OCTOBER 2019

PROVIDER QUALITY NEWSLETTER

MedPOINT MANAGEMENT
Pointing Healthcare In The Right Direction

Interpreta – https://portal.interpreta.com

Many can attest, Interpreta is great for pulling gap reports to identify patients due for preventive and chronic care screenings. We have noticed that many providers are not using this simple tool to identify important screenings due. Don't miss an opportunity to close your patients' care gaps! Please let us know if you need a Refresher Training by emailing **qualitymeasures@medpointmanagement.com** or call us at **(818) 702-0100, ext. 1353**

Supplemental Data – New Guides!

Supplemental data is important to capture medical records and data that cannot be submitted through the regular encounter process. This year, there is a new option to submit data and medical records through the Interpreta Supplemental Data Portal. The process is easy and intuitive, and the attached Interpreta Supplemental Data Portal Reference Guide 2019 will assist you with the details. This Guide also includes coding samples pertaining to specific measures.

We have also updated the MedPOINT Management's (MPM) Supplemental Data Process guide with details on submitting data using the Excel lab and medical templates. Please NOTE that non-standard data files for MY2019 must be submitted to MPM by 1-15-2020. All medical records must be included when submitting non-standard files. For standard data (EMR extracts), files must be submitted to MPM by 2-28-2020.

Now is the time to submit supplemental data. Don't wait for 2020! Files are accepted monthly. See the Guide for further information or call **(818) 702-0100, x1353**. We are here to help!

Flu Shots and Colorectal FIT Kits go Together

When your senior patients come in for a flu shot, this is the perfect opportunity to check to see if they are due for a colorectal screening and if so, give out the FIT screening kit. Make sure you are stocked up with the FIT kit envelopes!

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Access Compliance

Tis the season for health plans to conduct the annual Provider Appointment Availability and After-Hours Surveys. Please review the attached Access to Care Standards with your staff to make sure you are in compliance.

Primary Care Providers must be available by telephone 24 hours per day/7 days per week. If the primary care provider is not available on-call, there should be another provider or nurse triage available.

Please make sure you or your staff answer the survey call and reply to questions in a timely manner. If you get a voicemail or message from an answering service, please call back right away. Your office will also be called after business hours to check compliance for after-hours availability.

Educate Patients on Types of Care – What's the Difference?

Patients are often confused about the differences between primary vs. urgent vs. emergency care. Talk with your patients and encourage them to call their primary care provider first, if they believe their situation is not life threatening. They can also call the Nurse Advice Line 24/7 – every health plan has one. Share information explaining when to go to the Emergency Room and when to use Urgent Care. Current Urgent Care locations are available at **medpointmanagement.com/urgent-care/**.

Monthly Health Themes

October:

- National Breast Cancer Awareness Month
- National Depression Screening Day (11)
- National Health Education Week (16-20)
- National Check Your Meds Day (21)

November:

- American Diabetes Month
- Diabetic Eye Disease Month

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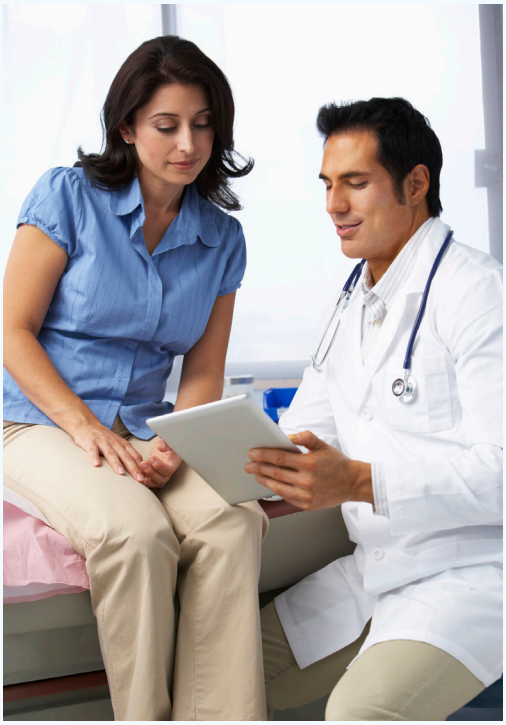
Primary Care and Specialist Providers

Access to Care Standards

Members have the right to receive timely access to care and services from their provider. Per DMHC requirements, providers are to ensure members proper availability within a specific number of days or hours for ...

EMERGENCY EXAM

If your patient is having a medical emergency, you should instruct them to go to the emergency room or have them call 911. If the issue is not life threatening, you should provide medical advice over the phone and schedule an appointment as shown below. (Only licensed staff with appropriate training should provide telephone assessments.)



APPOINTMENT AVAILABILITY STANDARDS

Type of Appointment:	Offer the Appointment within:
Primary Care Provider – Non-Urgent Appointment	Within **10 business days** of request
Specialist Providers – Non-Urgent Appointment	Within **15 business days** of request
Urgent appointments that do not require prior authorization	**48 hours** of request
Urgent appointments that require prior authorization	**96 hours** of request
Non-Urgent appointments for Ancillary services	**15 business days** of request
Non-Urgent appointments with a non-physician mental health care provider	**10 business days** of request

AFTER HOURS ACCESS REQUIREMENTS

Primary Care Providers must be available by telephone 24 hours per day/7 days per week.

*If the primary care provider is not available on-call, there should be another provider or nurse triage available.

ANSWERING MACHINE RECORDING MUST PROVIDE THE FOLLOWING:

> “If this is an emergency, please hang up and dial 911 immediately or go to the nearest emergency room ”

> “Hello, you have reached the *(Name of doctor/Office or Clinic Name)*. If you wish to speak to with the provider on-call, ...”

Select one of the following three options to complete recording:

a) Please hold and you will be directly connected to the provider on call.

b) You may reach the on-call provider directly by calling *(provide number)*.

c) Please call *(provide number)*. The on-call provider will be paged and you may expect a return call within the next 30 minutes.

d) You may include Urgent Care Center information, if applicable (give address and phone number).

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AFTER HOURS ANSWERING SERVICE SAMPLE SCRIPT:

Calls answered by a live voice – answering service or centralized triage

If the caller believes the situation is urgent, advise the caller to hang up and dial 911 immediately or proceed to the nearest Emergency Room.

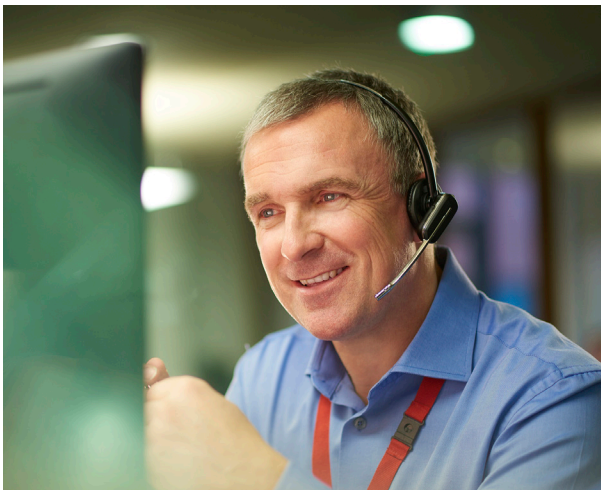
If the member indicates a need to speak with a provider

a) Place the caller on hold and then connect them to the on-call provider, or page the provider and let the caller know the provider has been paged and he/she will return call within the next 30 minutes.

b) Ask the member for their call back information and advise a provider will call them back within the next 30 minutes.

OR

c) If a member indicated a need for interpreter services, facilitate the contact by accessing interpreter services. You can find interpreter information at **www.medpointmanagement.com/download-category/culture-linguistic-information/**.



A Strong Defense Against Flu: **Get Vaccinated!**

FIGHT FLU

The best way to protect yourself and your loved ones against influenza (flu) is to get a flu vaccine every flu season. Flu is a contagious respiratory disease that can lead to serious illness, hospitalization, or even death. CDC recommends everyone six months and older get an annual flu vaccine.

What are some key reasons to get a flu vaccine?

- Flu vaccine has been shown to reduce flu illnesses, hospitalization, and even death in children.
- During the 2016–2017 season, vaccination prevented an estimated 5.3 million illnesses, 2.6 million medical visits, and 85,000 influenza-associated hospitalizations.
- Flu vaccination also is an important preventive tool for people with chronic health conditions.
- Vaccinating pregnant women helps protect them from flu illness and hospitalization, and also has been shown to help protect the baby from flu infection for several months after birth, before the baby can be vaccinated.
- A 2017 study showed that flu vaccine can be life-saving in children.
- While some people who get vaccinated still get sick, flu vaccination has been shown in several studies to reduce severity of illness.

Why is it important to get a flu vaccine EVERY year?

- Flu viruses are constantly changing, so flu vaccines may be updated from one season to the next to protect against the viruses that research suggests will be common during the upcoming flu season.
- Your protection from a flu vaccine declines over time. Yearly vaccination is needed for the best protection.

