Department of Family and Community Medicine Grand Rounds

Compliance Education FY2017
Objectives: At the end of the session, the participants should be able to:

- Apply HIPAA regulations in identifying patients.
- Address issues discovered in an audit of FCM services.
- Apply documentation requirements for preventive service visits such as Medicare’s Annual Wellness Visit and Medicaid’s Well Child visits.
How To Avoid HIPAA Privacy Incidents

• During the patient registration/scheduling process allow the patient to provide you pertinent information that will identify the patient: Last Name, First Name, Middle name, Date of Birth, Address, Last 4 of SSN. (Do not give them the information to confirm instead have them provide it to you!);

• Disclose only the minimum necessary amount of patient identifiable information (MRN, initials)

• Use MyChart when communicating with a patient;

• Double Check!! When mailing or handing documents to patients and/or family members, slow down and verify that each document belongs to the patient.

• Dispose documents containing confidential information by shredding;
Department Action Plan

Suggestions:

• Standardize the process of patient correspondence among all physicians
• Utilize secured electronic means, MyChart, as the preferred method of communication with patients
• Patient correspondence, letters and/or lab results, shall be printed, matched appropriately, prepared for mailing, as each occurrence requires rather than tasked together with other patient records
• Another staff person prior to mailing will check patient letters and/or lab results
• Provide education to staff concerning the importance of HIPAA confidentiality
Mobile Devices

- All mobile devices must be encrypted and when taken off the worksite premises, must not be separated from employees at airports, automobiles, hotel rooms, etc.
- Do not leave mobile devices unsecured.
- When not being used, all mobile devices should be locked up.
Audit Findings

Under Coded by 1 level
Over Coded by 1 level
Medicaid preventive service
   ~ TB Screening
   ~ Dental Referral or record of Dental Home
   ~ Vision/Hearing Screening
   ~ Unclothed Exam *modifier*
   ~ Review of Milestones
   ~ Mental Health Screening

Medicare Annual Wellness Visit
History Tips

Status of Chronic conditions alternative to HPI elements

Status of 1-3 chronic conditions for codes such as:
- New patient office visit 99201-99202
- Established patient office visit 99212-99213
- Subsequent hospital days 99231-99232

Status of 4 or more chronic conditions for codes such as:
- New patient office visit 99204-99205
- Established patient office visit 99214-99215
- Admit to inpatient 99221-99223

Required Documentation
“Hypertension well controlled” not simply hypertension
“Poorly controlled type 2 diabetes with neurological complications” rather than simply diabetes
History Tips

ROS:
Document the pertinent positives and negatives then once you have reviewed all other systems remember to document “All others negative”

Family History:
Reviewed and noncontributory

Unable to Obtain History:
If you are unable to obtain history for whatever reason and there is no other person available to obtain the history from, you would document the HPI and that you were unable to obtain history and why and this would give you a comprehensive history.
Example: HPI documentation… then “Patient was intubated and I was unable to obtain history. There was no one else available to obtain the patient’s history from.”
Examination Tips

**Novitas Solutions 4x4 rule** (1995 guidelines)
Allows providers to achieve a detailed examination without the necessity of examining systems that may not be necessary to examine

If you examine and document 4 items from 4 organ systems it fulfills the detailed examination requirement for codes such as

- New patient office visit 99203
- Established patient office visit 99214
- Hospital admission 99221
Expanded Problem Focused vs. Detailed
1995 EXAM

Expanded (99202, 99213)
- Eyes – PERRLA
- Heart – Regular rate & rhythm
- Lungs – Clear to auscultation
- Abdomen – soft

Detailed*(99203, 99214, 99221)
- Eyes – watery, non-icteric, PERRLA
- Heart – s1/s2, regular rate and rhythm, no gallops, no rubs
- Lungs – Clear to auscultation, no rhonchi, rales or crackles
- Abdomen – soft, non-distended, BS present, no hernias noted

*Note: Novitas 4X4 Rule: Four or more items from 4 or more body areas or organ systems for a detailed exam. Clinical inference can override this rule.
Medical Decision Making Tips

**Table of Risk**

**Nature of presenting problem**
- Builds case for medical necessity
- Indicates appropriate level of intensity for service

**Prescription drug management**
- Documentation of simple refill is not sufficient,
- indicate medical decision making involved in assessing
  the efficacy of drug and dose

**Amount and Complexity of Data**
Document research add to complexity of next visit when you reference it

To reference something elsewhere in the chart no need to copy and paste, say what it is and the date for example, “See CBC from 4/1/2016 for WBC”
## Evaluation and Management
### Nature of Presenting Problem
(From the Table of Risk)

<table>
<thead>
<tr>
<th>Nature of Presenting Problem</th>
<th>Level of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor problem</td>
<td><strong>Office</strong></td>
</tr>
<tr>
<td></td>
<td>99201/99202 - 99212</td>
</tr>
<tr>
<td>Two or more self-limited or minor problems&lt;br&gt;One stable chronic illness&lt;br&gt;Acute uncomplicated illness or injury</td>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td></td>
<td>99221 - 99231</td>
</tr>
<tr>
<td>Two or more chronic illnesses with mild exacerbation, progression, or side effects of treatment&lt;br&gt;Two or more stable chronic illnesses&lt;br&gt;Undiagnosed new problem with uncertain prognosis&lt;br&gt;Acute illness with systemic symptoms&lt;br&gt;Acute complicated injury</td>
<td><strong>Office</strong></td>
</tr>
<tr>
<td></td>
<td>99203 - 99213</td>
</tr>
<tr>
<td></td>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td></td>
<td>99222 - 99232</td>
</tr>
<tr>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment&lt;br&gt;Acute or chronic illness or injury that poses a threat to&lt;br&gt;life or bodily function&lt;br&gt;Abrupt change in neurologic status</td>
<td><strong>Office</strong></td>
</tr>
<tr>
<td></td>
<td>99204 - 99214</td>
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<tr>
<td></td>
<td><strong>Inpatient</strong></td>
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<td>99223 - 99233</td>
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</tbody>
</table>
Preventive Service

Preventive services are not like other E&M codes. In E&M we have a range of intensity of service so that if an encounter fails to meet all the billing requirements of a level of intensity of service it most likely will meet the requirements of a lower level of intensity encounter.

