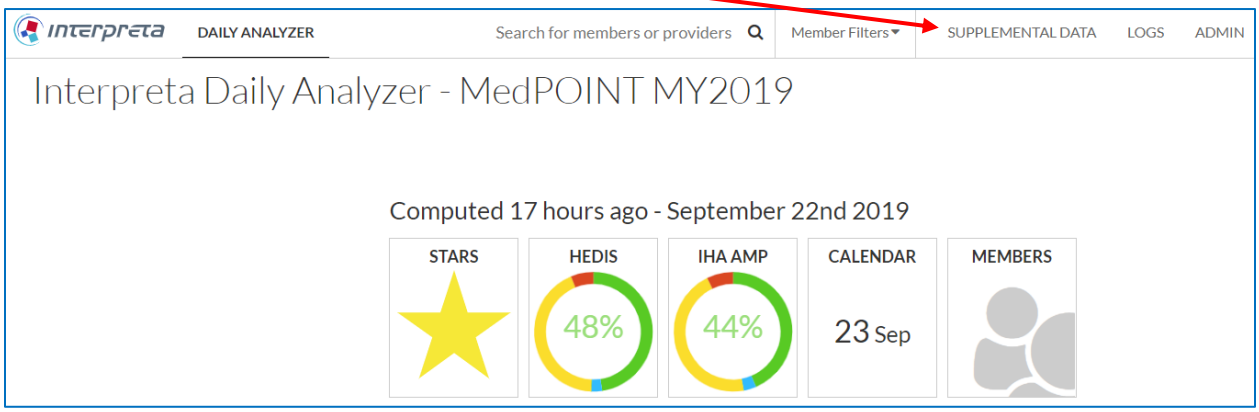
NEW USER
To request access for a **new user**, please fill out the Interpreta User Request Form located here: Interpreta - User Request Form (https://app.smartsheet.com/b/form/0adb2ae54f7147508030909fbedd1621).

An email will be sent to the user by Interpreta and the password must be set up within 24 hours. If the email is not received, please check the spam folder.

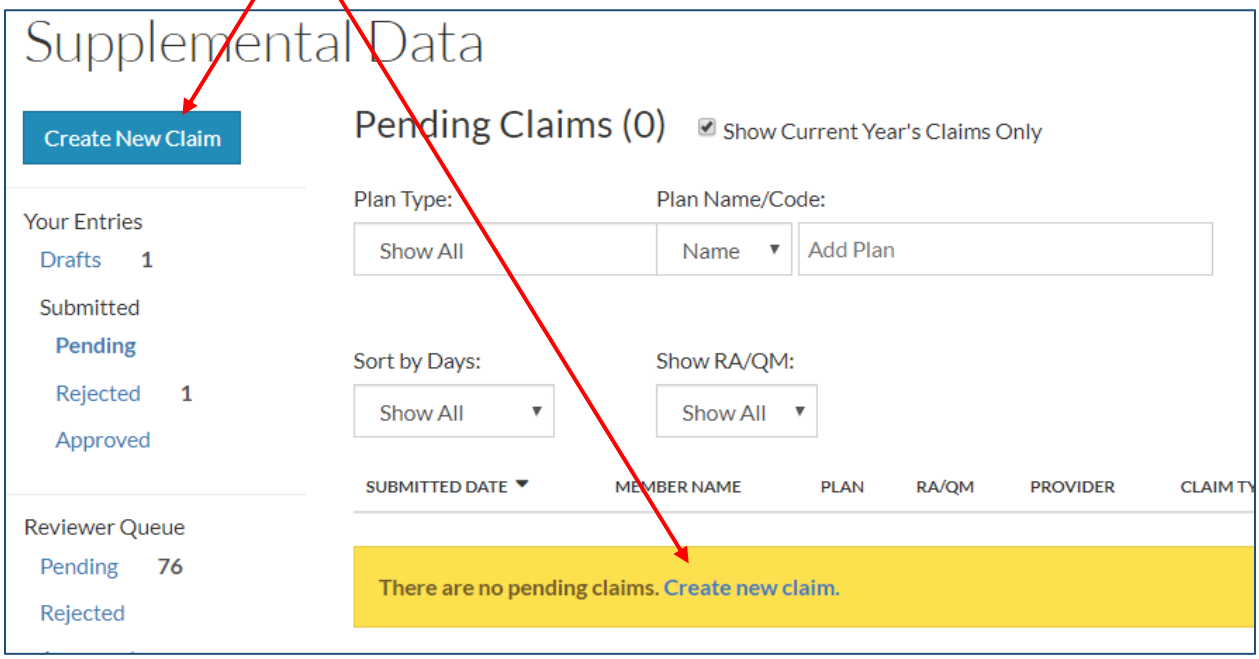
Within this document you will find common codes used for specific measures.
Please refer to HEDIS 2020 & 2021 Volume 2 Technical specifications for Health Plans and NCQA's HEDIS 2020 Value Set Directory for a complete list of codes.

1: Starting a Record

- Click “Supplemental Data.”



- Start a New Claim - There are two choices to start a new claim. Both will get you to the same screen.



2: Entering Member Information

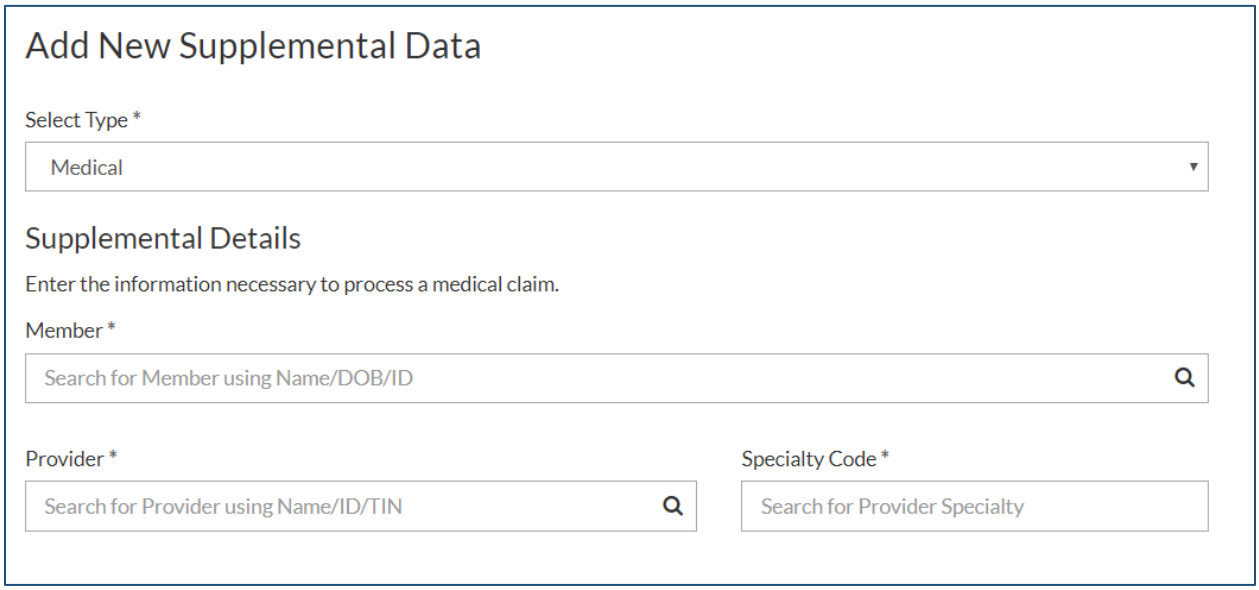
- Select Type – Select the type of record. Medical is for all medical records except lab records. Lab is for records from Quest or point-of-care services (cytology, HbA1c, nephropathy). Pharmacy/Rx is inactive so do not use this.