For more information, visit: **www.cdc.gov/flu**
or call **1-800-CDC-INFO**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

What kinds of flu vaccines are recommended?

There are several licensed and recommended flu vaccine options this season:

- Standard dose flu shots made from virus grown in eggs.
- Shots made with adjuvant and high dose for older adults.
- Shots made with virus grown in cell culture instead of eggs.
- Shots made using a recombinant vaccine production technology that does not require the use of a flu virus.
- Live attenuated influenza vaccine (LAIV, the nasal spray vaccine), which is made with live, weakened influenza viruses. It is an option for people 2 through 49 years of age who are not pregnant.

Is the flu vaccine safe?

Flu vaccines have a good safety record. Hundreds of millions of Americans have safely received flu vaccines over the past 50 years. Extensive research supports the safety of seasonal flu vaccines. Each year, CDC works with the U.S. Food and Drug Administration (FDA) and other partners to ensure the highest safety standards for flu vaccines. More information about the safety of flu vaccines is available at www.cdc.gov/flu/protect/vaccine/vaccinesafety.htm.

What are the side effects of flu vaccines?

Flu shots: Flu shots are made using killed flu viruses (for inactivated vaccines), or without flu virus at all (for the recombinant vaccine). So, you cannot get flu from a flu shot. Some minor side effects that may occur include soreness, redness and/or swelling where the shot was given, low grade fever, and aches.

Nasal spray flu vaccines: The viruses in nasal spray flu vaccines are weakened and do not cause the severe symptoms often associated with influenza illness. For adults, side effects from the nasal spray may include runny nose, headache, sore throat, and cough. For children, side effects may also include wheezing, vomiting, muscle aches, and fever.

If these problems occur, they are usually mild and go away on their own, but serious reactions are also possible. Almost all people who receive flu vaccine have no serious problems from it.

When and Where to get vaccinated?

You should get a flu vaccine by the end of October. However, as long as flu viruses are circulating, vaccination should continue throughout flu season, even in January or later.

Flu vaccines are offered in many doctors' offices and clinics. Flu vaccine is available in many other locations, including health departments, pharmacies, urgent care clinics, health centers, and travel clinics. Vaccines may also be offered at your school, college health center, or workplace. Use thevaccine finder at to find a flu vaccination clinic near you.

CS HCVG-15-FLU-108 10/01/2018

Una fuerte defensa contra la influenza (gripe):
¡Vacúnese!

#COMBATA LA INFLUENZA

La mejor manera de protegerse a sí mismo y a sus seres queridos contra la influenza (gripe) es vacunarse en cada temporada de influenza. La influenza es una afección respiratoria contagiosa que puede enfermar gravemente, requerir la hospitalización e incluso provocar la muerte. Los CDC recomiendan que todas las personas de 6 meses de edad o más se vacunen todos los años contra esta enfermedad.

¿Cuáles son alguna de las razones principales para vacunarse contra la influenza?

- Se ha demostrado que la vacuna contra la influenza reduce en los niños los casos de enfermedad, las hospitalizaciones e incluso la muerte.
- Durante la temporada del 2016-2017, la vacunación previno una cantidad estimada de 5.3 millones de casos de enfermedad, 2.6 millones de visitas médicas y 85 000 hospitalizaciones asociadas a la influenza.
- La vacunación contra la influenza también es una herramienta preventiva importante para las personas con afecciones crónicas.
- Vacunar a las mujeres embarazadas ayuda a protegerlas de enfermarse de influenza y de ser hospitalizadas, y también se ha demostrado que ayuda a proteger al bebé de una infección por este virus durante varios meses después del nacimiento, antes de que pueda ser vacunado.
- Un estudio del 2017 mostró que la vacuna contra la influenza puede salvarles la vida a los niños.
- Si bien algunas de las personas que se vacunan aún se enferman, se ha visto en varios estudios que la vacuna reduce la gravedad de la enfermedad.

¿Por qué es importante vacunarse contra la influenza CADA año?

- Los virus de la influenza cambian constantemente, por lo cual es posible que las vacunas contra esta enfermedad se actualicen de una temporada a otra para que brinden protección contra los virus que las investigaciones señalan que serán comunes durante la próxima temporada de influenza.
- La protección que le ofrecen las vacunas contra la influenza disminuye con el tiempo. La vacunación anual es necesaria para obtener la mejor protección.

Para obtener más información, visite
https://espanol.cdc.gov/enes/flu/
o llame al **1-800-CDC-INFO**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

¿Qué tipos de vacuna contra la influenza se recomiendan?

Para esta temporada, hay varias opciones de vacunas contra la influenza aprobadas y recomendadas.

- Vacunas inyectables de dosis estándar elaboradas con virus cultivados en huevos.
- Vacunas inyectables elaboradas con adyuvante y de dosis alta para adultos mayores.
- Vacunas inyectables elaboradas con virus cultivados en células en lugar de huevos.
- Vacunas inyectables elaboradas con una tecnología de producción de vacunas recombinantes que no requiere el uso del virus de la influenza.
- Vacuna contra la influenza con virus vivos atenuados (LAIV, la vacuna en atomizador nasal), que está elaborada con virus de influenza vivos debilitados. Esta es una opción para personas de 2 a 49 años de edad, con excepción de las mujeres embarazadas.

¿Es segura la vacuna contra la influenza?

Las vacunas contra la influenza tienen un buen historial de seguridad. Cientos de millones de personas han recibido la vacuna contra la influenza de manera segura en los últimos 50 años en los Estados Unidos. Investigaciones exhaustivas respaldan la seguridad de las vacunas estacionales contra la influenza. Todos los años, los CDC trabajan con la Administración de Alimentos y Medicamentos (FDA) de los EE. UU. y otros socios para garantizar los estándares de seguridad más altos para las vacunas contra la influenza. Se puede encontrar más información sobre la seguridad de las vacunas contra la influenza en https://espanol.cdc.gov/enes/flu/prevent/vaccinesafety.htm.

¿Cuáles son los efectos secundarios de las vacunas contra la influenza?

Vacunas inyectables contra la influenza: Las vacunas inyectables contra la influenza se elaboran con virus de la influenza muertos (en el caso de las vacunas inactivadas), o sin el virus (en el caso de la vacuna recombinante). Por lo tanto, usted no puede contraer la influenza por aplicarse la vacuna. Algunos de los efectos secundarios leves que pueden ocurrir son dolor, enrojecimiento o hinchazón en el lugar que le pusieron la inyección, fiebre baja y molestias.

Vacunas contra la influenza en atomizador nasal: Los virus contenidos en la vacuna contra la influenza en atomizador nasal están debilitados y no causan los síntomas graves que con frecuencia se asocian a esta enfermedad. En los adultos, los efectos secundarios leves de la vacuna en atomizador nasal pueden incluir moqueo nasal, dolor de cabeza, dolor de garganta y tos. En el caso de los niños, los efectos secundarios también pueden incluir sibilancias, vómitos, dolores musculares y fiebre.

Si estos problemas ocurren, generalmente son leves y desaparecen solos, pero las reacciones graves también son posibles. Casi todas las personas que reciben la vacuna contra la influenza no tienen problemas serios.

Cuándo y dónde vacunarse

Debería ponerse la vacuna contra la influenza antes de finales de octubre. Sin embargo, mientras los virus de esta enfermedad estén circulando, se debería continuar la vacunación a lo largo de toda la temporada de influenza, incluso en enero o después.

Las vacunas contra la influenza se ofrecen en muchos consultorios y centros médicos. La vacuna contra la influenza está disponible en muchos lugares, como departamentos de salud, farmacias, centros de urgencia, centros de salud y centros de medicina del viajero. Es posible que las vacunas también se ofrezcan en su escuela, centro de salud universitario o lugar de trabajo. Use el buscador de vacunas "Vaccine Finder" para encontrar un centro de vacunación contra la influenza que esté cerca de su casa.

CS HCVG-15-FLU-202 06/05/2019

INTERPRETA SUPPLEMENTAL DATA PORTAL REFERENCE GUIDE 2019

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

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 follow the steps below and let us know if you have any questions.

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

- To request access for a new user, please email interpreta@medpointmanagement.com with the name of the person, title and email address.

