Adult and Pediatrics Wellness Visits Coding Guide

Updated 3.4.2021

Vanderbilt Health
Affiliated Network

Adult Wellness

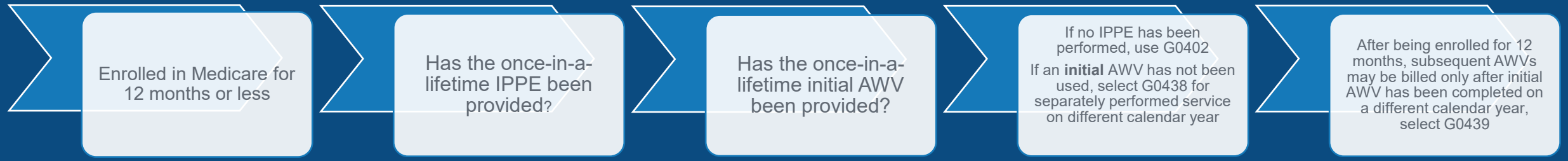
Completed	Task	Notes
✓	**Determine Medicare eligibility and timeframe for patient preventive services**	Traditional Medicare covers Annual Wellness Visit (AWV), whereas Medicare Advantage may cover annual physical exams in addition to AWV. Wellness visits and preventive services are allowed every 12 months. To determine the date the patient had their last preventive service: • Utilize the CMS HIPAA Eligibility Transaction System (HETS) Medicare Administrative Contractor (MAC) • Health plan reporting previously completed wellness visit dates • Medicare AWV codes include: G0402, G0438, G0439, G0513
✓	**Satisfy general coding and documentation requirements**	• Member's name on each page • Date all entries • M.E.A.T (Medical Risk Adjustment) • Submit claim with ICD-10/CPT codes • Signature • Credentials • Document reason for lack of screening if not performed
✓	**Satisfy specific minimum coding requirements for a particular wellness visit code**	• IPPE (G0402) • AWV, Initial (G0438) or • AWV, Subsequent (G0439) • AWV, Prolonged Service, 30 min (G0513) • ICD-10-CM codes- health status and SDH; Z codes required only during actual screening • CPTII codes- screening results reviewed/documented
✓	**Code for E/M services if performed (e.g., 99213-14 *25) and inform patient of responsibility for additional deductible/copay according to their plan**	If illness or abnormality is discovered, or preexisting problem is addressed during preventive care, use E/M code with modifier 25 in addition to preventive code. View eligibility and documentation requirements of services before performing to ensure: • Coverage criteria applies • Frequency limits are maintained • Total time spent, or start/stop times are documented for timed services • Document elements of medical-decision making (MDM)

Adult Wellness

Completed	Task	Notes
✓	**Consider performing other preventive services, physicals, and E/Management Services**	View eligibility and documentation requirements of services/screenings before performing to ensure: • Coverage criteria applies (physicals for MA, not original Medicare) • Frequency limits are maintained • Total time spent, or start/stop times are documented for timed services • Document billed services in the medical record
✓	**Consider performing relevant quality measures to close care gaps and document exclusion reasons**	• Document screenings ordered, labs requested, lab results in the medical chart • Document possible reasons for patient not able to address screenings, such as excluded medical reasons (i.e., frailty diagnosis end stage renal disease, dialysis, etc.)
✓	**Consider referral for disease management, case management or behavioral health**	• VHAN Care Management and BH programs to assist with coordination of care • Document these services in medical chart after referral is made
✓	**Submit completed claim within 60 days of the original date of service**	• Ensure use of **CPTII codes** on claims for relevant screening results documented (i.e., med list documented, functional status) • Ensure use of **ICD-10-CM codes; chronic conditions and encounter screening codes (Z codes)** on claims to support medical decision making or time spent with patient for wellness service(s) • Screening codes (Z codes) are not necessary if the screening is inherent to a routine examination