- Member - Type the member's first and last name or date of birth or ID number, pick the correct member and it will auto populate. The provider information will also auto populate.
    - It is recommended you have the Provider's NPI number and Specialty available to make this process more efficient.
    - Verify that the member you searched is the same as the member on the medical record.
    - If the member is due for HEDIS measures, **the open and closed gaps will appear in the right-hand side of the screen.**

- Provider – Provider will be auto populated as the default. Please **do not** change this field.

- Type the specialty, i.e. family practice, internal medicine, etc. The system will auto populate the specialty name, along with the code. Common Specialty Codes include:

01 - General Practice	43 - Certified Registered Nurse Practitioner
08 - Family Practice	42 - Certified Nurse Midwife
11 - Internal Medicine	41 - Optometry
37 - Pediatric Medicine	18 - Ophthalmology
30 - Diagnostic Radiology	69 - Clinical Laboratory
50 - Nurse Practitioner	10 - Gastroenterology



3: Date and Place of Service Information

1. **Quality Measures** - Under Provider name, you will see: "Use Supplemental Data details to close gaps related to." Click on the circle by "**Quality Measures**" or you will not be able to proceed to Service Line 1. (The "Risk Adjustment" choice is inactive.)

2. **Date of Service** - Use the calendar icon or type in the Date of Service (DOS).
   - The minimum to report is the Month and Year. If Month and Year are reported, the last day of the month will be used as the DOS.
   - Example with month/year - Patient reported procedure took place on 06/2021. The DOS on Supplemental Data would be 06/30/2021.
   - Example with just year - If a patient reports they had a procedure done last year and does not remember when (pap smear, for example), use the last day of the year as the DOS for Supplemental Data, which would be 12/31/2019.

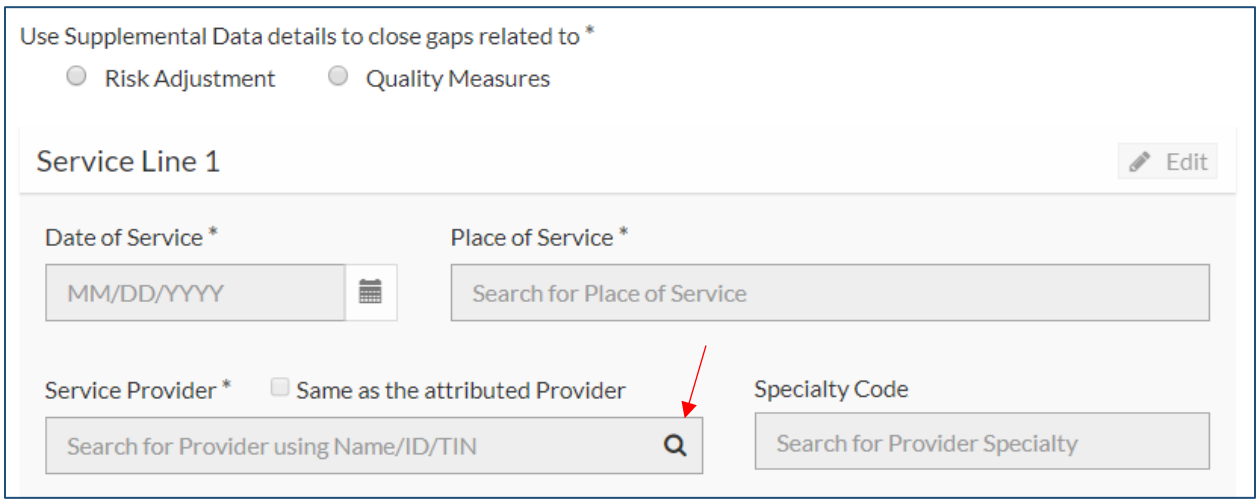
3. **Place of Service** – "Office" or "11" is used when the service was done at the office. Type "Lab" or "Optometrist," etc. for other locations. Type a word for the place of service and it will come up. Common codes include:

   02 – Telehealth
   11 - Office – used for most office visits including Radiology Center's visits
   81 - Independent Laboratory – for stand alone Labs such as Quest/LabCorp
   20 - Urgent Care Facility
   21 – Inpatient Hospital
   15 – Mobile Unit (mammogram)
   50 - Federally Qualified Health Center
   95 - Radiology

4. **Service Provider** – If the provider is the same as the member's PCP, just click the little box that says, "**Same as the attributed Provider**" (located right above the Search box) and the Service Provider and Specialty Code information will auto populate.

   If the provider was other than the PCP, you can search by Provider NPI, Provider TIN or last name and first name with 'space' or a comma (for example: Cooper,Lee or Cooper Lee) and choose the correct provider. The specialty of the provider will come up automatically.

   NOTE: If the Service Provider name does not appear, click the magnifying glass icon to the right of the box. If it still does not appear, please call us for further instructions.



4: Coding for Other Measures - Summary

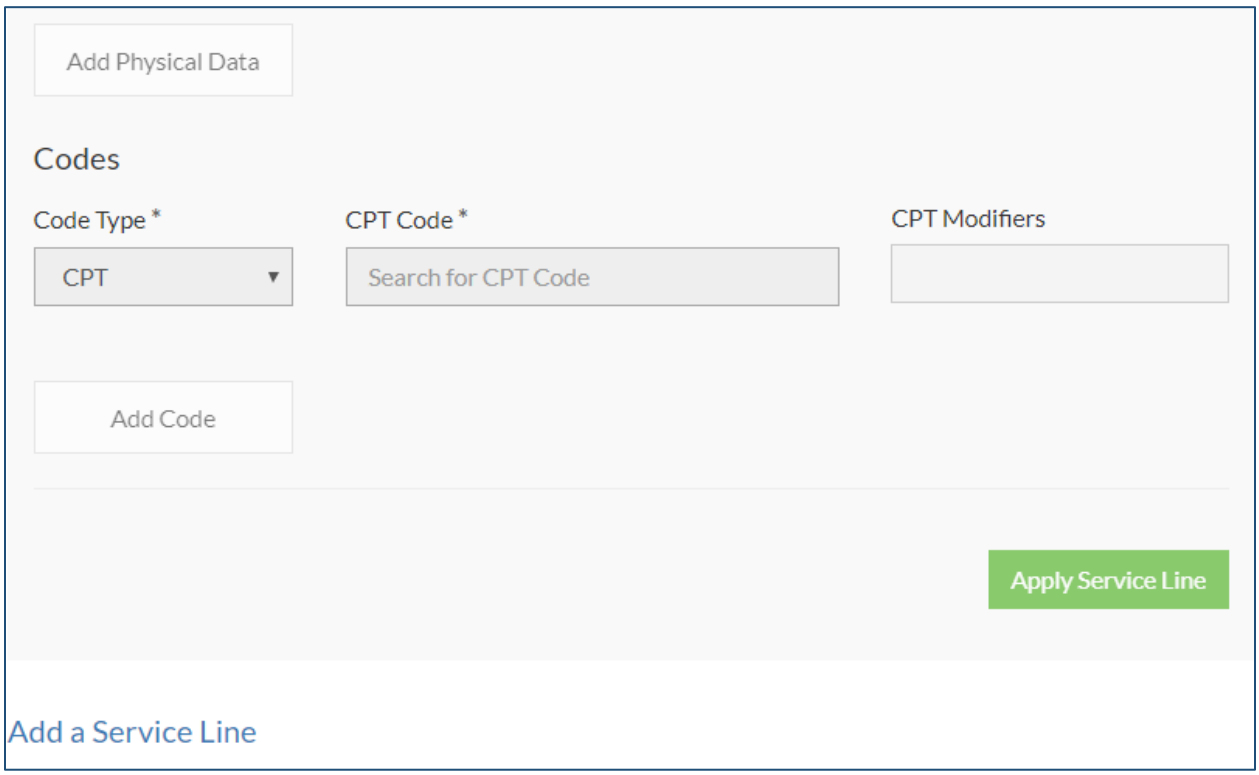
- Refer to "Coding for Other Measures" on page 12 for the most common codes.
- "Code Type" - Choose type of code you will enter first – CPT, HCPCS or ICD9/10.
- Enter code or name of test to see list of code options.
- Modifiers – Add modifiers if applicable.
- "Add Code" – Click this box if you would like to enter another HCPCS or ICD9/10 code. If you click it by accident and do not want to enter another code, click the X on the right side to get out of it.

