Tennessee Department of Health
Billing and Codes Manual

11/1/2015
Revised: 10/01/2016

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SECTION 1: INTRODUCTION

Date: 11/1/2015; Rev 10/01/2016

The Billing and Codes Manual is designed to be a universal tool for all TDH providers. Guidance in this Manual is intended to ensure that providers are coding services consistently and appropriately within all health departments in Tennessee.

This Manual covers the most frequent services provided in health departments. It is impossible to describe every special circumstance or possible service related to patient care. For coding situations and guidance not listed in this Manual, providers should consult the most current editions of the AMA Current Procedural Terminology (CPT®), International Classification of Diseases (ICD-10-CM), and the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS) for the clinical situation that best describes the special circumstance. Providers should rely on professional judgment and experience to decide how best to code a service according to the appropriate reference manuals listed above.

When using CPT Evaluation and Management (E/M) codes there are specific CPT (E/M) Services Guidelines that should be followed. Levels of E/M service descriptors and examples in the selected category or subcategories should be reviewed. For example, when selecting a new patient office visit, level 99201 - 99205, the key components of history, exam and medical decision making should be properly determined in the selection of the office visit level **and documented accordingly in the medical record.**

Public Health Nurses are recognized by Medicaid as "Other Healthcare Providers" and may report:

- o Preventive visit codes for New patients 99381-99387
- o Preventive visit codes for Established patients 99391-99397
- o Other office visit codes for New patients 99201-99203
- o Other office visit codes for Established patients 99211-99213
- o Preventive counseling codes 99401-99404

This Manual is the result of continuous input from TDH providers and program staff. Updates and changes to the Manual will be generated as necessary and appropriate.

SECTION 1: NEW vs. ESTABLISHED PATIENT

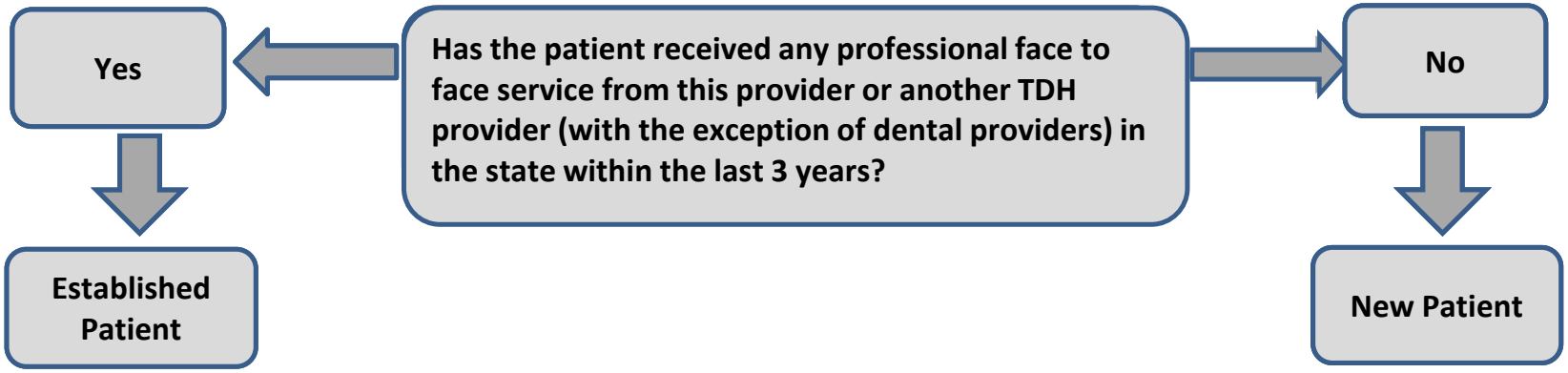
Date: 11/1/2015; Rev 10/01/2016

A **"New"** patient is one who has not received any professional face to face services from the provider or another provider of the same specialty who belongs to the same group practice, within the past three years.

An **"Established"** patient is one who has received professional face to face services from the provider or another provider of the same specialty who belongs to the same group practice, within the past three years. Although groups with multiple practice sites may operate independently, with each caring for its own patient population and maintaining its own medical records, they are considered a single group if they have the same tax identification number.

All TDH health departments file claims under the same state tax ID number and are considered part of the same group.

Decision Tree for New vs. Established Patients



Example 1: Patient was seen face to face on 1/15/2011 for immunizations only and returns 2/15/2014 for STD program services - **"New"** patient office visit is indicated since last visit was **over 3 calendar years** from the initial visit date.

Example 2: Patient was seen face to face on 3/1/2011 for EPSDT and returns 2/1/2014 for Family Planning services - **"Established"** patient office visit is indicated since last visit was **less than 3 years** from the 3/1/2011 visit date.