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

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

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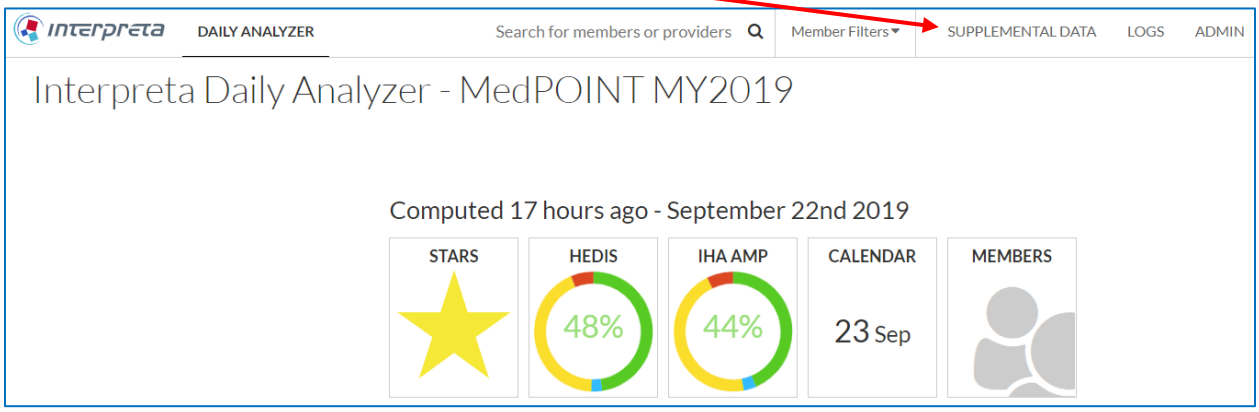
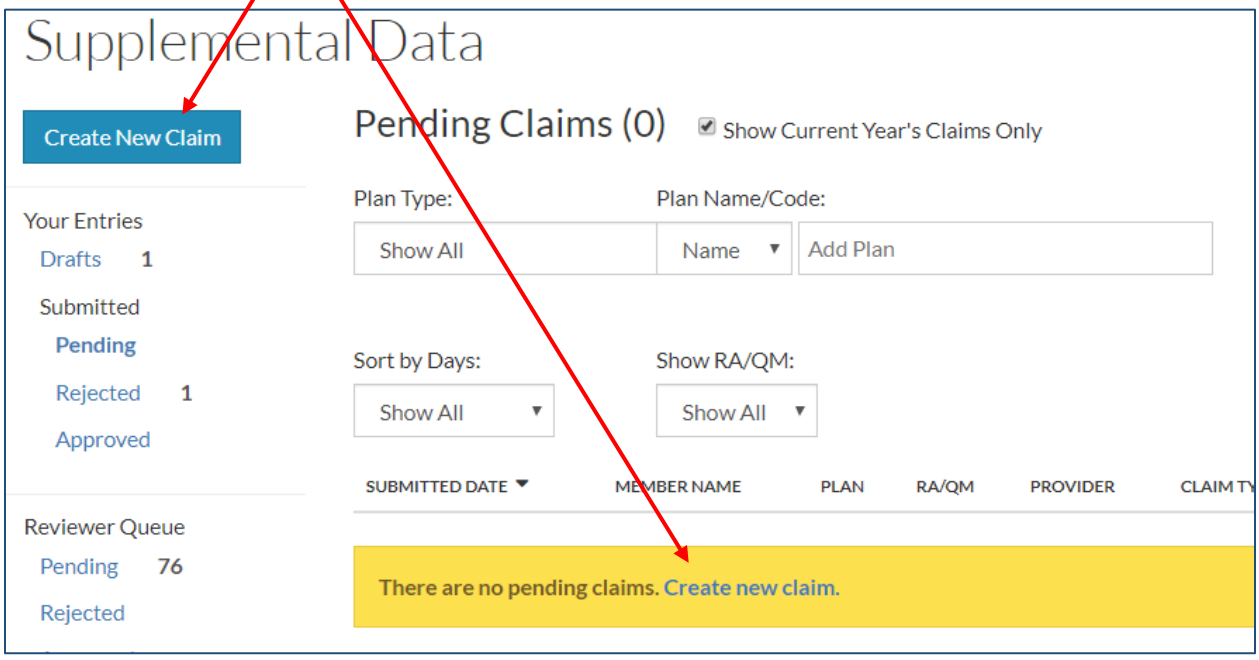
1: Starting a Record

- 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

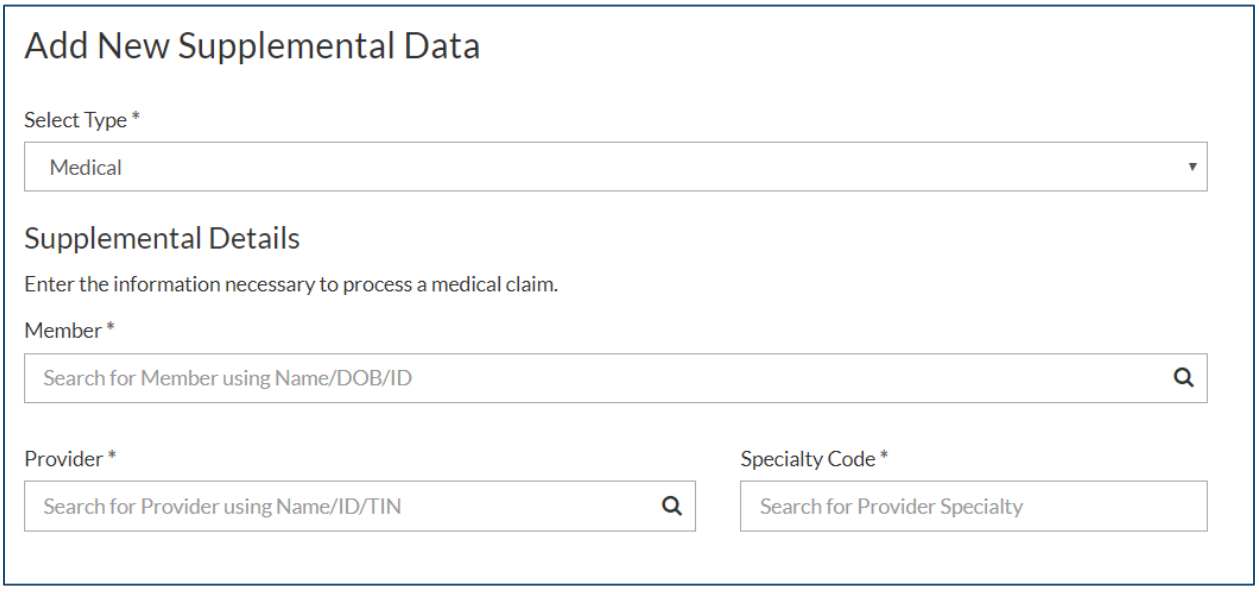
- Select Type – Select the type of record. Medical is for all medical records. Lab is for records from the lab (Quest, LabCorp, ABC Lab or point-of-care services) for cytology, HbA1c, nephropathy. Pharmacy/Rx is inactive, do not use this.

- Member - Type the member's first and last name or date of birth or ID number, pick the correct member and the program will auto populate the member demographics. The provider information will also auto populate.
  - Verify that the member you searched is the same as the member on the medical record.
  - The member's care gaps list will appear on the right-hand side of the screen where you can see the measures that are due.

- Provider – refers to the member's assigned Primary Care Provider (PCP) and will be auto populate. **Do not** change this field.

- 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

- "Use Supplemental Data details to close gaps related to*" – Select "**Quality Measures**" or you will not be able to proceed. The "Risk Adjustment" option is inactive at this time.

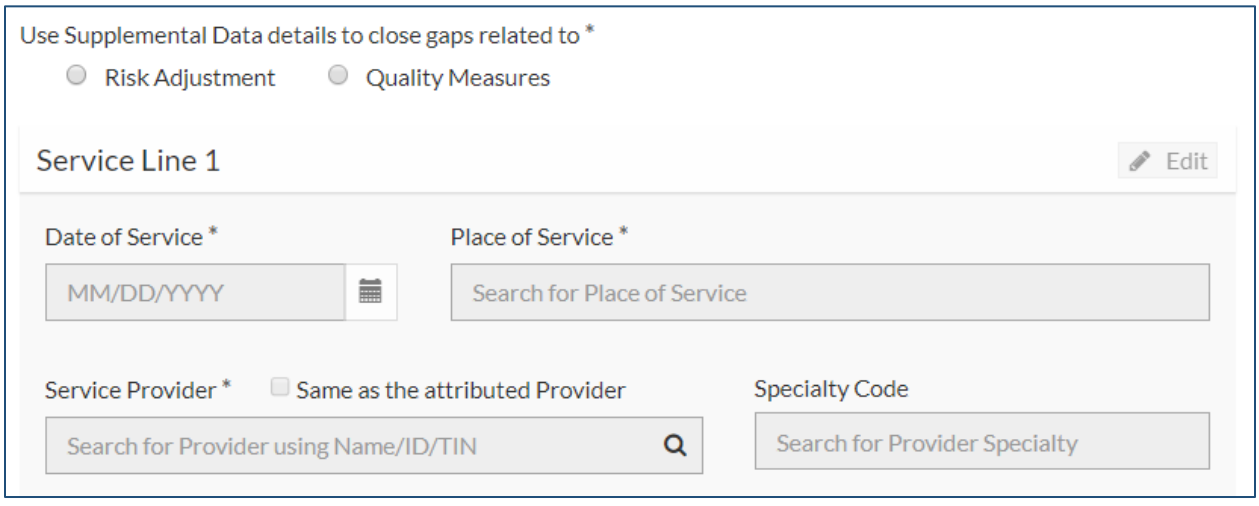
- Date of Service - Use the calendar or type in the Date of Service (MM/DD/YYYY).