  NOTE: Interpreta will only allow one CPT code per Service Line at this time. This means that if you have another CPT or CPT II code you want to add, you click "Add a Service Line," re-enter the date of service, place of service and provider information and then add the code. Example: HbA1c test is 83036, add a service line to add CPT II code 3045F.

  Please do not enter CPT or ICD-10 codes as a modifier. The record will be rejected.

  Once you click "Add a Service Line," you can make changes to what you just entered by clicking the "Edit" box on the upper right side.

- "Apply Service Line" – Click this box to apply the code(s) to your record. You will be moved down to the "Additional Supporting Documents" section.

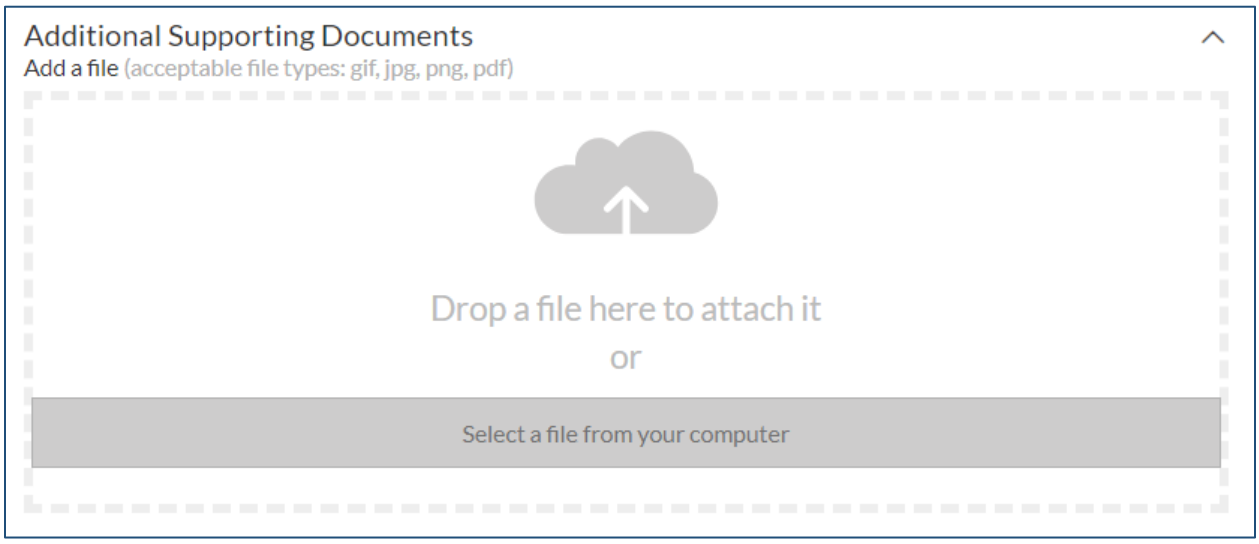


Add a Service Line

5: Uploading Records

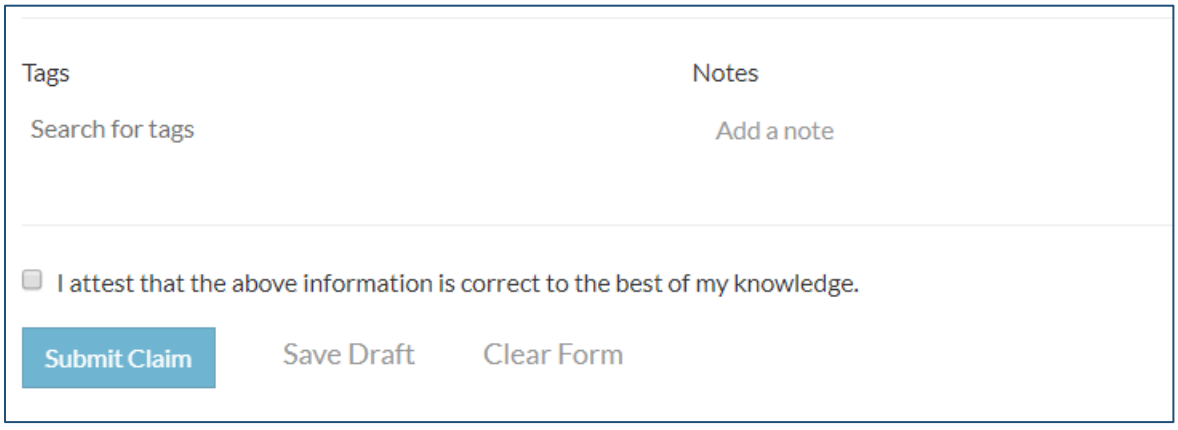
- Additional Supporting Documents – Click within the dotted line to bring up your file menu to attach the medical records. Files accepted include gif, jpg, png and pdf. This is a required field and every claim entered must have medical records supporting the data elements entered in to Interpreta.

  Please see guidance on page 9 of this Guide for details required for medical records.



8: Submitting Data

- Tags – This section is inactive.
- Notes – Add any notes you wish before submitting.
- Attest – Click the box that says, "I attest that the above information ins correct to the best of my knowledge." You cannot proceed without clicking this box.
- Submit – Click the blue "Submit Claim" box. You can also "Save Draft" or "Clear Form."



6: Medical Record Documentation Requirements

- Medical record must be accurate and legible to pass audit as follows:
  - Member's name and date of birth is clearly identified on all pages of progress note.
  - Provider is clearly identified on the progress note and include name, signature and credentials.

- If any of the information received is not correct, missing, or illegible, the claim will be rejected.

- If you made a mistake such as the following, it will be rejected with a note and put in Pending for the submitter to correct and resubmit.
  - Incorrect date of services entered.
  - Member name does not match medical record received.
  - Date of birth does not match medical record received.
  - Medical record does not meet NQCA measure requirements.

- Patient reported results:
  When a patient has had a test in the past and a note is put in the medical record, the result must be present in order to be compliant for HEDIS. For example, if the patient says they had an eye exam, the result of normal or other outcome should be documented in the chart.

10: Coding for Specific Measures

Within this document, you will find the most common codes used for specific measures. Please refer to HEDIS 2020-2021 Volume 2 Technical specifications for Health Plans and the NCQA's HEDIS 2020 Value Set Directory for a complete list of codes.

1. Blood Pressure (CBP and CDC BP Control)

Blood pressure data counts for two HEDIS Measures:

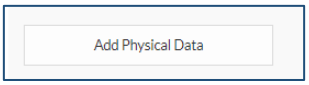
1. Controlling Blood Pressure (CBP) - for members with hypertension.
2. Comprehensive Diabetes Care (CDC) - Blood Pressure Control <140/90 for diabetics.

NOTE: Only enter compliant blood pressures <140/90. All other noncompliant entries will be rejected.