With preventive services it is all or nothing either the encounter meets the qualifications of the visit or it does not.

This holds true for both Medicaid and Medicare
In order for the Texas Health Steps (Medicaid) pediatric check up to be complete there must be documented:

1. Comprehensive health and developmental history, including physical and mental health development
2. Comprehensive unclothed physical examination
3. Immunizations appropriate for age and health history
4. Laboratory tests appropriate for age and risk, including toxicity at specific federally mandated ages
5. Health education including anticipatory guidance
6. Dental referral

When the Preventive Service visits were audited the following was found to have problematic or missing documentation:
- TB Screening
- Dental Referral or record of Dental Home
- Vision/Hearing Screening
- Unclothed Exam
- Review of Milestones
- Mental Health Screening
Texas Health Steps Checkup

Previous results may be used to meet the checkup requirements if completed within:
• Preceding 30 days for children who are two years of age and younger.
• Preceding 90 days for children who are three years of age and older.

Documentation must include:
• The date(s) of service.
• Clear reference to-
Previous visit by the same provider, or results obtained from another provider.
Components of TX Health Steps

A component may be omitted due to:

• Provider’s assessment of child’s condition
  -or-
• Lack of cooperation
  -or-
• Parent’s refusal to give consent.

May also omit specific screening tools if:
• A related condition has been identified, and
• Child is currently receiving treatment.

Documentation must include the rationale for the omission.
TB Screening

Risk screening tool must be administered annually to all clients who are 12 months or older.
If screening tool indicates risk of exposure then the TB skin test must be administered (CPT code 86580).
A follow-up visit (CPT code 99211) is required to read all TSTs.

Positive TST:
o Further evaluation is required to diagnose either latent TB infection or active TB disease.
o Report a diagnosis of latent TB infection or suspected TB disease to your local or regional health department.
Dental Referral

Dental Referral or record of Dental Home

State Requirement-
• Dental referral every 6 months until a dental home is established.

A referral depends on the result of the oral exam:
• Routine dental referral - Beginning at 6 months of age until a dental home has been established.

• Referral for dental care - At any age if the oral exam identifies a possible concern.

• Emergency dental referral - If a child has bleeding, infection, excessive pain, or injury, refer directly to the dental provider.
Physical Exam: Sensory Screening

VISION
• Visual acuity screening according to the THSteps Medical Checkup Periodicity Schedule.
• Subjective screening at all other checkups.

HEARING
• Audiometric screening according to the THSteps Medical Checkup Periodicity Schedule.
• Subjective screening at all other checkups.
Unclothed Exam

Complete THSteps Checkup
Complete only if it includes:
• All required components, or
• Documentation of why a particular component could not be completed.

Previous results may be used to meet the checkup requirements if completed within:
• Preceding 30 days for children who are two years of age and younger.
• Preceding 90 days for children who are three years of age and older.
Physical Exam

Comprehensive

• Must be unclothed

• May be completed by:
  • Physician
  • PA (Physician Assistant)
  • CNS (Clinical Nurse Specialist)
  • NP (Nurse Practitioner)
  • CNM (Certified Nurse-Midwife)
  • RN (Registered Nurse)
    ○ Under direct supervision of physician
## Physical Exam

Use the appropriate Modifier to document who performed the unclothed exam

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AM</td>
<td>Physician, team member service</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner rendering service in collaboration with a physician</td>
</tr>
<tr>
<td>TD</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>U7</td>
<td>Physician assistant</td>
</tr>
</tbody>
</table>
Procedures which are a benefit may be reimbursed on the same day as a medical checkup

Developmental screening (CPT code 96110).
• Autism screening (CPT code 96110 with U6 modifier).
• Mental health screening in adolescents (CPT code 99420).
• Tuberculin Skin Test (TST) (CPT code 86580).
• Point-of-care lead testing (CPT code 83655 with QW modifier).
• Immunizations administration (Individual MCOs may require the use of a modifier).
Children less than 12 months of age
• Checkups in this age group occur within two weeks of due date based on child's date of birth.

Children 12 months of age or older
• Should have a yearly checkup as soon as they become due.
• May be completed anytime after their birthday (timely).
• Will not be considered late unless the child does not have the checkup prior to their next birthday.
Online Provider Education (OPE)

http://www.txhealthsteps.com/

THSteps Online Provider Education system offers tutorials and modules on a variety of topics for health care providers FREE of charge.
Medicare AWV Annual Wellness Visit, Initial G0438

- Required Elements that must be Documented:
  1. Health Risk Assessment*
  2. List of Current Suppliers and Providers*
  3. Family and Medical History
  4. Review Risk Factors for Depression
  5. Review Functional Ability and Level of Safety
  6. Routine Measurements (Limited Physical Exam)
  7. Assess Cognitive Impairments
  8. Establish Written Screening Schedule for the Next 5-10 Years
  9. List of Risk Factors and Conditions where Interventions are Recommended
  10. Personalized Health Advice and Referrals for Health Education and Preventive Counseling
Health Risk Assessment* - How to Capture

• The HRA can be completed by
  • The patient prior to the appointment and brought with them
  • Staff at patient office visit

• It may be helpful to have a designated staff person call the patient or their representative and have them complete the HRA over the phone prior to the visit

• Anyone can document the information in the medical record for the HRA
List of Current Suppliers and Providers*

- List names of providers and suppliers and their role
  
  For example:
  
  Dr. ABC Pulmonologist
  Dr. DEF Endocrinologist
  Big Bob’s DME Barn for diabetic and O2 supplies

Note: If the beneficiary doesn’t have any “current suppliers and providers” then the current provider providing the AWV can state:

- None other that current provider or
- Name of current provider performing the AWV
Family and Medical History

- Medical events in the beneficiary’s parents, siblings and children including diseases that may be hereditary or place the beneficiary at increased risk

- Past medical history
  - Surgeries
  - Hospital stays
  - Illnesses
  - Allergies
  - Injuries
  - Treatments
  - Use of/exposure to medications and supplements (vitamins and calcium etc.)