- Place of Service – Type "Office" or "11" if the service was done at the office. Common codes include:
  - 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
  - 50 - Federally Qualified Health Center

- Service Provider – If the rendering provider of service is the same as the member's PCP, click the box next to, "**Same as the attributed Provider**" (located right above the Service Provider Search box) and the Service Provider and Specialty Code information will auto populate.

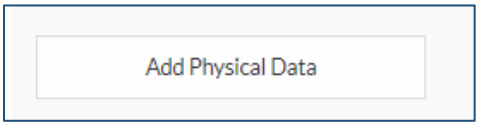
  If the rendering provider of service was not the PCP, you can search for the rendering provider by using the Provider NPI, Provider TIN or last name and first name with 'space' or a comma (for example: Cooper,Lee or Cooper Lee) and choose the correct provider. The specialty of the provider will come up automatically.

  - It is recommended you have the Provider's NPI number and Specialty available to make this process more efficient.

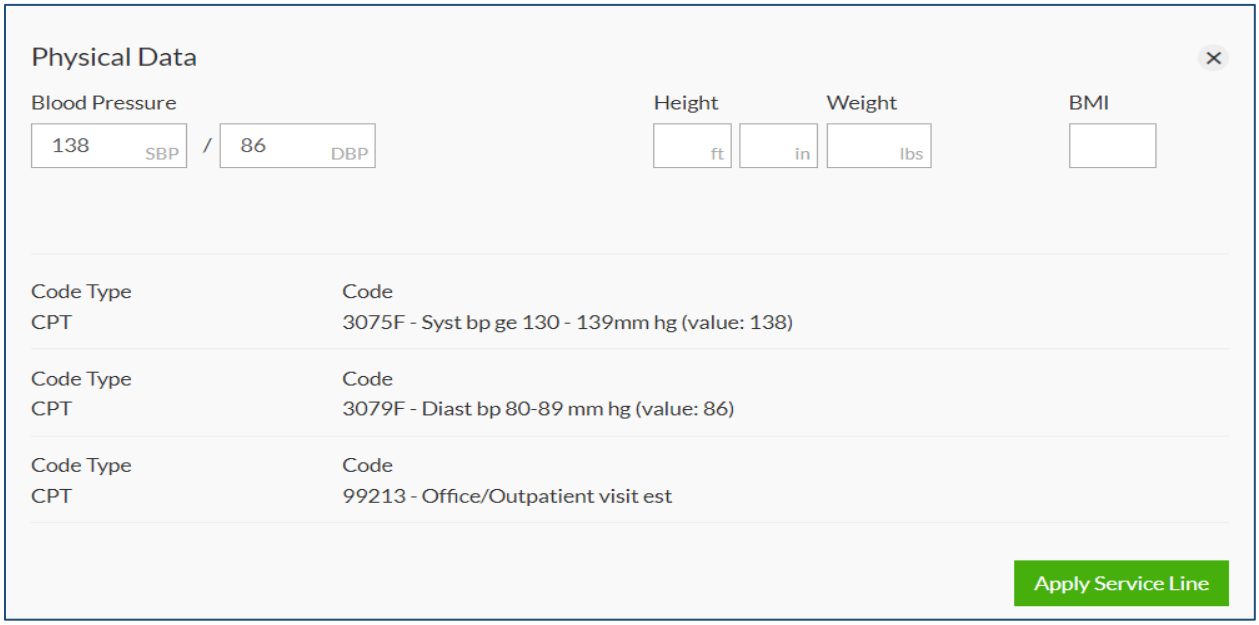


4: Coding - Blood Pressure

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

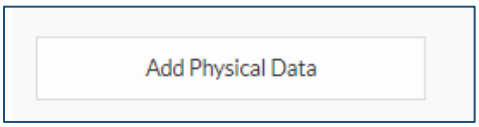


- Blood Pressure systolic and diastolic values must be added when uploading records for this service.
- Codes are automatically populated for the office visit and the CPT II blood pressure range codes based on your entries as shown below.
- "Apply Service Line" – Click this box to apply the code(s) to your record.



5: Coding BMI - Adults

- Click "Add Physical Data"

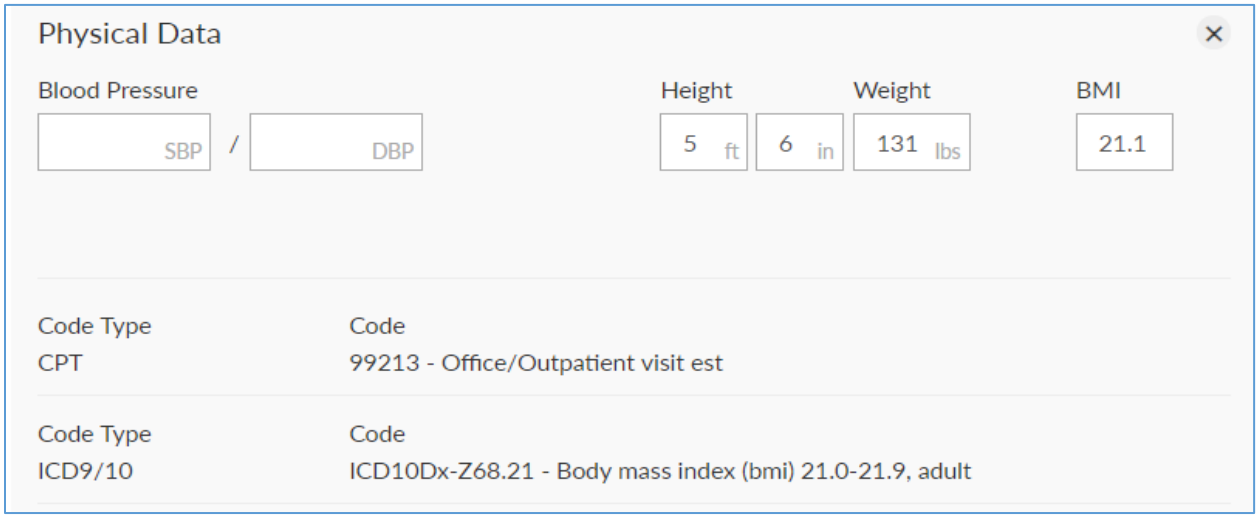


- Enter height in feet and inches, and the weight in pounds.
- The BMI value is auto populated in the BMI box.
- The CPT code for the office visit and BMI ICD-10 Z code are applied automatically based on your entries as shown below.
- "Apply Service Line" – Click this box to apply the codes to your record.

IMPORTANT:

- Make sure the BMI that auto populates matches the medical record or the record will be rejected.
- If the BMI does not match the auto populated number, close the Physical Data section by clicking on the X on the right side of the words "Physical Data." Then enter the BMI Z code in the Service Line section.
- An enhancement to Interpreta (available after Nov. 1, 2019) will allow you to manually enter the value on the medical record in the BMI box.
- The height, weight and BMI value (or percentile) must be on the chart note before entering the record into Interpreta. If they are not in the chart, the record should not be submitted and will be rejected.
- Calculation of the BMI value is not allowed to be entered into Interpreta if it is not noted in the record.

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



Coding BMI - Children

- 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 based on your selection.
- "Apply Service Line" – Click this box to apply the codes to your record.

