

## Capturing and Coding Clinical Actions

A single, well-documented visit can close several gaps at once — the blood pressure you record, the medications you review, and the labs you order each map to a distinct quality measure. Any medications impacting the visit should also be documented with the appropriate and correct diagnosis codes for those medications. Capture the following clinical actions during the encounter and submit the matching CPT-II codes. Measure attribution is noted in **teal**.

### 1. All Visits — medication review, functional status, and blood pressure

| CPT-II        | DESCRIPTION                                                                                                                                                                                            |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1160F         | Review of all medications by a prescribing practitioner or clinical pharmacist (prescriptions, OTCs, herbals, and supplements) documented in the medical record ( <b>COA – Care for Older Adults</b> ) |
| 1159F         | Medication list documented in medical record ( <b>COA – Care for Older Adults</b> )                                                                                                                    |
| 1170F         | Functional status assessed ( <b>COA – Care for Older Adults</b> )                                                                                                                                      |
| 3074F – 3080F | Blood pressure — submit one systolic and one diastolic result code (select from the thresholds below) ( <b>CBP – Controlling High Blood Pressure</b> )                                                 |

### 2. Transition of Care — every follow-up after an inpatient discharge

During all post-discharge follow-ups, complete a medication reconciliation, functional assessment, and blood pressure, then submit:

| CPT-II        | DESCRIPTION                                                                                                                                                                       |
|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1111F         | Discharge medications reconciled with the current medication list in the outpatient medical record ( <b>TRC – Transition of Care – Medication Reconciliation Post-Discharge</b> ) |
| 1170F         | Functional status assessed ( <b>COA – Care for Older Adults</b> )                                                                                                                 |
| 3074F – 3080F | Blood pressure — submit one systolic and one diastolic result code (select from the thresholds below) ( <b>CBP – Controlling High Blood Pressure</b> )                            |

## Blood Pressure — select one systolic and one diastolic

| CPT-II       | DESCRIPTION                                                            |
|--------------|------------------------------------------------------------------------|
| <b>3074F</b> | Most recent systolic blood pressure less than 130 mm Hg                |
| <b>3075F</b> | Most recent systolic blood pressure 130–139 mm Hg                      |
| <b>3077F</b> | Most recent systolic blood pressure greater than or equal to 140 mm Hg |
| <b>3078F</b> | Most recent diastolic blood pressure less than 80 mm Hg                |
| <b>3079F</b> | Most recent diastolic blood pressure 80–89 mm Hg                       |
| <b>3080F</b> | Most recent diastolic blood pressure greater than or equal to 90 mm Hg |

*Submitting the correct reading directly supports the Controlling Blood Pressure (CBP) measure.*

## 3. Diabetic-Related Labs — kidney function and HbA1c

When ordering kidney function testing for the Kidney Health Evaluation (KED) measure, order **82043 AND 82570 on the same day** so the urine albumin-to-creatinine ratio (uACR) is captured as a complete pair. As a reminder, please make sure your diagnosis codes are also coded correctly, reflecting any kidney conditions that are affecting the diabetic condition. Then submit the appropriate HbA1c result code below:

| CPT-II       | DESCRIPTION                                                                          |
|--------------|--------------------------------------------------------------------------------------|
| <b>3044F</b> | Most recent hemoglobin A1c (HbA1c) level less than 7.0%                              |
| <b>3051F</b> | Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%             |
| <b>3052F</b> | Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0% |
| <b>3046F</b> | Most recent HbA1c level greater than 9.0%                                            |

*Best practice: complete both urine tests on the same day — a missing or mismatched pair is the most common reason KED gaps stay open.*

*Reporting the A1c result code supports the Glycemic Status Assessment for Diabetes (GSD) measure.*

### Clearing up Concerns

We know the first reaction is often “we can’t submit CPT-II codes.” In nearly every case, that’s a workflow or configuration issue we can solve together — not a dead end.

| What we often hear                                                                          | Here’s the reality — and how we help                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>“Our EHR doesn’t support CPT-II codes.”</b>                                              | Almost every major EHR can submit CPT-II codes — they usually just need to be enabled or mapped. We’ll work directly with your EHR vendor to get the codes turned on and ready to submit with your existing documentation.                                                                                                                                                                                                 |
| <b>“These codes don’t pay anything.”</b>                                                    | Correct — CPT-II codes carry a \$0 charge by design. But they are the lowest-burden way to close a quality gap, and every code submitted is one less chart chase, record request, or audit your staff has to field later.                                                                                                                                                                                                  |
| <b>“It’s extra clicks for already-busy providers.”</b>                                      | Setup is largely one-time. Once the codes are enabled, they attach to documentation you’re already completing — the BP you took, the meds you reviewed, and the A1c you ordered. We’ll work with your EHR vendor on the initial setup, so it fits your existing workflow.                                                                                                                                                  |
| <b>“We’re not sure which codes apply to which patients.”</b>                                | This bulletin is your reference, and our team will sit down with your practice to match the right codes to the measures you see most. You don’t have to figure it out alone.                                                                                                                                                                                                                                               |
| <b>“We don’t get the A1c result until later, so someone has to go back in and code it.”</b> | That after-visit step is the intended workflow — the A1c result code carries the date of the test, not the office visit, so it’s meant to be submitted once the result is back. To avoid a second touch, order the lab before the appointment so it’s codable at the visit, or use in-office point-of-care testing and code it same-day. Otherwise, add the \$0 code at the result-review step you have already completed. |

### We’re Here to Make This Seamless

HealthTeam Advantage will coordinate directly with your EHR vendor to get CPT-II codes enabled and mapped.

Reach out to me directly – Abby Hoffman, Director of Quality – to schedule a working session, and we’ll coordinate with your EHR vendor from there.

**Questions or ready to get started?** Contact me directly via email at [ahoffman@htanc.com](mailto:ahoffman@htanc.com).

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