**Tip!**
- Be careful of documenting a condition as a “history of” a condition rather than as an active condition.
- By documenting “history of” you are saying that the patient no longer has that condition.
Depression Risk Factors

• Required for patients without current diagnosis of depression

• Use appropriated screening instrument
  • Standardized screening tests
  • PHQ 2 or PHQ 9 can be used for this purpose.

• If depression is identified document referral to mental health professional
Functional Ability and Safety

- Direct observation of patient or use of appropriate screening questionnaire (recognized by National Professional Medical Org) to assess at a minimum
  - Fall Risk
  - Home Safety
  - Hearing impairment
  - Ability to successfully perform ADL’s
Routine Measurements

- Blood Pressure
- Height
- Weight
- BMI (waist circumference if appropriate), and
- Other measurements as appropriate
Detection of Cognitive Impairment*

- Direct observations, with considerations of information from reports or concerns raised by family, friend, caretakers or others
  - Mood
  - Affect
  - Appearance

- Not the same as the Mental Health exam
Written Screening Schedule (Next 5-10 Years)

Base schedule on:

- Age appropriate preventive services Medicare covers (See Handout)
- Beneficiary’s HRA, health status, and screening history
- Recommendations from the US Preventive Services Task Force and Committee and Advisory Committee on Immunization Practices
List of Risk Factors and Conditions Where Interventions are Recommended

• Any risk factors and/or mental health conditions identified through the Initial Preventive Physical Exam (IPPE)
  • This is not possible if you did not perform the IPPE

• List of treatment options with associated risks and benefits
Personalized Health Advice and Referrals for Health Education and Preventive Counseling

- Medically appropriate health advice for patient’s conditions

- Include referrals to programs aimed at
  - Community based lifestyle interventions that promote wellness and self-management and reduce health risks
  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Weight loss
Preventive Service with Acute Service on the Same Day

Must be medically necessary and must be severe enough to require an additional work up beyond what is required for the preventative service.
Preventive Service with Acute Service on the Same Day

- Many suggest writing an entirely separate note

- However it is done the portion of the encounter that is directed to the complaint must be clearly delineated, for example an additional paragraph following the HPI that lists HPI elements related to the patient’s compliant

  During the annual well visit the patient also mentioned that she was having excessive urination, thirst and hunger that started about 3 months ago and has slowly increased in severity. It has progressed to the point that she is rising 3-4 times a night to urinate and drink water. Patient says she notices that an hour or 2 after eating the symptoms worsen and that nothing improves the symptoms.

Clearly identify the elements for the complaint service HPI, Exam and MDM so it is obvious that they are distinct from the annual wellness visit.
Preventive Service with Acute Service on the Same Day

The encounter for the complaint must have all elements documented and then calculated SEPERATELY from the AWV/other preventive service.

You may not use the elements of HX EXAM and MDM for both visits.

Append 25 modifier to the complaint service.

If pressed for time you may want to reschedule the well visit.
When ICD-10 began in October 2015 there was a grace period that allowed less specificity in coding for diagnoses. The grace period ended October 2016 and less specific (unspecified) codes will be scrutinized much more carefully by Medicare and other insurance carriers.
ICD-10 Tips: Patient Non Compliance

Non compliance with medical treatment should be documented

- **Z91.11** Patient's noncompliance with dietary regimen
- **Z91.120** Patient’s intentional under dosing of meds regimen due to financial hardship
- **Z91.128** Patient’s intentional under dosing of meds regimen for other reason
- **Z91.130** Patient’s unintentional under dosing of meds regimen due to age-related debility
- **Z91.138** Patient's unintentional under dosing of meds regimen for other reason
- **Z91.14** Patient's other noncompliance with medication regimen
- **Z91.15** Patient's noncompliance with renal dialysis
- **Z91.19** Patient's noncompliance w other medical treatment and regimen
ICD-10 Tips: Health Status

Certain health status situations should be documented when present

• Dialysis dependence Z99.2
• Low limb amputation status
  - Z89.4 Acquired absence of toe(s), foot, and ankle
  - Z89.5 Acquired absence of leg below knee
  - Z89.6 Acquired absence of leg above knee
• Asymptomatic HIV status Z21
• Ostomy (specific site)
  - Z93.0 Tracheostomy status
  - Z93.1 Gastrostomy status
  - Z93.2 Ileostomy status
  - Z93.3 Colostomy status
  - Z93.4 Other artificial openings of gastrointestinal tract status
  - Z93.51-Z93.59 Cystostomy status
  - Z93.6 Other artificial openings of urinary tract status
  - Z93.8 Other artificial opening status
ICD-10 Tips: Documenting Common Conditions

CVA documentation
- Unless the patient is currently being treated for a CVA, document the history of the CVA
- Residual effects of the CVA should be documented as such with a clear statement indicating the origin of the residual effect
- If hemiparesis is present due to a late effect of a CVA document as such and indicate if the dominant or non-dominant side is effected

Angina
- Document type of angina, e.g. stable
- Document related factors such as tobacco use or Hx of tobacco use

CKD
- Document stage of CKD
- Document dialysis if appropriate

CHF
- Document acuity e.g. acute, chronic, acute on chronic
- Document type e.g. systolic, diastolic
- Document any additional information such as heart failure due to hypertension
ICD-10 Tips: Documenting Common Conditions

**COPD**
- Document if the patient is on oxygen therapy
- Document acuity e.g. acute exacerbation
- Document related factors such as tobacco use or history of tobacco use

**Diabetes**
- Link complications to diabetes
  - Diabetic neuropathy rather than diabetes and neuropathy
  - Diabetic kidney disease rather than diabetes and kidney disease
- Document all manifestations as such

**Hypertension**
- Document if linked to other issues e.g. hypertensive heart disease

**MI**
- Document history of MI if appropriate

**Dementia**
- Document any underlying physiological conditions if appropriate
- Document if there are or are not behavioral disturbances
For comments or questions please contact the Compliance Team:

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Medicare covers an Annual Wellness Visit (AWV) providing Personalized Prevention Plan Services (PPPS) for beneficiaries who:
- Are not within the first 12 months of their first Medicare Part B coverage period; and
- Have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months.