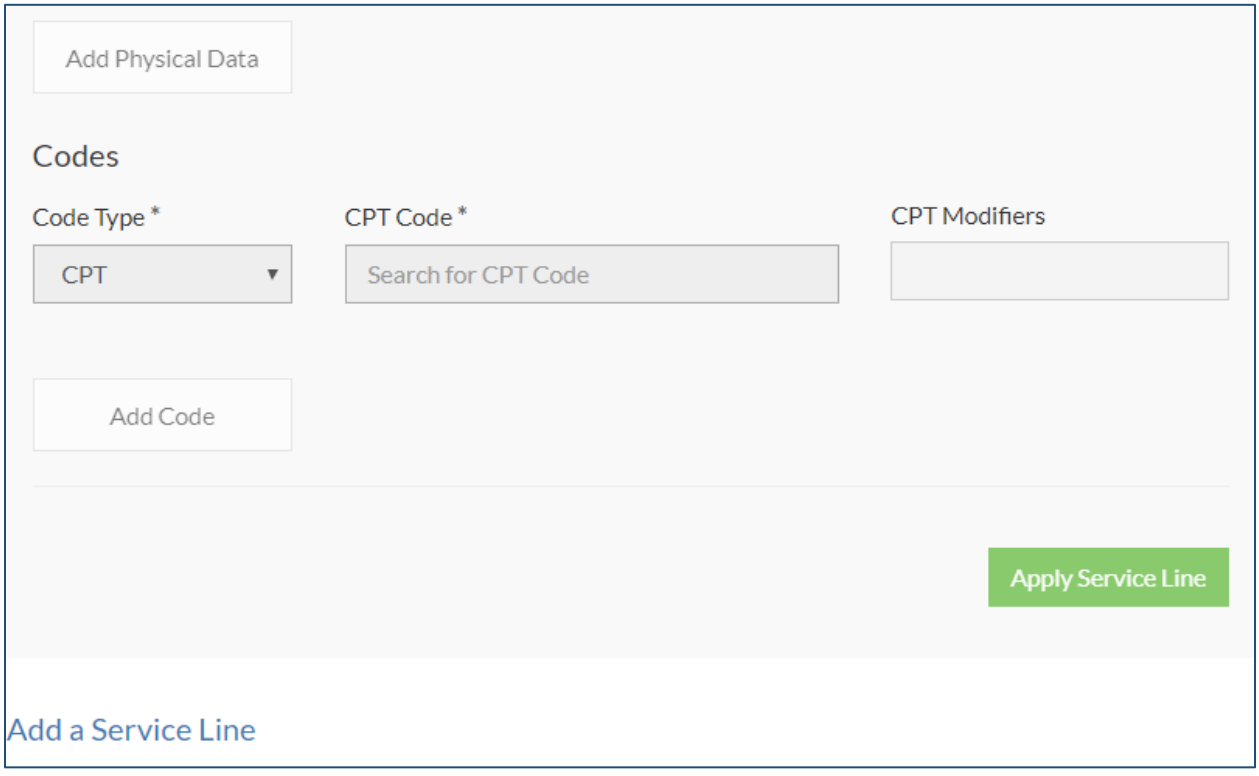
6: Coding for Other Measures

- Refer to "Coding for Other Measures" on page 11 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 a CPT II code that reflect the result of the test.

  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.

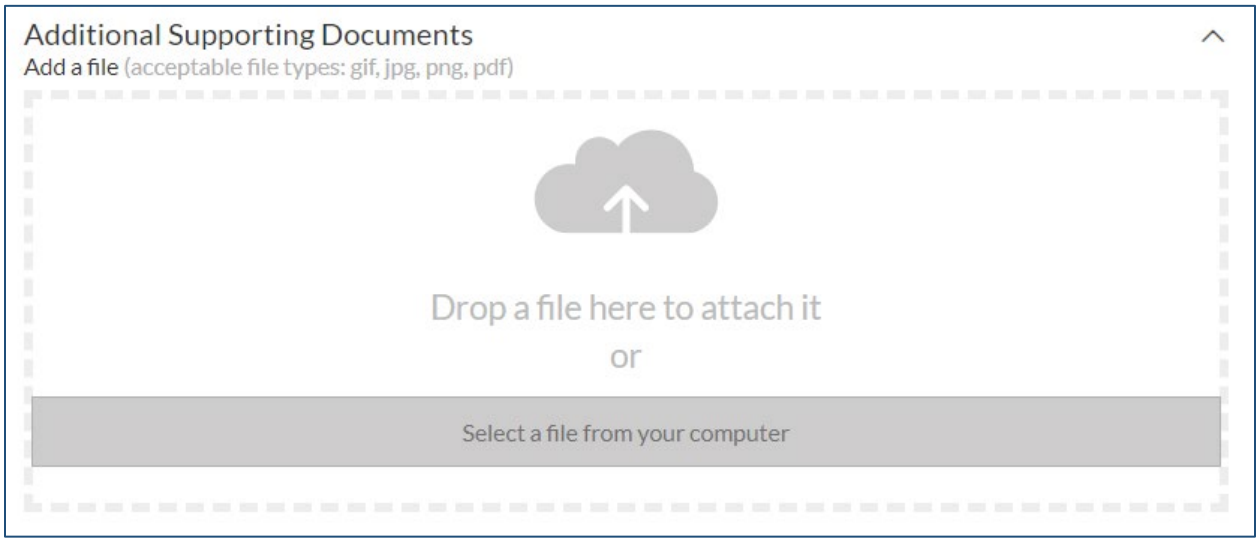


7: Uploading Records

- Additional Supporting Documents – Click within the dotted line to open your file menu to attach the medical records or drag and drop the record in this area. Files accepted include gif, jpg, png and pdf.

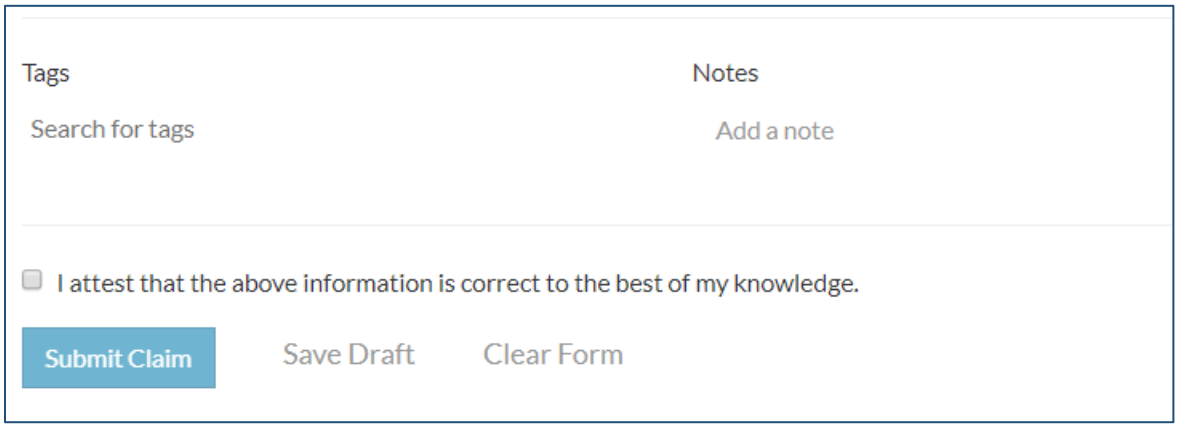
  This is a required field and every claim entered must have medical records supporting the data elements entered into Interpreta.

  Please refer to page 10 of this guide, for details required in the medical record.



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 is 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."



9: 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 includes name, signature and credentials.

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

- If a mistake is such as the following, the claim will be rejected with a note and put in a Pending status 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.

10: Coding for Specific Measures

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

1. Breast Cancer Screening (BCS) (Medical)

Codes:

- 77067 - Scr mammo bi incl cad
- 77066 - Dx mammo incl cad bi
- 77065 - Dx mammo incl cad uni
- 77062 - Breast tomosynthesis bi

Exclusions codes for Breast Cancer screening follows:

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

2. Cervical Cancer Screening (CCS) (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.

  - **88142** - Cytopath c/v thin layer.
  - 88141 - Cytopath c/v interpret.
  - 18500-9 - Thin Prep Cvx.

If patient is 30-64 years of age, code for HPV.

- 87625 - HPV types 16 & 18 only.
- 87624 - HPV high-risk types.
- 21440-3 – HPV I/H Risk DNA CVX QI Probe.

EXCLUSION:

- 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"

- Ordering provider = rendering provider, i.e. Quest, LabCorp, ABC Labs.
- For point care, put facility name or FQHC name.

3. 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.

- **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

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

Medical records must be from an Ophthalmologist or Optometrist.

For dates of services done in the **previous year,** and the note clearly states, "No retinopathy" or "NDR" or "negative" or "w/o Retinopathy," you can enter the following CPT code:

- 3072F - Low risk for retinopathy

For eye exams done in the **current year**, enter the following CPT code:

- 2022F - Dil retina exam interp rev
- 2024F - 7 field photo interp doc rev
- 2026F - Eye image valid to dx rev
- S0625 - Digital screening retina

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

5. 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

6. Comprehensive Diabetes Care (CDC) - Hba1c (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.

- There are 3 steps to enter the two HbA1c codes.
  1) Enter the CPT A1c test code.
     - 83036 - Glycosylated hemoglobin test.
  2) Click on "Add Service Line" to enter second CPT II code and re-enter service information.
  3) Enter the result CPT II code.
     - 3044F - Hemoglobin A1c level < 7.0%.
     - 3045F - Hemoglobin A1c level 7.0-9.0%.
     - 3046F - Hemoglobin A1c level > 9.0.

7. Blood Pressure Screenings (CBP) (Medical)

- **See page 5** of this Guide for details on entering the data for this measure.
- Codes auto-populate when systolic and diastolic values are entered.

8. BMI Adult (ABA) (Medical)

- **See page 6** of this Guide for details on entering the data.
- 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.

9. 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.