Comments:

A patient who has received professional services such as school vaccines, WIC services, and oral screenings/varnish application by healthcare clinical staff within the past 3 years would be considered an **Established Patient.**

A patient who has received services such as vital records or services provided by dental health providers, and have never received clinical medical services or it has been greater than 3 years since those medical services were provided, would be considered a **New Patient.**

SECTION 1: OTHER OFFICE VISITS

NEW PATIENTS

Date: 10/01/2016

Code	Description and Documentation Requirements; Codes can be used by PHNs, APNs, and MDs	Average Face-Face Time
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history, a problem focused examination, straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor.	10 minutes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history, an expanded problem focused examination, straightforward medical decision making. Usually the presenting problem(s) are of low to moderate severity.	20 minutes
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history, a detailed examination, medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity	30 minutes
Code	**Description and Documentation Requirements; Due to complexity of medical decision making, the following codes can only be used by APNs and MDs.**	**Average Face-Face Time**
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history, a comprehensive examination, medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity	45 minutes
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history, a comprehensive examination, medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity	60 minutes

SECTION 1: OTHER OFFICE VISITS

ESTABLISHED PATIENTS

Date: 10/01/2016

Code	Description and Documentation Requirements; Codes can be used by PHNs, APNs, and MDs	Average Face-Face Time
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	5 minutes
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history, a problem focused examination, straightforward medical decision making. Usually, the presenting problem(s) are self limited or minor.	10 minutes
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history, an expanded problem focused examination, medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity.	15 minutes
Code	**Description and Documentation Requirements; Due to complexity of medical decision making, the following codes can only be used by APNs and MDs.**	**Average Face-Face Time**
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history, a detailed examination, medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity.	25 minutes
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history, a comprehensive examination, medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity.	40 minutes

SECTION 1: PREVENTIVE VISIT GUIDELINES

Date: 11/1/2015; Rev 10/01/2016

Comprehensive Preventive Medical Exams (codes 99381 - 99397) - Evaluation and management of an individual which includes an age and gender appropriate history/exam; comprehensive multi-system evaluation; identification of risk factors; counseling/anticipatory guidance/risk factor reduction interventions and ordering of laboratory/diagnostic procedures.

When performing a preventive exam and a 'significant problem' is found:

- Code the preventive exam (99381 - 99397) AND
- Code an other office visit (99201 - 99215) for the problem
- Add modifier 25 to the office visit

An insignificant problem/abnormality encountered while performing a preventive medicine evaluation and management service which does not require additional work and performance of key components of a problem-oriented other office visit should not be reported.

Refer to codes 99401 - 99412 for reporting counseling/anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.

Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (i.e., vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90460, 90461, 90471-90474. For vaccine/toxoid products, see 90476-90479.

Example 1: 7 year old new patient brought in by mother for a Preventive Medicine Service. The provider found the patient had 1st degree sunburn on face and shoulders. Provider counseled the mother on sun exposure and recommended cool compresses and Aloe Vera gel. **The provider would report a 99383 for preventive medicine because it includes counseling and risk factor reductions.**

Example 2: 22 year old established patient presented for a Preventive Medicine Service. During the visit, the patient complained of irregular menses. The provider took a comprehensive history of the problem and wrote a prescription for birth control pills to help regulate her periods. She is to follow-up in 3 months. **The provider would report a 99395 preventive exam and a 99213 with a 25 modifier for the irregular menses.**

SECTION 1: INITIAL COMPREHENSIVE PREVENTIVE MEDICINE

NEW PATIENT

Date: 11/1/2015

Code	Description and Documentation Requirements
99381	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, under 1 YEAR
99382	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, 1 through 4 YEARS
99383	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, 5 through 11 YEARS
99384	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, 12 through 17 YEARS
99385	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, 18 through 39 YEARS
99386	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, 40 through 64 YEARS
99387	E/M of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, NEW PATIENT, 65 YEARS AND OLDER

SECTION 1: PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE

ESTABLISHED PATIENT

Date:11/1/2015

Code	Description and Documentation Requirements
99391	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, under 1 YEAR
99392	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, 1 through 4 YEARS
99393	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, 5 through 11 YEARS
99394	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, 12 through 17 YEARS
99395	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, 18 through 39 YEARS
99396	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, 40 through 64 YEARS
99397	Reevaluation and management of an individual including an age and gender appropriate history, exam, counseling/anticipatory guidance/risk factor reduction intervention, and the ordering of lab/diagnostic tests, ESTABLISHED PATIENT, 65 YEARS AND OLDER

SECTION 1: COUNSELING RISK AND BEHAVIOR CHANGE INTERVENTIONS

Date: 11/1/2015; Rev 10/01/2016

Face to face services provided to new or established patients for the purpose of promoting health and preventing illness or injury.

Risk factor reductions should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention,

Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and

It may also be reported as part of the treatment of condition(s) related to or potentially made worse by harmful behavior that has not yet

These are all time based codes. In order to support the use of these codes the documentation must contain the following:
1) The total face-to-face time that was spent with the patient
2) A brief statement that reports that over 50% of that total time was spent on counseling
3) Specific information about the subjcts that were counseled, any pertinent patient questions and/or responses, and that the patient voiced their understanding

SECTION 1: COUNSELING RISK AND BEHAVIOR CHANGE INTERVENTIONS

Date: 11/1/2015

Code	Description and Documentation Requirements	Time Requirement
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual	60 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting	30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting	60 minutes

SECTION 1: MODIFIERS

OVERVIEW

Date: 11/1/2015; Rev 06/20/2016

A modifier is used to report or indicate that a service or procedure that has been performed has been altered by some specific circumstances but not changed in its definition or code. Modifiers also enable providers to effectively respond to payment policy requirements established by other entities.