This document is divided into two sections: the first explains the elements of a beneficiary’s initial AWV; the second explains the elements of all subsequent AWVs. You must provide all elements of the AWV prior to submitting a claim for the AWV.


Health Risk Assessment (HRA)

The AWV includes a Health Risk Assessment (HRA). While you can find a brief summary of the minimum elements in the HRA below, the Centers for Disease Control and Prevention’s (CDC) “A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries” includes sections about:
- The history of HRAs;
- Definition of the HRA framework and rationale for its use;
- HRA use and follow-up interventions that evidence suggests can influence health behaviors; and
- A suggested set of HRA questions.

For more information about HRAs, including a sample HRA, refer to http://www.cdc.gov/policy/hst/hra_FrameworkForHRA.pdf on the CDC website.

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<table>
<thead>
<tr>
<th>Acquire Beneficiary Information</th>
<th>Required Elements</th>
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</thead>
</table>
| Administer HRA                  | • Collects self-reported information from the beneficiary;  
|                                 |   • You or the beneficiary can complete the HRA before or during the AWV encounter;  
|                                 |   • Accounts for the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs and is appropriately tailored to their needs;  
|                                 |   • Takes no more than 20 minutes to complete; and  
|                                 |   • At a minimum, addresses the following topics:  
|                                 |     • Demographic data;  
|                                 |     • Self-assessment of health status;  
|                                 |     • Psychosocial risks;  
|                                 |     • Behavioral risks;  
|                                 |     • Activities of Daily Living (ADLs), including, but not limited to: dressing, bathing, and walking; and  
|                                 |     • Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances. |
| Establish a list of current providers and suppliers | Include current providers and suppliers regularly involved in providing medical care to the beneficiary. |
| Establish the beneficiary’s medical/family history | At a minimum, collect and document the following:  
|                                 |   • Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk;  
|                                 |   • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; and  
|                                 |   • Use of, or exposure to, medications and supplements, including calcium and vitamins. |
| Review the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders | Use any appropriate screening instrument for beneficiaries without a current diagnosis of depression, which you may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations. |
| Review the beneficiary’s functional ability and level of safety | Use direct observation of the beneficiary, or select appropriate screening questions or a screening questionnaire, from various available screening questions or standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics:  
|                                 |   • Ability to successfully perform ADLs;  
|                                 |   • Fall risk;  
|                                 |   • Hearing impairment; and  
|                                 |   • Home safety. |
### Begin Assessment

<table>
<thead>
<tr>
<th>Begin Assessment</th>
<th>Required Elements</th>
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<tbody>
<tr>
<td>☐ Assess</td>
<td>Obtain the following measurements:</td>
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<tr>
<td></td>
<td>▪ Height, weight, body mass index (or waist circumference, if appropriate), and blood pressure; and</td>
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<tr>
<td></td>
<td>▪ Other routine measurements as deemed appropriate based on medical and family history.</td>
</tr>
<tr>
<td>☐ Detect any cognitive impairment the beneficiary may have</td>
<td>Assess the beneficiary’s cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others.</td>
</tr>
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### Counsel Beneficiary

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<thead>
<tr>
<th>Counsel Beneficiary</th>
<th>Required Elements</th>
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</thead>
<tbody>
<tr>
<td>☐ Establish a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years, as appropriate</td>
<td>Base written screening schedule on:</td>
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<tr>
<td></td>
<td>▪ Age-appropriate preventive services Medicare covers;</td>
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<td>▪ Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP); and</td>
</tr>
<tr>
<td></td>
<td>▪ The beneficiary’s HRA, health status, and screening history.</td>
</tr>
<tr>
<td>☐ Establish a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary</td>
<td>Include the following:</td>
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<tr>
<td></td>
<td>▪ Any mental health conditions or any risk factors or conditions identified through an IPPE; and</td>
</tr>
<tr>
<td></td>
<td>▪ A list of treatment options and their associated risks and benefits.</td>
</tr>
<tr>
<td>☐ Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs</td>
<td>Includes referrals to programs aimed at:</td>
</tr>
<tr>
<td></td>
<td>▪ Community-based lifestyle interventions to reduce health risks and promote self-management and wellness;</td>
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<td></td>
<td>▪ Fall prevention;</td>
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<td></td>
<td>▪ Nutrition;</td>
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<td>▪ Physical activity;</td>
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<td>▪ Tobacco-use cessation; and</td>
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<td>▪ Weight loss.</td>
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## Acquire Update of Beneficiary History

<table>
<thead>
<tr>
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<th>Required Elements</th>
</tr>
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</table>
| Update HRA                              | - Collects self-reported information from the beneficiary;  
  - You or the beneficiary can complete the update of HRA before or during the AWV encounter;  
  - Takes no more than 20 minutes to complete; and  
  - At a minimum, addresses the following topics:  
    - Demographic data;  
    - Self-assessment of health status;  
    - Psychosocial risks;  
    - Behavioral risks;  
    - ADLs, including, but not limited to: dressing, bathing, and walking; and  
    - Instrumental ADLs, including, but not limited to: shopping, housekeeping, managing own medications, and handling finances. |
| Update the list of current providers and suppliers | Include current providers and suppliers regularly involved in providing medical care to the beneficiary. |
| Update the beneficiary’s medical/family history | At a minimum, update and document the following:  
  - Medical events in the beneficiary’s parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk;  
  - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; and  
  - Use of, or exposure to, medications and supplements, including calcium and vitamins. |

## Begin Assessment

<table>
<thead>
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<th>Required Elements</th>
</tr>
</thead>
</table>
| Assess           | Obtain the following measurements:  
  - Weight (or waist circumference, if appropriate) and blood pressure; and  
  - Other routine measurements as deemed appropriate based on medical and family history. |
| Detect any cognitive impairment that the beneficiary may have | Assess the beneficiary’s cognitive function by direct observation, with due consideration of information obtained via beneficiary reports and concerns raised by family members, friends, caretakers, or others. |
Counsel Beneficiary