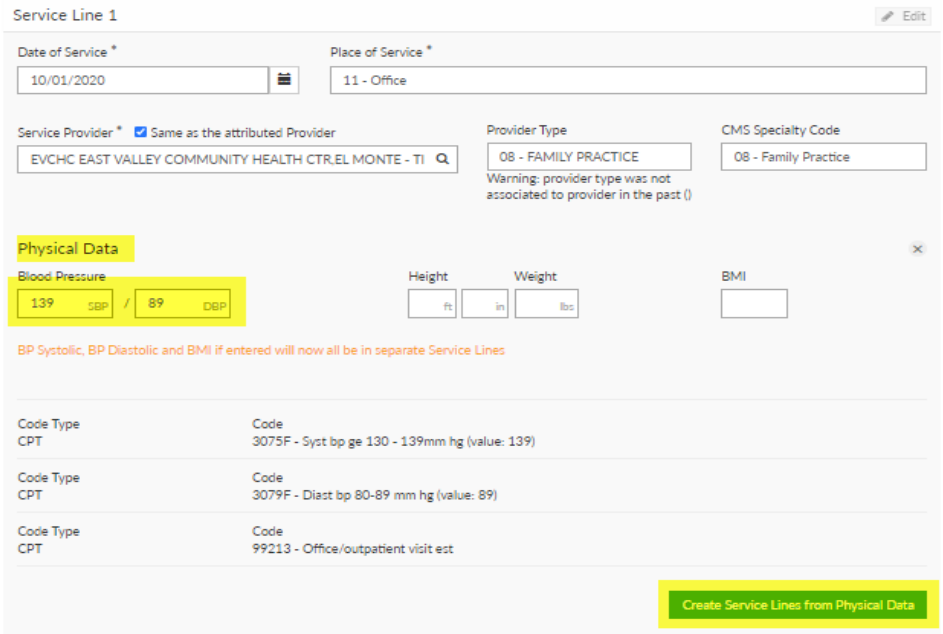
CPT II BP Codes:

3074F - Systolic <130	**3078F** - Diastolic <80 mm Hg
3075F - Systolic 130-139	**3079F** - Diastolic 80-89 mm Hg
3077F - Systolic >= to 140	**3080F** - Diastolic >= to 90

Click "Add Physical Data"
For Blood Pressure and BMI data only.



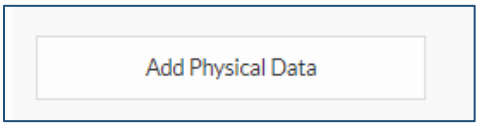
- Blood Pressure systolic and diastolic values <140/90 must be added when uploading records for this service under "Add Physical Data".
- CPT II blood pressure range codes and the office visit CPT code are automatically populated.
- Click "Create Service Lines from Physical Data" to apply additional codes to your record. Separate service lines will be created for each code. Attach record and submit.



2. BMI (ABA) – Adults – Do not submit

The Adult BMI (ABA) measure was retired in 10/2020 so please **do not submit supplemental data for this measure.** The information below is included as FYI only.

- Click "Add Physical Data"

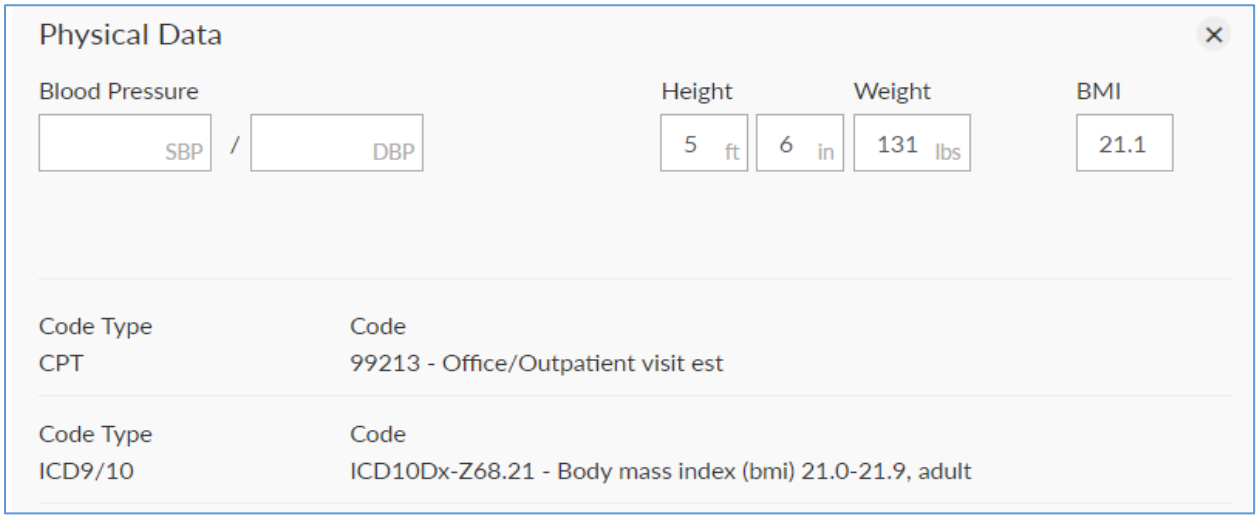


- Enter height in feet and inches, and the weight.
- Enter the BMI value noted in the record.
- The CPT code for the office visit and BMI ICD-10 Z code are applied automatically.
- "Apply Service Line" – Click this box to apply the codes to your record.

IMPORTANT:

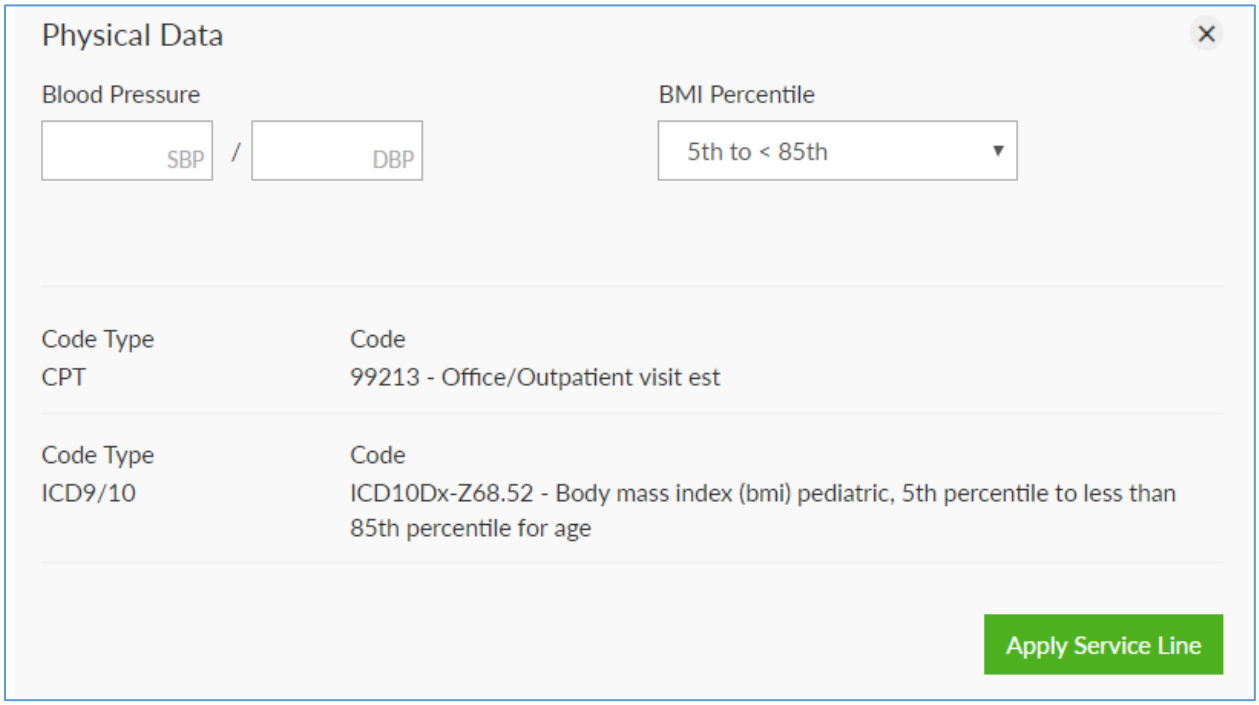
- The height, weight and BMI value (or percentile) must be on the chart note before entering into Interpreta. If they are not in the chart, the record should not be submitted. Calculation of the BMI value is not allowed to be entered into Interpreta if it is not in the record.

Codes are automatically populated for the office visit and BMI as shown below.