Adult Wellness-Medicare Codes

Code	Description Name	Notes
G0402	**IPPE**	• Limited to a new Medicare member during the first 12 months of Medicare enrollment • Used once in a lifetime
G0438	**Initial AWV**	• Limited to a Medicare member after the first 12 months of Medicare enrollment, including new or established patients • Used once in a lifetime
G0439	**Subsequent AWV**	• Used the following calendar year after any wellness visit (IPPE, initial AWV or subsequent AWV)
G0513	**Prolonged AWV Service**	• Prolonged preventive services(s) beyond the typical service time of the primary procedure in office/outpatient setting; first 30 minutes • List separately in addition to code for preventive service
General Coding Requirements		• Patient's name should appear on every page of the medical record • All encounters must be dated • Use M.E.A.T documentation for HCC coding • Code all documented conditions that require or affect treatment or management of care • Document whenever a screening is not indicated, or patient refuses • Include physician's signature and credentials on each encounter



Pediatric Wellness

Completed	Task	Notes
✓	**Determine timeframe for patient preventive services**	Verification in medical chart and health plan reporting previously completed wellness visit dates (NCQA HEDIS recommendations): • 6 or more well-child examinations by 15 months • One or more comprehensive well-child visits with PCP per year • One annual comprehensive well-care encounter per year for adolescents and young adults 12-21
✓	**Satisfy general coding and documentation requirements**	The components of a Well-child Visit, as indicated by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) criteria, are: • Health and developmental history • Physical exam • Laboratory tests (as appropriate for the age of the child) • Immunizations (use all visits, preventive and sick, if medically appropriate) • Health education and age-appropriate anticipatory guidance (including schedule of care and dental home referral
✓	**Satisfy specific minimum coding requirements for a particular well-child visit code**	Child and Adolescent Well-Care Visits: First 15 months, 3rd, 4th, 6th years of life: • New patients: 99381, 99382/ Established patients: 99391, 99392 • ICD-10-CM; ICD-10-CM codes- health status and SDH; Z codes required only during actual screening Adolescent Well-Care Visits: • New patients: 99384, 99385/ Established patients 99394, 99395 • ICD-10-CM; ICD-10-CM codes- health status and SDH; Z codes required only during actual screening
✓	**Code for E/M services if performed (e.g., 99213 *25) and inform patient of responsibility for additional deductible/copay according to their plan**	If illness or abnormality is discovered, or preexisting problem is addressed during preventive care, use E/M code with modifier 25 in addition to preventive code. View eligibility and documentation requirements of services before performing to ensure: • Coverage criteria applies • Frequency limits are maintained • Total time spent, or start/stop times are documented for timed services or • Document elements of medical-decision making (MDM)

Pediatric Wellness

Completed	Task	Notes
✓	**Consider performing other preventive services, physicals, and e/management services**	View eligibility and documentation requirements of services/screenings before performing to ensure: • Coverage criteria applies (physicals for MA, not original Medicare) • Frequency limits are maintained • Total time spent, or start/stop times are documented for timed services • Document billed services in the medical record
✓	**Consider performing relevant quality measures to close care gaps and document exclusion reasons**	• Document screenings ordered, labs requested, lab results in the medical chart • Document possible reasons for patient not able to address screenings, such as excluded medical reasons (i.e., frailty diagnosis end stage renal disease, dialysis, etc.)
✓	**Consider referral for disease management, case management or behavioral health**	• VHAN Care Management and BH programs to assist with coordination of care • Counseling codes 99401-99404 may not be reported in addition to preventive medicine codes • Document these services in medical chart after referral is made
✓	**Submit completed claim within 60 days of the original date of service**	• Ensure use of **CPTII codes** on claims for relevant screening results documented • Ensure use of **ICD-10-CM codes; chronic conditions and encounter screening codes (Z codes)** on claims to support medical decision making or time spent with patient for wellness service(s) • Screening codes (Z codes) are not necessary if the screening is inherent to a routine examination