<table>
<thead>
<tr>
<th>Counsel Beneficiary</th>
<th>Required Elements</th>
</tr>
</thead>
</table>
| ☐ Update the written screening schedule for the beneficiary | Base written screening schedule on:  
- Age-appropriate preventive services Medicare covers;  
- Recommendations from the USPSTF and the ACIP; and  
- The beneficiary’s health status and screening history. |
| ☐ Update the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary | Include any such risk factors or conditions identified. |
| ☐ Furnish personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs | Includes referrals to programs aimed at:  
- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness;  
- Fall prevention;  
- Nutrition;  
- Physical activity;  
- Tobacco-use cessation; and  
- Weight loss. |

Other Medicare Part B Preventive Services

- Alcohol Misuse Screening and Counseling
- Bone Mass Measurements
- Cardiovascular Disease Screening Tests
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use (for Asymptomatic Beneficiaries)
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training (DSMT)
- Glaucoma Screening
- Hepatitis C Virus (HCV) Screening
- Human Immunodeficiency Virus (HIV) Screening
- Influenza, Pneumococcal, and Hepatitis B Vaccinations and their Administration
- IPPE
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD), also known as a CVD risk reduction visit
- IBT for Obesity
- Medical Nutrition Therapy (MNT)
- Prostate Cancer Screening
- Screening for Sexually Transmitted Infections (STIs) Screening And High Intensity Behavioral Counseling (HiBC) to Prevent STIs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Examination (includes a clinical breast examination)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

For additional information on Medicare preventive services, visit [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html) on the CMS website, or scan the Quick Response (QR) code on the right.
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography


Coding, Diagnosis, and Billing

Coding
Use the following Healthcare Common Procedure Coding System (HCPCS) codes when filing claims for AWVs.

AWV HCPCS Codes and Descriptors

<table>
<thead>
<tr>
<th>AWV HCPCS Codes</th>
<th>Billing Code Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0438</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit</td>
</tr>
</tbody>
</table>

Diagnosis
Since CMS does not require a specific diagnosis code for the AWV, you may choose any appropriate diagnosis code. You must report a diagnosis code.

Billing
Medicare Part B covers AWV if performed by a:

- Physician (a doctor of medicine or osteopathy);
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary’s illness or injury or to improve the functioning of a malformed body member.

Who Can Get the AWV?
Medicare covers an AWV for all beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not gotten either an IPPE or an AWV within the past 12 months (that is, at least 11 months have passed following the month in which the IPPE or the last AWV was performed). Medicare pays for only one first AWV per beneficiary per lifetime and pays for one subsequent AWV per year thereafter.

Frequently Asked Questions (FAQs)

Is the AWV the same as a beneficiary’s yearly physical?
No. The AWV is not a “routine physical checkup” that some seniors may get every year or so from their physician or other qualified non-physician practitioner. Medicare does not cover routine physical examinations.

Are clinical laboratory tests part of the AWV?
No. The AWV does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWV, if appropriate.

Do deductible or coinsurance/copayment apply for the AWV?
No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWV.

Can I bill an electrocardiogram (EKG) and the AWV on the same date of service?
Generally, you may provide other medically necessary services on the same date of service as an AWV. The deductible and coinsurance/copayment apply for these other medically necessary services.
How do I know if a beneficiary already got his/her first AWV from another provider and know whether to bill for a subsequent AWV even though this is the first AWV I provided to this beneficiary?

You have different options for accessing AWV eligibility information depending on the jurisdiction where you practice. You may be able to access the information through the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) or through the provider call center Interactive Voice Responses (IVRs). CMS suggests providers check with their Medicare Administrative Contractor (MAC) to see what options are available to check beneficiary eligibility. For MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.

Preparation Eligible Medicare Beneficiaries for the AWV

Providers can help eligible Medicare beneficiaries get ready for their AWV by encouraging them to come prepared with the following information:

- Medical records, including immunization records;
- Family health history, in as much detail as possible;
- A full list of medications and supplements, including calcium and vitamins – how often and how much of each is taken; and
- A full list of current providers and suppliers involved in providing care.

Resources

AWV Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
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</table>
### AWV Resources (cont.)

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
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</thead>
</table>

This educational tool was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Check out CMS on:
**TABLE OF RISK**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Problem(s)</th>
<th>Dx Proced.</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Min</td>
<td>1 self-limited, minor problem</td>
<td>Labs; X-rays; UA, US; KOH prep</td>
<td>Rest; Gargle; Elastic bandages; superficial</td>
</tr>
<tr>
<td>Low</td>
<td>2 + minor problems; 1 stable chronic illness (well controlled HTN); Acute uncomplicated illness</td>
<td>Physiologic tests not under stress; Non-cardio imaging studies; superficial needle biopsies; labs requiring arterial puncture; skin biopsies</td>
<td>OTC drugs; minor surgery with no identified risks; PT; OT; IV fluids without additives</td>
</tr>
<tr>
<td>Mod.</td>
<td>1 or &gt; chronic illness with mild exacerbation; Undiagnosed new problem; Acute illness with systemic symptoms; Acute complicated injury</td>
<td>Physiologic tests under stress; Diagnostic endoscopies—no risk factors; Deep needle or incisional biopsy; Cardiovascular imaging studies with contrast—no risks; LP; thoracentesis, etc.</td>
<td>Minor surgery; Elective major surgery with no identified risk factors; prescription drug management; therapeutic nuclear medicine; IV fluids with additives; closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>1 or &gt; chronic illness with severe exacerbation; acute or chronic illness or injury that poses a threat to life or body; abrupt change in neurologic status</td>
<td>Cardiovascular imaging with contract with identified risks; cardiac electrophysiological tests; diagnostic endoscopies with identified risk factors; angiography</td>
<td>Elective major surgery with identified risks; emergency major surgery; parenteral controlled substances; drug therapy requiring intensive monitoring for toxicity; DNR or decision to de-escalate care due to poor prognosis</td>
</tr>
</tbody>
</table>