3. BMI – Children (WCC)

- The age of the member will determine that the BMI percentile is needed for children up to age 19.
- Choose the correct BMI percentile that is noted in the medical record by clicking the down arrow in the “BMI Percentile” box.
- Make sure the BMI percentile is legibly shown on the medical record or the record will be rejected.
- The office CPT code and BMI percentile ICD-10 code are applied automatically.
- “Apply Service Line” – Click this box to apply the codes to your record.



4. Breast Cancer Screening (BCS) (Medical)

Only enter mammograms done between October 1, two years prior, and December 31 of the measurement year (every 27 months), i.e. 10/1/2019 – 12/31/2021.

Most common codes:

- 77067 - Scr mammo bi incl cad
- 77063 – with 3D tomosynthesis
- 77066 - Dx mammo incl cad bilateral
- 77065 - Dx mammo incl cad unilateral
- 77062 - Breast tomosynthesis bi

Exclusions codes for Breast Cancer screening:

- ICD10Dx-Z90.11 - Acquired absence of right breast and nipple
- ICD10Dx-Z90.12 - Acquired absence of left breast and nipple
- ICD10Dx-Z90.13 - Acquired absence of bilateral breasts and nipples

5. Cervical Cancer Screening (CCS) (Lab)

- Use the Lab Layout.
- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.
- For "Ordering Provider," enter rendering provider, i.e. Quest, LabCorp, ABC Labs.
- For Point-of-Care lab, put facility name or FQHC name.
- IMPORTANT – The Date of Service on the Lab Layout should be the "Results date," "Reported date" or the latest date on the Lab Report.
- In the Service Line area, under "Place of Service," put 81 (Independent Laboratory).
- Use the "Notes" field at the bottom of the form to indicate a positive or negative result.

Most Common Coding:

- If the record has PAP (cytology Reflex test) results only, please code **88142** (good for 3 years).
- If both PAP and HPV (Co-test or separate HPV test) have results for women who were age 30 and above on the date of service, please code **87624** (HPV high-risktypes) with LOINC code **82675-0** (Thin Prep Cvx) (good for 5 years).

  Other codes that are compliant include:

  - 88141 - Cytopath c/v interpret - enter result for pap
  - 82675-0 - 16+18+31+33+35+39+45+51+52+56+58+59+66+68 DNA [Presence] in Cervix by NAA with probe detection
  - 87625 - HPV types 16 & 18 only.- enter result for HPV result
  - 21440-3 – HPV I/H Risk DNA CVX QI Probe.

EXCLUSION CODES:

- Z90.710 - Acquired absence of both cervix and uterus
- Q51.5 - Agenesis and aplasia of cervix

- Medical record must indicate any of the following to be excluded from the measure:
  - Total Abdominal Hysterectomy
  - "TAH"
  - Complete Hysterectomy
  - "NO Cervix"
  - Notation of just "Hysterectomy" does not meet criteria
  - For Date of Service, please see Date and Place of Service Information on page 7.

6. Colorectal Cancer screening (COL) (Lab)

- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.
- Use the report date or the latest date on the record (not the collection date).
- Provider should be laboratory where test was done or FQHC name, if done in-house.

- **82274** - Occult blood feces. "FOBT kit"
- 44388 - Colonoscopy
- **45378** - Diagnostic colonoscopy
- 45330 - Diagnostic sigmoidoscopy
- 74263 - CT Colonography
- G0464 - FIT-DNA

EXCLUSION: 44150 - Removal of colon

Note: "Place of Service" for point-of-care by a **FQHC** is **50** (Federally Qualified Health Center), then check "same as the attributed Provider" box.
For **outside lab**, enter **81** (Independent Laboratory) and name of lab.

7. Comprehensive Diabetes Care (CDC) - Eye Exam (Medical)

Medical records must be from an Ophthalmologist or Optometrist.
If record is from EyePACS or other vendor, please use date photos were taken.

For eye exams done in the **current year**, enter one of the following CPT II codes:

- 2022F - Dil retina exam interp rev – with retinopathy
- 2023F - Dil retina exam interp rev – without retinopathy
- 2024F - 7 field photo interp doc rev – with retinopathy
- 2025F - 7 field photo interp doc rev – without retinopathy
- 2026F - Eye image valid to dx rev (EyePACS) – with retinopathy
- 2033F - Eye image valid to dx rev (EyePACS) – without retinopathy
- S0625 - Digital screening retina

If reviewing results in the current year for dates of services done in the **previous year** and the note clearly state "No retinopathy" or "NDR" or "negative" or "w/o Retinopathy," you can enter the following CPT code:

- 3072F - Low risk for retinopathy in prior year

For clinics who have an Optometrist or Ophthalmologist **on staff**, use code 92250 and the specialist's NPI number should be used.

Do not submit record if result is "insufficient for any interpretation" or "unable to detect." We are waiting for guidance from NCQA regarding the correct code to use (1-16-20). Eye Exam Guide is available upon request.

8. Comprehensive Diabetes Care (CDC) – Nephropathy (Lab)

- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.

CPT codes:

- 82042 - Assay of urine albumin
- 81000 - Urinalysis nonauto w/scope

Result codes:

- 3061F - Negative microalbuminuria test result
- 3060F - Positive microalbuminuria test result

9. Comprehensive Diabetes Care (CDC) - Hba1c (Lab)

- Use the Lab template.
- The test result from the lab is the preferred record to submit.
- Enter the latest date on the record (usually report date).
- If using medical records, the result and test result date must be present.
- To enter the HbA1c:
  1) Enter the result CPT II code.
     - 3044F - Hemoglobin A1c level =< 6.9%.
     - 3051F - Hemoglobin A1c level 7.0 – 7.9%.
     - 3052F - Hemoglobin A1c level 8.0 – 8.9%.
     - 3046F - Hemoglobin A1c level => 9.0.

     Note: 3045F - Hemoglobin A1c level 7.0-9.0% - has been discontinued and is rejected effective 10/1/19.

  2) Enter the CPT A1c Test code.
     - 83036 - Glycosylated hemoglobin test. Use this code if A1c Test in Interpreta is noncompliant.
     - If only A1c Control measures are due and Test is compliant, enter the CPT II code only.
  3) Click on "Add Service Line" to enter second CPT II code and re-enter service information.

Note: If A1c was processed by an **outside laboratory** (i.e. Quest, etc.), enter 81 – Independent Laboratory for "Place of Service" in Service Line 1. Ordering Provider is the name of the lab (Quest, LabCorp, etc.).

If A1c was processed **in-house** by an FQHC, use 50 – Federally Qualified Health Center as the "Place of Service" and then check the "same as the attributed Provider" box.

10. Chlamydia Screening (CHL) (Lab)

- The test result from the lab is the preferred record to submit.
- If using medical records, the result and test result date must be present.
  - 87110 - Chlamydia culture.
  - 87270 - Chlamydia trachomatis ag if.
  - 87490 - Chylmd trach dna dir probe.
  - 87491- Chylmd trach dna amp probe.