10. Immunization for Adolescents (IMA) (Medical)

Meningococcal Vaccine:

- 90734 - Meningococcal vaccine im

TDAP / TD Vaccine

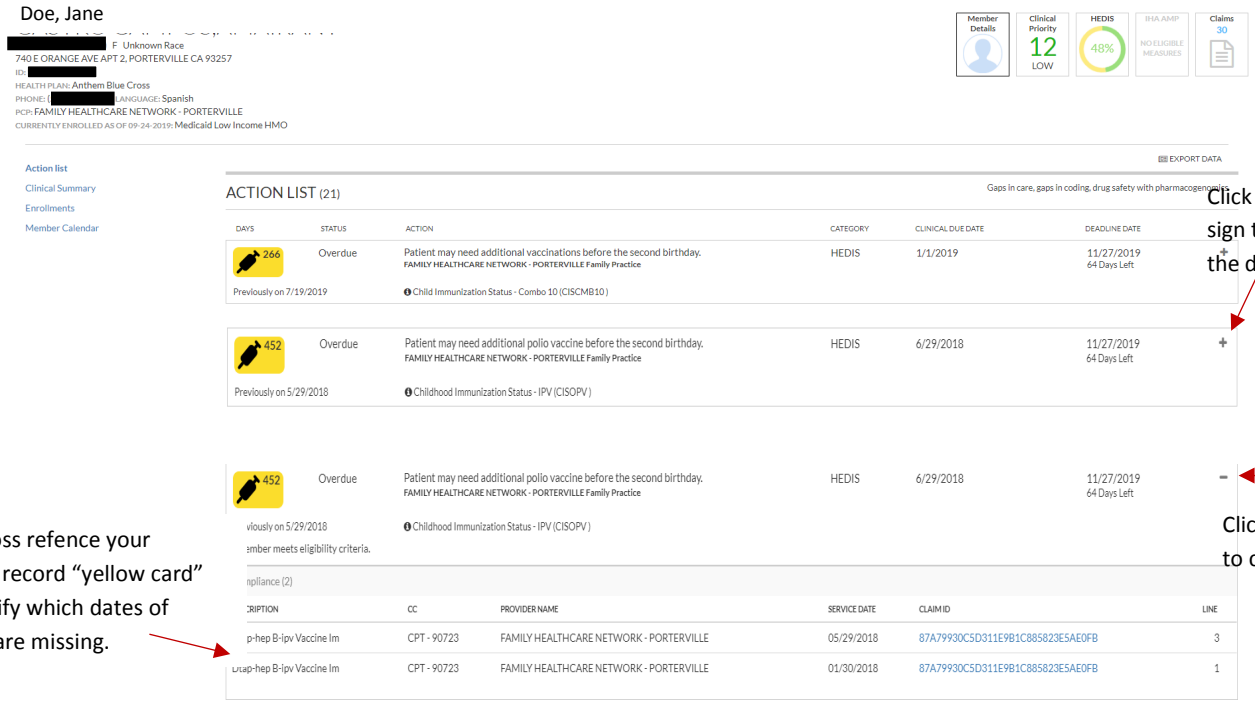
- 90715 - Tdap vaccine 7 yrs or older im

HPV Vaccine:

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

11. **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.



Tip: Cross refence your medical record "yellow card" to identify which dates of service are missing.

- 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.

(11) Childhood Immunization Status (CIS)

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

12. 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)

13. 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)

14. 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.

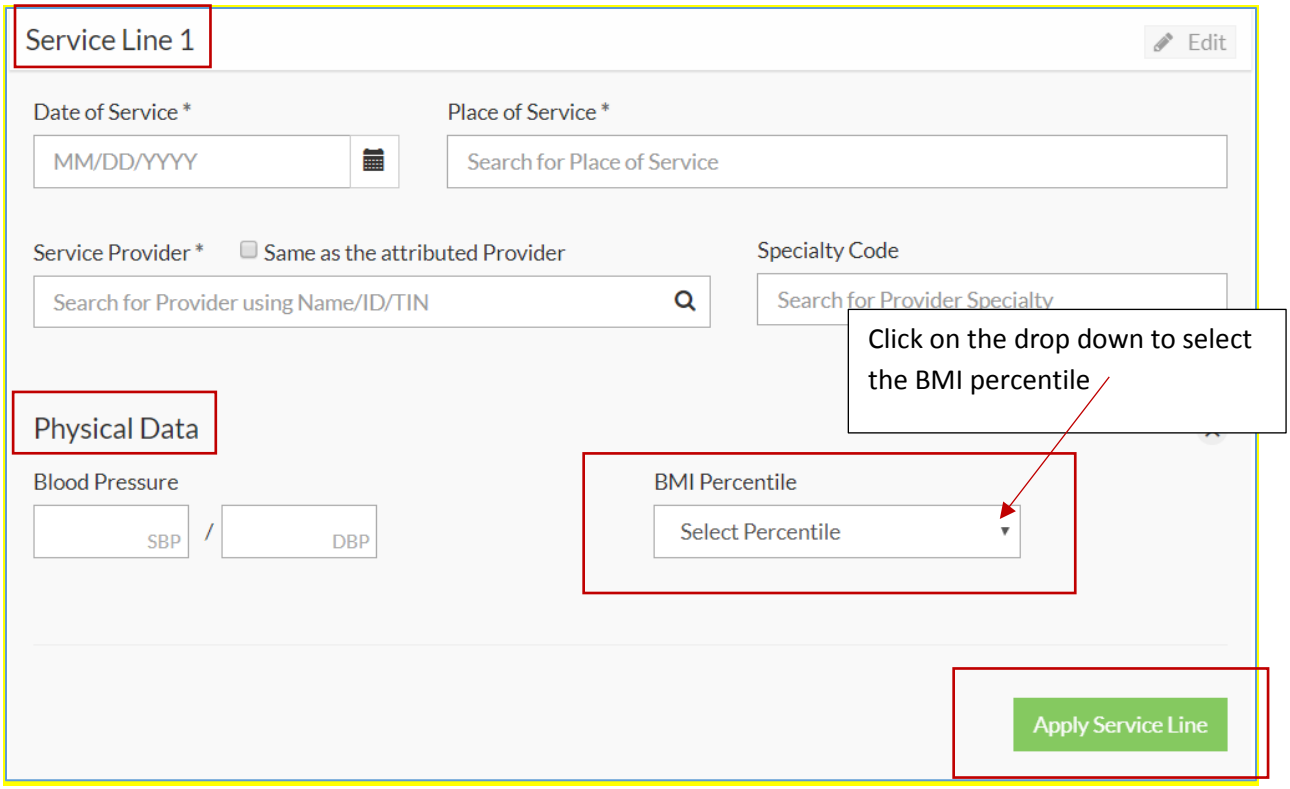
WCC - Nutrition

- 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.

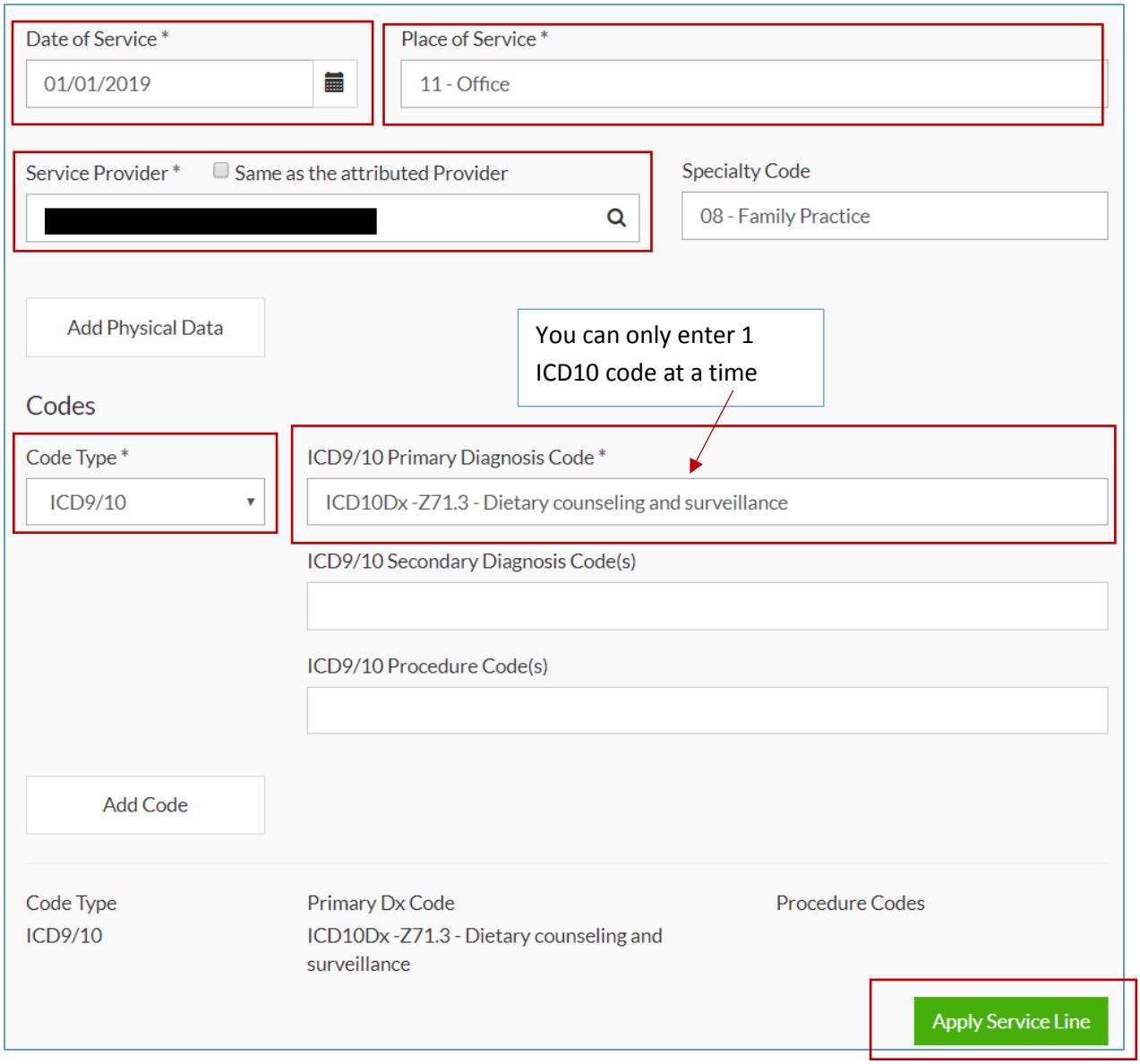
WCC - Physical Activity

- 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.