**1995 E&M Coding Guidelines**

**COMPONENTS: History, Exam & MDM**

1. **HISTORY (CC/HPI/ROS/PFSH)**
   - **Chief Complaint (CC):** Always Required
   - **History of Present Illness (HPI):** Location, Duration, Severity, Quality, Context, Modifying Factors, Associated Signs & Symptoms, Timing.
   - **Review of Systems (ROS):** Constitutional, Eyes, ENT & Mouth, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin, Neurological, Psychiatric, Endocrine, Hemo/Lymphatic, Immunological/Allergy.
   - **Past Medical, Family and/or Social History (PFSH):** Age Appropriate

2. **EXAM**
   - **Body Areas:** Head (incl. the face); Neck; Chest (incl. breasts & axillae); Abdomen; Genitalia, groin, buttocks; Back (incl. spine); Each extremity
   - **Organ Systems:** Constitutional, Eyes, ENT, Respiratory, Cardiovascular, GI, GU, Musculoskeletal, Skin, Neurologic, Psychiatric, and Hematologic/Lymphatic/Immunologic

3. **MEDICAL DECISION MAKING (MDM)**

<table>
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<tr>
<th>Type</th>
<th>#Dx/ Tx</th>
<th>Data</th>
<th>Risk*</th>
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</thead>
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<tr>
<td>Straightforward (SF)</td>
<td>≤ 1 pts</td>
<td>≤ 1 pts</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low (LC)</td>
<td>2 pts</td>
<td>2 pts</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate (MC)</td>
<td>3 pts</td>
<td>3 pts</td>
<td>Moderate</td>
</tr>
<tr>
<td>High (HC)</td>
<td>4 pts</td>
<td>4 pts</td>
<td>High</td>
</tr>
</tbody>
</table>

2 OF 3 elements must be met or exceeded for MDM

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**New Office; Office consult; and Inpatient consult (non-Medicare) – Requires all 3 components**

<table>
<thead>
<tr>
<th>New Off. (Time)</th>
<th>Off. Con (Time)</th>
<th>Inpt. Con (Time)</th>
<th>Codes (Time)</th>
</tr>
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<tbody>
<tr>
<td>99201(10)</td>
<td>99214(15)</td>
<td>N/A</td>
<td>99221(30)</td>
</tr>
<tr>
<td>99202(20)</td>
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<td>99222(50)</td>
<td>99223(70)</td>
</tr>
<tr>
<td>99203(30)</td>
<td>99243(40)</td>
<td>N/A</td>
<td>99221(30)</td>
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<td>99204(45)</td>
<td>99244(60)</td>
<td>99221(50)</td>
<td>99222(50)</td>
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<td>99205(60)</td>
<td>99245(80)</td>
<td>99223(35)</td>
<td>99224(70)</td>
</tr>
<tr>
<td>99255(110)</td>
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<td></td>
<td>99226(35)</td>
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</table>

**HX:**
- HPI: 1-3, 1-3, 4 or > 4 or >
- ROS: —, 1, 2-9, 10, 10
- PFSH: —, 1, 3, 3
- EXAM: 1, 2-7, 2-7+, 8
- MDM: SF, SF, LC, MC, HC

**Established Office; Subsequent Nursing**

<table>
<thead>
<tr>
<th>Est Office Sub Nursing</th>
<th>Codes (Time)</th>
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<tbody>
<tr>
<td>99211(5) N/A</td>
<td>99212(10)</td>
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<td>99213(15)</td>
<td>99214(25)</td>
</tr>
<tr>
<td>99215(40)</td>
<td>99216(50)</td>
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<tr>
<td>99217(60)</td>
<td>99218(70)</td>
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</tbody>
</table>

**HX:**
- Staff HPI: 1-3, 1-3, 4 or > 4 or >
- Staff ROS: —, 1, 2-9, 10
- Staff PFSH: —, 1, 3, 3
- Staff EXAM: 1, 2-7, 2-7+, 8
- Staff MDM: SF, SF, LC, MC, HC

**Discharge (Other than Admit Date)**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>99238 – 30 min. or less</td>
<td>99217—No Time</td>
</tr>
<tr>
<td>99239 – &gt; 30 minutes</td>
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</tbody>
</table>

**Prolonged Services**

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99354</td>
<td>30-74 minutes beyond E/M</td>
</tr>
<tr>
<td>99355</td>
<td>Each additional 30 min.</td>
</tr>
</tbody>
</table>

**Admit, Medicare Inpt Consult; Observation or Nursing Facility – Requires all 3 components**

<table>
<thead>
<tr>
<th>Admit/Med. Consult (Time)</th>
<th>Initial Obs (Time)</th>
<th>Int. Nursing (Time)</th>
<th>Codes (Time)</th>
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<tbody>
<tr>
<td>99211(30)</td>
<td>99218(30)</td>
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<td>99212(40)</td>
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<td>99224(70)</td>
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<td>99225(35)</td>
<td>99226(70)</td>
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<td>99214(60)</td>
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<td>99226(45)</td>
<td>99227(70)</td>
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</tbody>
</table>

**HX:**
- HPI: 4 or > 4 or > 4 or >
- ROS: 2-9, 10, 10
- PFSH: 1, 3, 3
- EXAM: 2-7+, 8
- MDM: SF/LC, MC, HC

**Subsequent Hospital & Observation Visits**

<table>
<thead>
<tr>
<th>Sub. Hosp (Time)</th>
<th>Sub. Ob (Time)</th>
<th>Codes (Time)</th>
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<tbody>
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<td>99211(15)</td>
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<td>99213(25)</td>
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<td>99224(70)</td>
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<tr>
<td>99215(35)</td>
<td>99216(35)</td>
<td>99225(70)</td>
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</tbody>
</table>

**HX:**
- Staff HPI: 1-3, 1-3, 4 or >
- Staff ROS: —, 1, 2-9
- Staff PFSH: —, —
- Staff EXAM: 1, 2-7, 2-7+
- Staff MDM: SF/LC, MC, HC

**Admit/Observation & Discharge (Same Day) - Requires all 3 Components**

<table>
<thead>
<tr>
<th>Codes (Time)</th>
<th>Codes (Time)</th>
<th>Codes (Time)</th>
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<tbody>
<tr>
<td>99234(40)</td>
<td>99235(50)</td>
<td>99236(55)</td>
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</tbody>
</table>

**HX:**
- HPI: 4 or > 4 or > 4 or >
- ROS: 2-9, 10, 10
- PFSH: 1, 3, 3
- EXAM: 2-7+, 8
- MDM: SF/LC, MC, HC

**Prolonged Services**

- Outpatient—only count time face-to-face with the patient; Inpatient—count floor/unit and face-to-face time.