11. Immunization for Adolescents (IMA) (Medical)

Meningococcal Vaccine:

- 90734 - Meningococcal vaccine im

TDAP / TD Vaccine

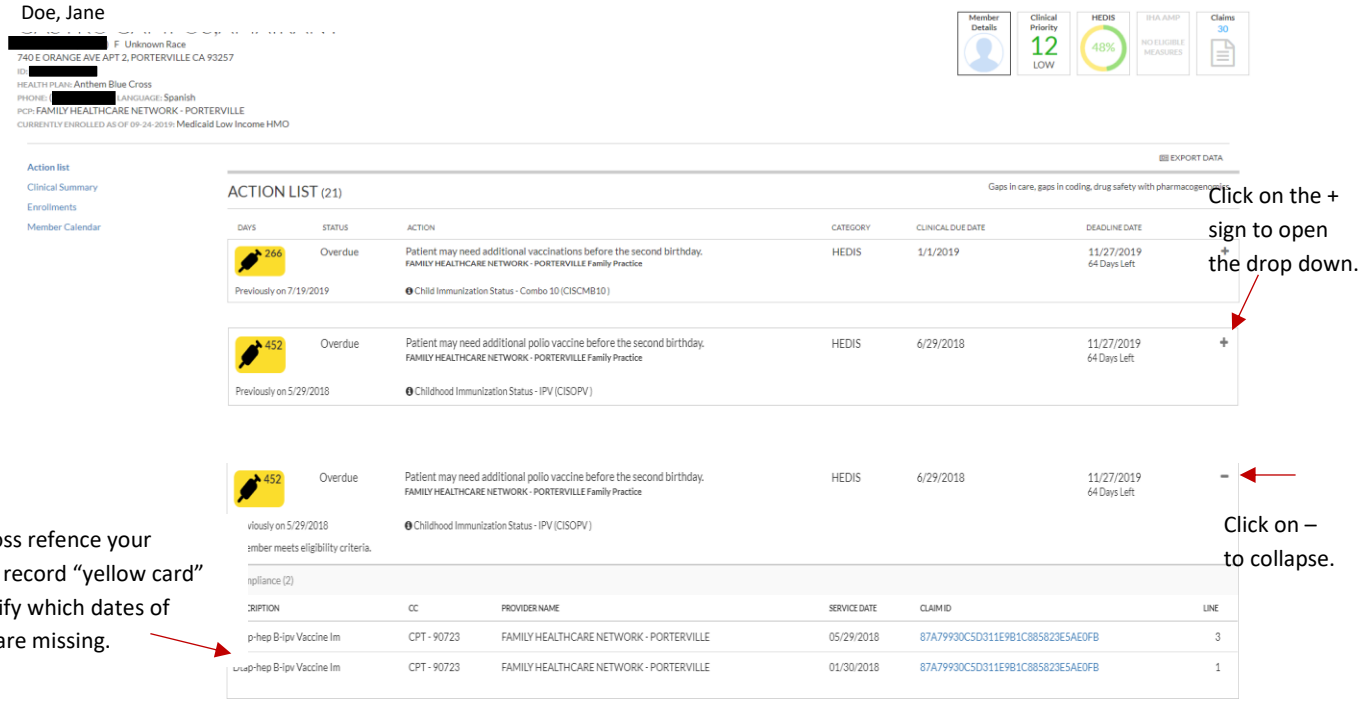
- 90715 - Tdap vaccine 7 yrs or older im

HPV Vaccine:

- 90651 - Human Papilloma Virus Nonavalent HPV 3 Dose IM
- 90650 - HPV vaccine 2 valent im
- 90649 - HPV vaccine 4 valent im

12. Childhood Immunization Status (CIS) - Combo 10 (Medical)

- Combo 10 includes all vaccines for children up to age 2.
- Before entering supplemental data into Interpreta, always first **check the member's dashboard** to identify which vaccines are missing as follows below.
- To be compliant for Combo 10, make sure all vaccines were completed before the child's 2nd birthday.
- Enter all vaccines even if the child missed a few shots and is not compliant.
- Use the <u>date that each vaccine was given</u> and <u>rendering provider</u>.



Childhood Immunization Status (CIS) - continued

- After identifying missing vaccines, enter the supplemental data using the codes on the next page.
- Combo 10 includes the following vaccines:
  - four diphtheria, tetanus and acellular pertussis (DTaP)
  - three polio (IPV)
  - one measles, mumps and rubella (MMR)
  - three haemophilus influenza type B (HiB)
  - three hepatitis B (HepB)
  - one chicken pox (VZV)
  - four pneumococcal conjugate (PCV)
  - one hepatitis A (HepA)
  - two or three rotavirus (RV)
  - two influenza (flu) vaccines.

The most common codes for CIS 10 are as follows:

1) **DTaP:**
   90700 - DTaP vaccine < 7 yrs im (single vaccine)
   90698 - DTaP-ipv/HiB vaccine im (combo vaccine)
   90721 - DTaP/ HiB vaccine im (combo vaccine)

2) **IPV**:
   90713 – Polio virus IPV sc/im (single vaccine)
   90698 - DTaP-IPV/HiB vaccine im (combo vaccine)
   90723 - DTaP-HepB-IPV vaccine im (combo vaccine)

3) **MMR:**
   90707 - MMR vaccine sc live
   90710 - MMRV vaccine sc (combo code MMR and VZV)

4) **VZV:**
   90716 - Var vaccine live subq (VAR)

5) **Pneumococcal Conjugate (PCV):**
   90670 - PCV13 vaccine im
   90732 – PPSV23 pneumococcal polysaccharide vaccine, 23-valent

6) **ROTA:**
   90681 - Rv1 vacc 2 dose live oral – (Rotarix)
   90680 - Rv5 vacc 3 dose live oral – (Rota Teq)

7) **HEP A:**
   90633 - HepA vacc ped/adol 2 dose im

8) **Hep B:**
   90744 - HepB vacc 3 dose ped/adol im
   90723 - DTaP-HepB-IPV vaccine im
   90748 - HiB- HepB vaccine im

9) **HIB:**
   90647 - Hib PRP-OMP vacc 3 dose im
   90648 – Hib PRP-T vaccine 4 dose im
   90698 – DTaP-IPV/Hib vaccine im
   90721 - DTaP /Hib vaccine im
   90748 - HepB vaccine im

10) **INFLUENZA:**
   90655 - IIV3 vacc no prsv 6-35 mo im
   90657 - IIV3 vaccine 6-35 months im
   90661 - ccIIV3 vac im cult prsv free
   90662 - IIV no prsv increased ag im
   90673 - RIV3 vaccine no preserv im
   90685 - IIV4 vacc no prsv 6-35 m im

13. Well Child Visit age 3-6 (W34) (Medical)

Enter two codes – ICD-10 and CPT age specific code.

ICD-10 (age 0-17):

- Z00.121 – Encounter for routine child health examination with abnormal findings
- Z00.129 – Encounter for routine child health examination without abnormal findings

CPT age specific codes:

- 99382 - Init pm e/m **new** patient age 1-4
- 99392 - Prev visit **est** age 1-4 (established)
- 99383 - Prev visit **new** age 5-11
- 99393 - Prev visit **est** age 5-11 (established)

14. Adolescent Well Care (AWC) (Medical)

Enter two codes – ICD-10 and CPT age specific code. This measure is for age 12-21.

ICD-10:

- Z00.121 – Encounter for routine child health examination with abnormal findings (age 0-17)
- Z00.129 – Encounter for routine child health examination without abnormal findings (age 0-17)
- Z00.00 – Encounter for general adult medical examination without abnormal findings (18+)
- Z00.01 – Encounter for general adult medical examination with abnormal findings (18+)

CPT age specific codes:

- 99384 - Prev visit **new** age 12-17
- 99394 - Prev visit **est** age 12-17 (established)
- 99385 - Prev visit **new** age 18-39
- 99395 - Prev visit **est** age 18-39 (established)

15. Weight Assessment and Counseling for Nutriition and Physical Activity for Children/Adolescents (WCC) (Medical)

- This measure is for age 3-17.
- Multiple dates of services or a single date of service can make this measure complaint.
- If submitting multiples dates of service, please be sure to attach all medical records.

WCC - BMI (Body Mass Index)

- **See page 7** for details on entering the BMI for children.
- BMI percentile must be used (not value) for children under age 19.
- The following codes will auto populate based on the percentile chosen.

  - Z68.51 - BMI pediatric, less than 5th percentile for age
  - Z68.52 - BMI pediatric, 5th percentile to less than 85th percentile for age
  - Z68.53 - BMI pediatric, 85th percentile to less than 95th percentile for age
  - Z68.54 - BMI pediatric, greater than or equal to 95th percentile for age

For the following, only one ICD-10 code can be entered at a time.