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



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



(14) **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	

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

(Medical)

- Enter the code that meets the medical record 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

16. Medication Reconciliation Post Discharge (MRP) (Medical)

- 1111F – Discharge medications reconciled with the current medication list in outpatient medical record.

17. 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."

Advanced Care Planning – 1 code required

- 1157F - Advnc care plan in rcrd
- 1158F - Advnc care plan tlk docd
- 99497 - Advncd care plan 30 min

Fuctional Status assessment – 1 code required

- 1170F - Fxnl status assessed

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

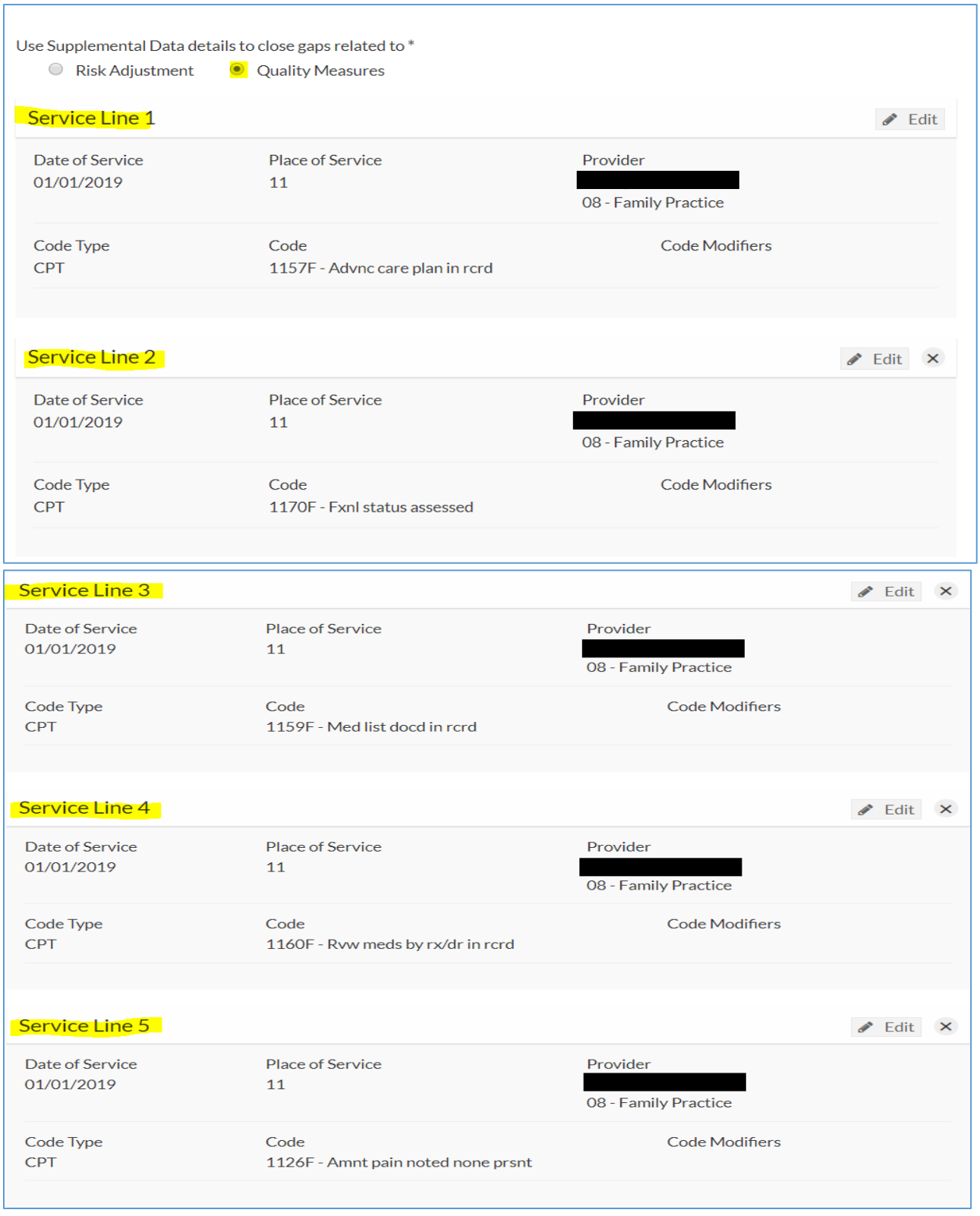
- 1159F - Med list docd in rcrd
- 1160F - Rvw meds by rx/dr in rcrd

Pain assesment – 1 code required

- 1125F - Amnt pain noted pain prsnt
- 1126F - Amnt pain noted none prsnt

(17) **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.

MedPOINT Management's Supplemental Data Process

The process for submitting supplemental data is tedious, resource intense and is always subject to Primary Source Verification (PSV) audit. Based on this, MedPOINT strongly recommends that data should be submitted through the encounter/claim process whenever possible.

MedPOINT Management (MPM) on behalf of the contracted IPA/medical group accepts electronic supplemental data files for HEDIS for the current measurement year. Complete and correct data will be submitted for processing to Interpreta and the health plans simultaneously. Interpreta data is refreshed weekly on Thursday.

Please note, supplemental data submitted to the health plan for processing may not be reflected in health plan Gap in Care (GIC) or summary reports/report cards until the close of the Reporting Year.

- **EHR data files** must be submitted using one of MedPOINT's Supplemental Excel Layouts.
- **Medical records** must be submitted through Interpreta's Supplemental data portal.

Please review the Interpreta Summary Reports to identify measures that are low overall and work with your IT Staff to generate an Electronic Health Record (EHR) data extract for those measures. Also look for members on the Interpreta's "HEDIS Members" report to identify member with measures that are Due, Past Due or Failed and compare them to your members' medical records. If you identify services that are over two months old, please submit this information electronically using Interpreta's Supplemental data portal.

Dates to Remember:

There are strict guidelines that must be met in order for the Health Plans to accept supplemental data. MPM must receive all files for the current measurement year by the following date of the reporting year:

Non-Standard Data: 1/15
Standard Data: 2/28

Due dates vary by health plan; the dates above are based on the most stringent guidelines we have.

Types of Data

Below are the various types of supplemental data that can be submitted.

1. Standard Data – This is data extracted directly from an EHR system with no modification needed. The codes are already in the EHR and the data is extracted with all the required layout fields and then copied onto the claim or lab layout template form provided by MedPOINT. An example of this type of data capture is BMI.

2. Non-Standard Data – This category includes codes have not been documented in your EHR system. The data is extracted and modified to include the appropriate service codes and then copied onto the claim or lab layout template form provided by MedPOINT.

3. Non-Standard (medical record submission) – This submission requires that the medical record is validated to confirm that the documentation needed to meet the measure is present. A record is created in Interpreta, and the medical record is then uploaded into Interpreta for processing. Self-reported services noted in the chart or proof of former services are considered non-standard. Also, records for services not submitted through an encounter/claim should be submitted through Interpreta.

It is important that the information submitted accurately reflects the services documented in the member's medical record. Data files that do not meet the requirements below will be returned for correction or completely rejected. Medical Records submitted through Interpreta that do not meet the criteria established for meeting the measure will also be rejected.

Excel Layout Spreadsheets to Fill Out

- LAB_Layout.xlsx (Lab file layout) – This format is for submitting lab data that supports a specific measure.
  - Measures that require lab tests are (Comprehensive Diabetes Care) CDC HbA1c, CDC Nephropathy, Medication Monitoring (MPM), CCS (Cervical Cancer Screening), CHL (Chlamydia Screening in Women) and (Colorectal Cancer Screening) COL (FOBT test only).
  - This file requires LOINC codes and test results to be reported. Data submitted on this file without this information **will not be** processed.
  - The record must also include member demographics, the name of the provider who rendered the service, and their License or NPI number.