**TIME:** Numbers in parens ( ) represents time if services are billed based on time rather than History, Exam and MDM. If >50% of time with patient is counseling/co-ordination of care, document total time and time spent counseling and/or co-ordination of care.
# THSteps MEDICAL CHECKUP PERIODICITY SCHEDULE FOR BIRTH THROUGH 10 YEARS OF AGE

<table>
<thead>
<tr>
<th>AGE</th>
<th>DEVELOPMENTAL SURVEILLANCE</th>
<th>MEASUREMENTS</th>
<th>VISION</th>
<th>HEARING</th>
<th>LABORATORY TESTS</th>
<th>LABORATORY TESTS</th>
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<tbody>
<tr>
<td></td>
<td>Nutritional Screening</td>
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<tr>
<td></td>
<td>Review of Milestones</td>
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<td>ASQ, ASQ:SE, or PEDS</td>
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<td>Mental Health Psychosocial/Behavioral Health Screening</td>
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<td></td>
<td>TB Questionnaire with Skin Test if Risk Identified</td>
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<tr>
<td></td>
<td>Unclothed Physical Examination</td>
<td>Critical Congenital Heart Defect Screening</td>
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<td>Weight</td>
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<td>Fronto-Occipital Circumference</td>
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<td>Subjective Vision</td>
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<td>Newborn Hearing Test (OAE or ABR)</td>
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<td>Subjective Hearing</td>
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<td>Screen/Adm Immunizations According to ACIP Guidelines</td>
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<td>Newborn Screening Panel</td>
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<td>Blood Lead Screening</td>
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<td>Anemia</td>
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<td>Type 2 Diabetes</td>
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<td>Health/Education/Anticipatory Guidance</td>
</tr>
</tbody>
</table>

### Newborn
- D/C to 5 days
  - 2 weeks

### Months
- 2
- 4
- 6
- 9
- 12
- 15
- 18
- 24
- 30

### Years
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
<table>
<thead>
<tr>
<th>AGE</th>
<th>History</th>
<th>Nutritional Screening</th>
<th>Mental Health: Psychosocial/Behavioral Health Screening</th>
<th>PSC-35, Y-PSC, PHQ-9, or CRAFFT</th>
<th>TB Questionnaire with Skin Test if Risk Identified</th>
<th>Uncovered Physical Examination</th>
<th>MEASUREMENTS</th>
<th>VISION</th>
<th>HEARING</th>
<th>LABORATORY TESTS</th>
<th>Health Education/Anticipatory Guidance</th>
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<td>Height</td>
<td>Weight</td>
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<td>Blood Pressure</td>
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<td>20</td>
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</tbody>
</table>

**LEGEND OF SYMBOLS**

- **Mandatory at this age.**
- **If a component is not completed at the required age, it is mandatory for the provider to complete at the first opportunity if age-appropriate.**
- **When symbols appear at the same age for developmental, mental health, vision, or hearing screening, perform the most appropriate-level screen.**
- **Risk-based.**
### Immunizations Administered

Use code Z23 to indicate when immunizations are administered.

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>90700’ with (90460/90461 or 90471/90472)</td>
<td>DTaP</td>
</tr>
<tr>
<td>90702’ with (90460/90461 or 90471/90472)</td>
<td>DT</td>
</tr>
<tr>
<td>90707’ with (90460/90461 or 90471/90472)</td>
<td>MMR</td>
</tr>
<tr>
<td>90710’ with (90460/90461 or 90471/90472)</td>
<td>MMRV</td>
</tr>
<tr>
<td>90713’ with (90460/90461 or 90471/90472)</td>
<td>IPV</td>
</tr>
<tr>
<td>90714’ with (90460/90461 or 90471/90472)</td>
<td>Td</td>
</tr>
<tr>
<td>90715’ with (90460/90461 or 90471/90472)</td>
<td>Tdap</td>
</tr>
<tr>
<td>90716’ with (90460/90461 or 90471/90472)</td>
<td>Varicella</td>
</tr>
<tr>
<td>90723’ with (90460/90461 or 90471/90472)</td>
<td>DTaP-Hep B-IPV</td>
</tr>
<tr>
<td>90732’ with (90460/90461 or 90471/90472)</td>
<td>PPSV23</td>
</tr>
<tr>
<td>90733 or 90734’ with (90460/90461 or 90471/90472)</td>
<td>MPSV4</td>
</tr>
<tr>
<td>90743, 90744’, or 90746 with (90460/90461 or 90471/90472)</td>
<td>Hep B</td>
</tr>
<tr>
<td>90748’ with (90460/90461 or 90471/90472)</td>
<td>Hib-Hep B</td>
</tr>
</tbody>
</table>

### Modifiers

#### Performing Provider
Use to indicate the practitioner who is performing the unclothed physical examination component of the medical checkup.

- AM (Physician)
- SA (Nurse Practitioner)
- TD (Nurse)
- U7 (Physician Assistant)

#### Exception to Periodicity
Use with THSteps medical checkups procedure codes to indicate the reason for an exception to periodicity.

- 23 (Unusual Anesthesia)
- 32 (Mandated Services)
- SC (Medically Necessary)

### FQHC and RHC
Federally qualified health center (FQHC) providers must use modifier EP for THSteps medical checkups. Rural health clinic (RHC) providers must bill place of service 72 for THSteps medical checkups.