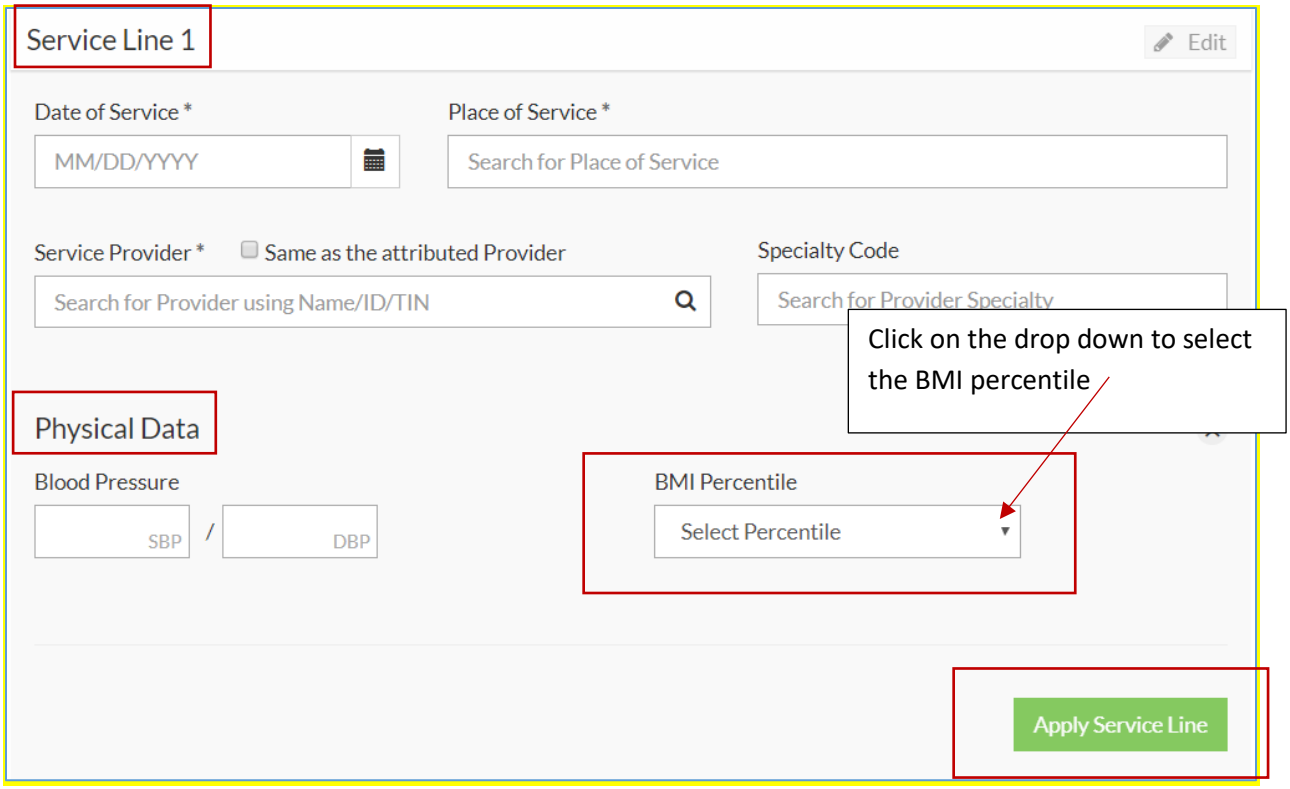
WCC - Nutrition

- Click "Add a Service Line.".
- Re-enter date of service, place of service and click "Same as the attributed Provider."
- Change "Code Type" to ICD9/10 and type in code below.
  - **Z71.3** - Dietary counseling and surveillance
- The code will be applied.
- NOTE: You cannot add the physical activity code in the Secondary Diagnosis Code box as it will not be applied correctly.
- Click "Apply Service Line" to apply the data.

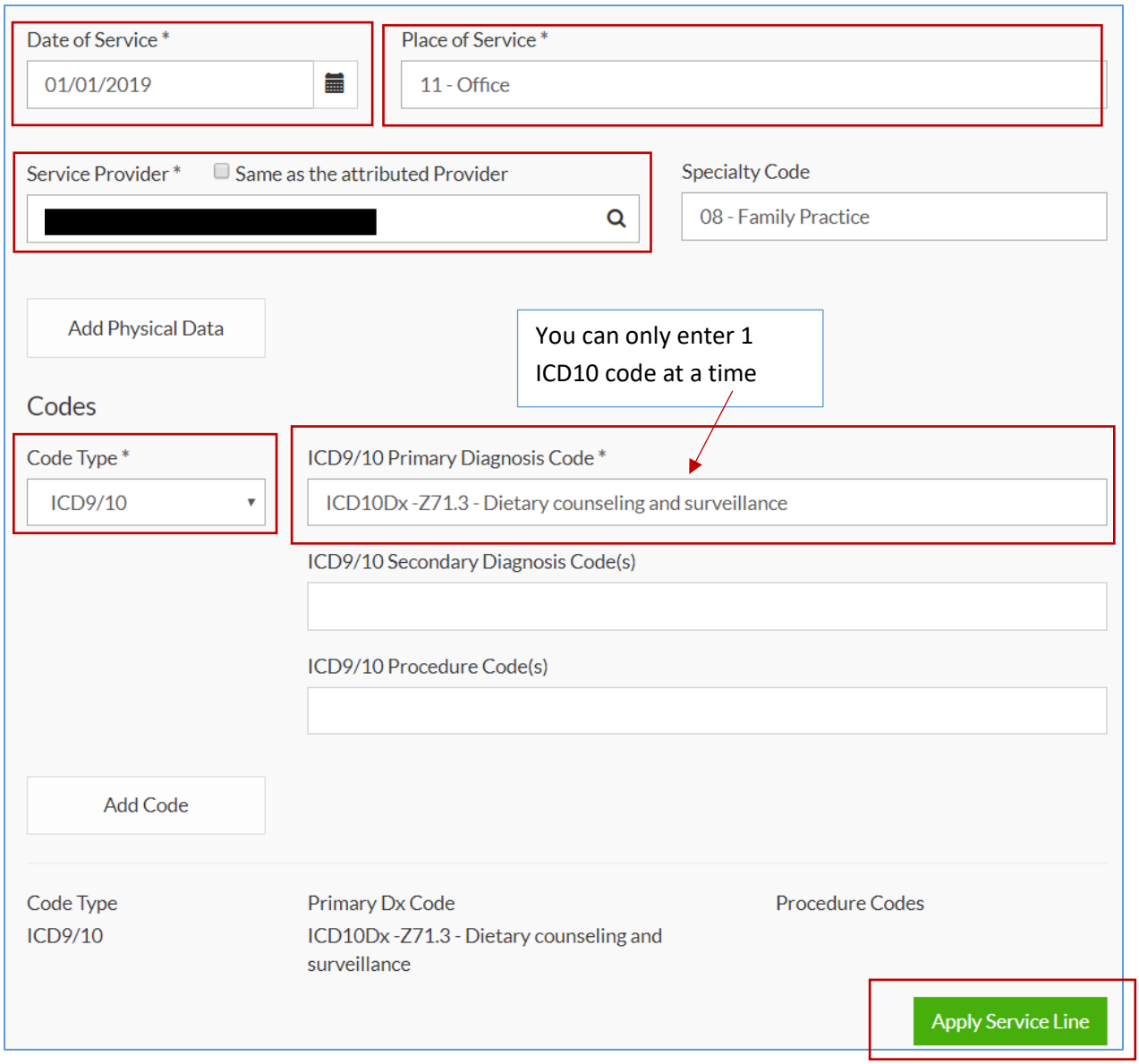
WCC - Physical Activity

- For the final time, click "Add a Service Line.".
- Re-enter date of service, place of service and click "Same as the attributed Provider."
- Change "Code Type" to ICD9/10 and type in code that applies below.
  - **Z71.82** - Exercise counseling
  - Z02.5 – Sports Physical
- The code will be applied.
- Click "Apply Service Line" to apply the data.