- Claim_Layout.xlsx (Claim file layout) – This format is for submitting data that would normally be submitted through the standard encounter process.
  - Measures that apply to this spreadsheet:
    - ABA (Adult BMI Assessment)
    - AWC (Adolescent Well-Care)
    - BCS (Breast Cancer Screening)
    - CBP (Controlling Blood Pressure)
    - CCS (Cervical Cancer Screenings)
    - CDC (Comprehensive Diabetes Care) - Retinal Eye
    - CIS (Childhood Immunization Status)
    - COL (Colorectal Cancer Screening) Colonoscopy or Sigmoidoscopy
    - IMA (immunizations for Adolescent) Combo 1 and 2
    - PPC (Prenatal and Postpartum)
    - W34 (Well Child 3-6 years)
    - WCC (Weight Counseling for Children).

  - Look for medical records that include child and adolescent wellness visits, mammogram radiology reports, optometrist or ophthalmologist letters, immunizations, colonoscopies, prenatal and postpartum visits.
  - This file should also be used to submit Blood Pressure CPT II codes.
  - In addition to providing the member demographics, the record must include diagnosis and/or or procedure code (CPT) that make the member measure compliant, the name of the

provider who rendered the service, their specialty and National Provider Identification number (NPI).

Ways to Submit Data

1. **EHR Data Extracts:** Work with your IT staff to query your EHR system to extract measure specific data by searching for specific codes (coding details are available in the HEDIS Reference Guide for Providers). The data should be submitted using the Claim or Lab file layout described above.

2. **Medical Record Data:** Interpreta's Supplemental Data module should be used to document and upload medical records for services that are not marked compliant in Interpreta.

Dates of Service

1. Calendar year measures must occur annually; examples below:

    a. AWC (Adolescent Well-Care)
    b. Comprehensive Diabetes Care (HbA1c, Nephropathy)
        i. For A1c Control, you must report the most recent A1c result; not the best one for the year.

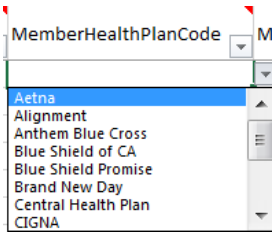
2. Multi-year measures must be reported based on the measure requirements; examples below:

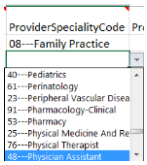
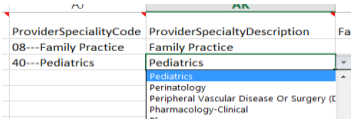
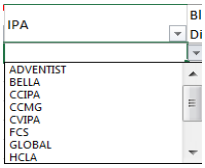
    a. (BCS) Breast Cancer Screening – every 27 months starting 10/1/17 (for MY2019).
    b. (CCS)Cervical Cancer Screening – every 3 years up to age 29, every 5 years for age 30+.

Populating the Files – What Information to Include

The files contain multiple columns, and some may seem redundant. The files have been designed to meet the needs of multiple health plans and to separate like data into its own column to simplify the data processing steps. The following chart outlines the like fields and describes the items that are required. This information is also included in a tab on the Excel layout templates.

Column Names	Comment
Member CINNumber Member HIC Number	These 3 columns are all unique ID numbers issued by the State, CMS or the Health plan. **Only 1 column required.**
Member HealthPlan ID	This column is the unique ID number issued by the Health plan. **This field is required.**
Member_Internal_ID	This column is for your internal use only and is **optional**. If you issue the member a medical record or internal ID; this is where you would store this internal ID
MemberLastName MemberFirstName	Include the member's Last Name and First Name separately in these columns
MemberHealthPlanCode	Data consistency is very important in this column. The field is formatted with a dropdown list so that

Column Names	Comment
	you can select the member's health plan from a predefined list. This helps to separate the data by plan so that the data can submitted to the member's respective health plan.
MemberDOB	Member's Date of Birth
MemberGender	Member's sex (F or M)
DateOfService_From	Start Date that the member first received the services
DateOfService_Thru	This should be the same date used in the DateOfSErvice_From column
ICD Indicator	If the service was performed prior to 10/1/2015, the indicator is "9". This indicates that the ICD Diagnosis Code is an ICD-9 code. For services performed 10/1/2017 and forward, the indicator is "10" to reference ICD-10 codes.
ICD Primary Diagnosis Code	Populate this column with the member's primary diagnosis code for the date of service.
ICD Diagnosis Secondary Code 1 ICD Diagnosis Secondary Code 2 ICD Diagnosis Secondary Code 3 ICD Diagnosis Secondary Code 4 ICD Diagnosis Secondary Code 5 ICD Diagnosis Secondary Code 6 ICD Diagnosis Secondary Code 7 ICD Diagnosis Secondary Code 8 ICD Diagnosis Secondary Code 9 ICD Diagnosis Secondary Code 10	Multiple columns have been added so that more than one code can be added per row. If a member had more than one diagnosis on a specific date of service, you can add up to ten codes per row. If the member had more than ten diagnosis codes on a given date, a new row would need to be added to document the additional codes.
CPTCode1 CPTCode2 CPTCode3 CPTCode4	Multiple columns have been added so that more than one code can be added per row. If a member had more than one service on a specific date of service, you can add up to four CPT/HCPCs (procedure) codes per row. If the member had more than four services on a given date, a new row needs to be added to document the additional codes.
PlaceOfService	The value for this column is "11" which represents that the services were performed as an outpatient or office visit. FQHCs and RHCs may use '3', '50' or '72' as well to correctly reflect the place of service.
ProvFirstName	Enter the provider's first name in this column. If the services are completed by a radiology vendor, this column should remain blank.
ProvLastName	Enter the provider's last name in this column. This is also where you enter the full name of the lab or radiology vendor who performed the services.

Column Names	Comment
ProvTaxID ProvLicense ProvNPI	These are unique identifiers that are associated with the provider of service. The provider's Tax ID, License or NPI is being requested; only one is required.
Prov PCP (Y/N?)	Is the Provider of Service on the claim a Primary Care Physician (PCP)? Yes or No
ProviderSpecialityCode 	This is a standard code used to indicate the provider's specialty. It must be populated with the correct code. The column has been formatted to include a dropdown list so that the correct code can be selected. [This is very important as some measures require that the services are performed by a specific specialty type.]
ProviderSpecialtyDescription 	This is a predefined code established by the health plans. It must be populated with the correct code. The column has been formatted to include a dropdown list so that the most appropriate option can be selected.
FacilityName	Where were the services performed? This column is optional
IPA 	Select the IPA is the member affiliated with? The column has been formatted to include a dropdown list so that the most appropriate option can be selected.
Blood Pressure - Diastolic	Enter the Diastolic value when submitting data for Blood Pressure (BP) measures
Blood Pressure - Systolic	Enter the Systolic BP result value when submitting data for BP measures
BMI Value	Enter the BMI value when submitting data for the ABA and WCC-BMI measures. The BMI percentile must be used for members up to age 19.
Height	Enter the member's height (in inches) when submitting data for ABA and WCC-BMI measures
Weight (lbs)	Enter the member's weight (in pounds) when submitting data for ABA and WCC-BMI measures

The following additional columns are part of the Lab Data file

Column	Comments
HCPCS Code	Enter the HCPCS code if applicable
LOINC	**Required code, if you do not have a LOINC code for the test performed, enter the data in the Claim file format.**
Result	Enter a numeric result value. Example: HbA1c "7.8"
PosNegResult	Enter a value of "1" for Positive Lab results and a value of "0", for Negative lab results.
LabClaimAltID1	Optional field:

Column Names	Comment
LabClaimAltID2	Use for Non-Numeric lab results - ie: yellow, +3, etc, If lab results are all numeric, leave blank.

Where to Submit the Data

Please Email all files to: QIFiles@medpointmanagement.com

For questions, please call Connie Martinez at 818-702-0100 x1288, or email **QIFiles@medpointmanagement.com**

NCQA Definition of Non-Standard Supplemental Data

For your reference, we are including further information on Non-Standard Supplemental Data (medical records).

Non-Standard Supplemental Data is used to capture missing service data not received through administrative sources (claims or encounters) or in the standard files, whether collected by an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.

Examples of non-standard supplemental data are:

- EHR modules (e.g., uncertified eMeasure modules).
- Provider portals (i.e., electronic systems that providers use to enter information about services rendered).
- Health information registries.
- Provider abstraction forms.
- Member reported services.

Audit requirements
All non-standard supplemental data must be substantiated by proof-of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit's annual primary source verification.

Proof-of-service documentation that *is allowed* for primary source verification:

- A copy of the information from the member's chart from the service provider or the PCP.
- A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports (i.e., forms from the rendering provider proving the service occurred).
- A screen shot of:
  - Online EHR records.
  - State-sponsored or county-sponsored immunization registry records.

Proof-of-service documentation that is *not allowed:*

- Member surveys. Organizations and providers may not use information obtained from surveys or other documents completed by the member, except for data collected for *Language Diversity of Membership* and *Race/Ethnicity Diversity of Membership*.
- Phone calls. Recorded phone calls to collect information about services rendered are not proof of service.