### Vaccine/Toxoids
Use to indicate a vaccine/toxoid not available through TVFC and the number of state defined components administered per vaccine.

- **U1** Vaccine/toxoid privately purchased by provider when TVFC vaccine/toxoid is not available

### Vaccine Administration and Preventive E/M Visits
Use with THSteps preventive visit checkup procedure codes to indicate a significant, separately identifiable E/M service that was rendered by the same provider on the same day as the immunization administration.

- 25 Significant, separately identifiable evaluation

### Condition Indicator Codes
Use one of the Condition Indicators below if a referral was made.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>NU</td>
<td>Not used (no referral)</td>
</tr>
<tr>
<td>Y</td>
<td>ST</td>
<td>New services requested</td>
</tr>
<tr>
<td>Y</td>
<td>S2</td>
<td>Under treatment</td>
</tr>
</tbody>
</table>
Vendor Drug Program (fee-for-service)
The Medicaid Vendor Drug Program makes payments to contracted pharmacies for prescriptions of covered outpatient drugs for Texas Medicaid, CSHCN Services Program, Kidney Health Care Program, and CHIP. Some Medicaid-covered drugs may require prior authorization (PA) through PA Texas.

Texas Prior Authorization Call Center: 1-800-728-3927
or online: https://paxpress.txpa.hidinc.com
(for prior authorizations of non-preferred drugs only)

General information, covered drug list, online pharmacy, and prescriber searches:
www.txvendordrug.com
www.hhsc.state.tx.us/medicaid/Chip-Pharmacy-Benefits.shtml

For managed care clients: Contact the client’s MCO.

Case Management for Children and Pregnant Women
(512) 776-2168 | www.dshs.state.tx.us/caseman

* Texas Health Steps Medical Checkup Claims Inquiries
* Call 1-800-577-5691 to obtain answers to questions or determine the status of claims. For managed care clients, contact the client’s MCO.

* Texas Health Steps Website
* General information for THSteps providers including forms, details on the required components of checkups, and other helpful resources.
  * www.dshs.state.tx.us/thsteps/default.shtm

* THSteps Child Health Record Forms and THSteps Provider Outreach Referral Form may be downloaded from the THSteps website at:
  * www.dshs.state.tx.us/thsteps/forms.shtm

* Online catalog of THSteps publications:
  * www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm

* THSteps Outreach & Informing Service
* Information for THSteps clients to expand awareness of existing medical, dental, and case management services. Provider information to include missed appointment referral services.
  * 1-877-THSteps (8847-8377), Monday to Friday, 8am-6pm

* THSteps Online Provider Education Website
* Free comprehensive online continuing education modules designed for health-care providers. All modules provide continuing education units (CEUs) for multiple disciplines and include information about Texas Health Steps, Medicaid for children and other health-care services.
  * www.txhealthsteps.com

* THSteps Website
* www.dshs.state.tx.us/thsteps/default.shtm

* THSteps Child Health Record Forms and THSteps Provider Outreach Referral Form may be downloaded from the THSteps website at:
  * www.dshs.state.tx.us/thsteps/forms.shtm

* Online catalog of THSteps publications:
  * www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm

* Laborator y
* The Department of State Health Services (DSHS) Laboratory performs testing for THSteps and NBS clients for the State of Texas. The following provides contact information for ordering laboratory supplies, inquiries on collection, submission and shipping of specimens, and obtaining test results.

* For THSteps
* Requests for THSteps laboratory supplies should be made on Form G399 and can be submitted to the DSHS Laboratory Container Preparation Group by:
  * Email: Container Prep Group@dshs.state.tx.us
  * Fax: (512) 776-7672
  * Phone: (512) 776-7661 or 1-888-963-7111, Ext 7661

  * Specimen shipping questions, call (512) 776-7569 or 1-888-963-7111, Ext 7569
  * Specimen collection and submission questions, call (512) 776-6236 or 1-888-963-7111, Ext 6236
  * Test result inquiries, call (512) 776-7578 or Fax (512) 776-7533
  * Online Results: Access THSteps test results online using the Results - Web Portal web application for Clinical Chemistry. To gain access, download, complete, and submit the required access forms. They are available at:
    * www.dshs.state.tx.us/lab/remotedata.shtm

  * For gonorrhea and chlamydia adolescent screening supplies, specimen collection and submission questions, call the DSHS Laboratory Customer Service, (512) 776-6030 or 1-888-963-7111, Ext 6030 or go to the DSHS website:
    * www.dshs.state.tx.us/lab/micCBintro.shtm

  * For HIV screening supplies, specimen collection and submission questions, call the DSHS Laboratory Customer Service, (512) 776-6030 or 1-888-963-7111, Ext 6030 or go to the DSHS website:
    * www.dshs.state.tx.us/lab/sero_about.shtm

* For NBS
* A written request for Newborn Screening (NBS) specimen collection form (NBS3) is required. To obtain an order form for written requests, call the Container Preparation Group at (512) 776-7661 or 1-888-963-7111, Ext 766.

  * Specimen submission and testing questions, call (512) 776-7333 or 1-888-963-7111, Ext 7333
  * Test result inquiries, call (512) 776-7578 or Fax (512) 776-7533
  * Online Results: Access Newborn Screening (NBS) test results online using the Texas NBS Web Application. To gain access, download, complete, and submit the required access forms. They are available at:
    * www.dshs.state.tx.us/lab/remotedata.shtm

To Report Potential Medicaid Fraud

HHSC Client or Provider Fraud Investigations:
1-800-436-6184
https://oig.hhsc.state.tx.us/Fraud_Report_Home.aspx

Comprehensive Care Program (CCP)
* Telephone: 1-800-846-7470 | Fax: (512) 514-4212

Medical Transportation Program (MTP)
1-877-633-8747 | www.hhsc.state.tx.us/medicaid/mtp/

Texas Medicaid & Healthcare Partnership (TMHP)
* General Inquiries Line: 1-800-925-9126 | www.tmhp.com

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