(15) **WCC - BMI** – Interpreta Sample Record



(15) **WCC – Nutrition and Physical Activity** – Interpreta Sample Record



(15) **WCC – All 3 components** – Interpreta Sample Record

Service Line 1

Date of Service	Place of Service	Provider
01/01/2019	11	BAEZ,ALFONSO M 08 - Family Practice

Code Type	Code
CPT	99213 - Office/Outpatient visit est

Code Type	Code
ICD9/10	ICD10Dx-Z68.52 - Body mass index (bmi) pediatric, 5th percentile to less than 85th percentile for age

Service Line 2 Edit ×

Date of Service	Place of Service	Provider
01/01/2019	11	BAEZ,ALFONSO M 08 - Family Practice

Code Type	Primary Dx Code	Procedure Codes
ICD9/10	ICD10Dx -Z71.3 - Dietary counseling and surveillance	

Service Line 3 Edit ×

Date of Service	Place of Service	Provider
01/01/2018	11	BAEZ,ALFONSO M 08 - Family Practice

Code Type	Primary Dx Code	Procedure Codes
ICD9/10	ICD10Dx -Z71.82 - Exercise counseling	

16. Osteoporosis Management in Women who had a fracture (OMW) (Medical)

- Enter the code that meets the medical records review requirement.
- Radiology Department is the most common Service Provider to use.
- 30-Diagnostic Radiology is the most common Specialty Code to use.
    - 77080 - Dxa bone density axial
    - 76977 - Us bone density measure

17. Medication Reconciliation Post Discharge (MRP) - TRC (Medical)

As of 10/2020, the MRP measure is a part of the Transitions of Care (TRC) measure. When a member is discharged from an inpatient setting, it is required to code that medications were reconciled and there was also patient engagement within 30 days of discharge.

- **1111F** – Discharge medications reconciled with the current medication list in outpatient medical record.
- **1159F and 1160F** – Code for COA medications component as well (see below).
- Each code should be entered on separate service lines.
- **99213** – Use Office Visit code on medical record or telehealth or home visit codes.
- The use of **99495** or **99496** (transitions of care management for moderate or high complexity) for Patient Engagement and Medication Post Discharge are compliant for both components without additional codes.

18. Care for Older Adults (COA) (Medical)

- This measure is for age 66 and older.
- Multiple dates of services or a single date of service can make this measure complaint.
- If submitting multiples dates of service, please be sure to attach all medical records.
- This measure requires 5 CPT II codes.
- Each code must be entered separately by clicking "Add a Service Line."

The Advanced Care Planning component of the COA measure has been retired so this does not need to be entered in the portal.

Advanced Care Planning – 1 code required

- 1157F - Advance care plan in record
- 1158F - Advance care plan discussion documented
- 99497 - Advance care plan 30 min

Fuctional Status assessment – 1 code required

- 1170F - Functional status assessed

Medication Review – BOTH CODES must be entered and reflected in the record

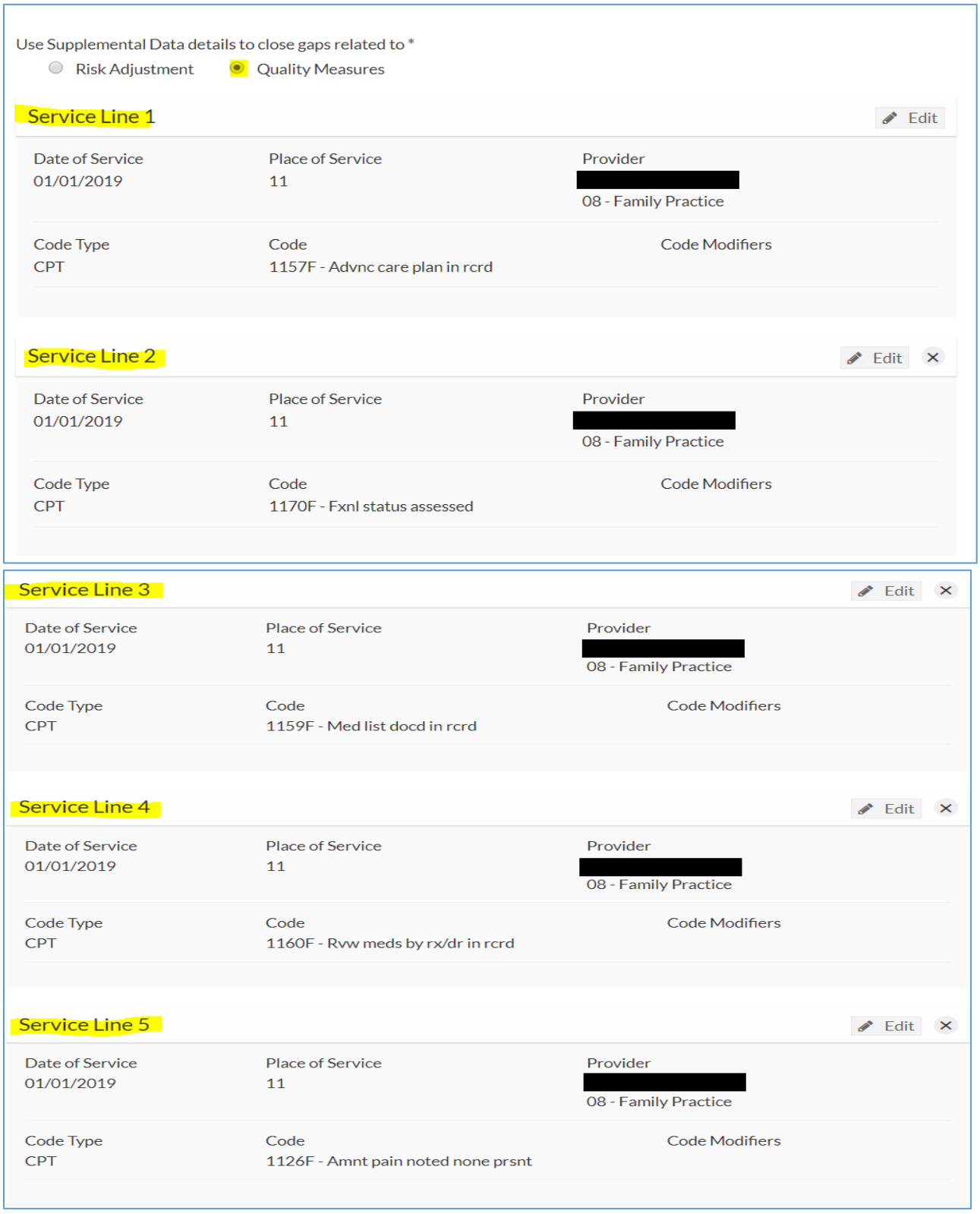
- 1159F - Medication list documented in medical record and
- 1160F – Review of all medications by a prescribing practitioner or clinical pharmacist

Pain assesment – 1 code required

- 1125F - Pain present or
- 1126F – Pain not present

(18) **Care for Older Adults** – Interpreta Sample Record

The sample below is what the multiple coding would look like before uploading the medical records.



If you have any questions, please refer to page 1 for our contact information.

19. Well-Child Visits in the First 15 Months of Life (W15) (Medical)

- This measure calls for a minimum of 6 well-child visits that include documentation of the following components:
  1) Health history
  2) Physical developmental history
  3) Mental developmental history
  4) Physical exam
  5) Health education/anticipatory guidance

- Enter each visit in one submission by adding Service Lines for each date of service and attaching all 6 records.

- Enter two codes for each service date – (1) ICD-10 and (2) CPT age specific code.

  ICD-10 (age 0-17):

  Z00.121 – Encounter for routine child health examination with abnormal findings
  Z00.129 – Encounter for routine child health examination without abnormal findings

  CPT age specific codes:

  99381 – age younger than 1 year, new patient
  99391 - age younger than 1 year, established patient
  99382 – age 1-4 new patient
  99392 – age 1-4 established patient