Modifiers that may be commonly used by TDH are:
25 = Significant, separately identifiable Evaluation and Management (E & M) service was performed on the same day by the same provider.
50 = Is used to indicate a procedure has been completed bilaterally.
53 = Indicates that a surgical/diagnostic procedure or service was started but discontinued and not completed.
59 = Indicates that a procedure or service was distinct or independent from other non E & M services performed on the same day. This modifier is used to identify procedures/services, other than E & M services, that are not normally reported together, but are appropriate under the circumstances.
79 = Is used to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure.
91 = Is used when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. The laboratory test performed can be identified by its usual procedure code with the addition of modifier 91.

SECTION 1: MODIFIERS

Date: 11/1/2015; Rev 10/01/2016

25 Modifier

1. The 25 modifier is used to explain that a significant and separately reportable Evaluation and Management (E/M) service was performed on the same day that a 'procedure is provided' or 'other service is provided', due to the patient's condition.

2. The E/M service must support the key components of an E/M service: history, examination, medical decision making, and/or counseling time. If an insignificant problem/abnormality is discovered in the process of performing the preventive or counseling service, and the problem/abnormality does

3. The 25 modifier is to be used when reporting a vaccine, venipuncture, injection, diagnostic x-rays and other services performed on the same date as other office visits, preventive med, or counseling/behavior modification services.

4. There are 4 scenarios that TDH provides frequently, that will require the use of a 25 modifier. There are different requirements for office visits, preventive med and counseling/behavior modification codes:

a) Injection 96372:

- The 25 modifier is only required on other office visit codes (99201-99205 & 99212-99215) when reported with an injection administration 96372.
- The 25 modifier is **NOT** required for preventive visit or counseling/behavior modification codes when reporting injections (96372) on the same date.

Example: 22 YO female, established patient, presents to clinic with complaint of fever, sore throat, and cough for 2 days which supports a 99213 other office visit code. During the exam the patient mentioned to the APN that she was due for her depo injection.

Report: 99213 other office visit (with a 25 modifier attached) for the sick visit and 96372 for the depo injection administration.

Note: If performing a 99211 level of service with a 96372, use the 99211NC in conjunction with 96372.

b) Vaccine administration 90460, 90471, 90473:

- The 25 modifier is required for other office visits (99201-99205 & 99212-99215), preventive visit (99381-99397), and counseling/behavior modification codes (99401-99409) when reported with a vaccine administration code (90460, 90471 or 90473).
- The 25 modifier should be attached to:

  Revised 10/01/2016

  Preventive visits (99381-99397),

  And counseling/behavior modification visits (99401-99409) when a vaccine administration code (90460, 90471 or 90473) is reported on the same date.

Example: 2 year old female, established patient, presents with mother for EPSDT exam. The patient was examined per protocol and flu vaccine was administered.

Report: 99392 Comprehensive Preventive Visit (with a 25 modifier attached), the appropriate flu vaccine code and 90460 for flu vaccine administration.

Note: If performing a 99211 level of service with a vaccine administration, use the 99211NC in conjunction with the vaccine administration code.

c) Venipuncture 36415:

- The 25 modifier is only required on the other office visit code 99211.
- The 25 modifier should be attached to the 99211 when reported with venipuncture 36415.
- The 25 modifier is **NOT** required for other office visit levels, preventive visit, or counseling/behavior modification codes when reporting venipuncture on the same date.

Example: 28 year old male, established patient, presents to nurse in STD clinic with symptoms. Per protocol the patient is examined and labs are drawn by venipuncture.

Report: 99211 other office visit (with a 25 modifier attached) and 36415 for the venipuncture.

d) Reporting Preventive med (99381-99397), counseling/behavior modification codes (99401-99409) and/or other office visit on same date:

- If a small or insignificant problem is discovered in the process of performing the preventive or counseling service, that does not require additional work or meet the key components of an E/M service; the other office visit code (99201-99215) should **NOT** be reported separately.
- A 25 modifier should be reported when a significant problem is discovered during the encounter that requires a separate evaluation and management service.
- The 25 modifier should be attached to the 'problem' other office visit code (99201-99215) when reported with a preventive visit (99381-99397) codes or counseling/behavior modification codes (99401-99409).

Example: 12 year old female, established patient, presents to clinic for EPSDT exam (periodic comprehensive exam), code 99394. During the annual exam the patient complained of constant moderate pain in right ear since swimming 2 days ago. The provider took a separate history for the ear complaint, physically examined the ears, diagnosed the patient with right middle ear infection and prescribed an antibiotic (which supports Evaluation and Management level 99213).

Report: 99394 for the EPSDT exam and 99213 (with a 25 modifier attached) for the ear infection.

SECTION 1: MODIFIERS

11/1/2015; Rev 06/20/2016

50 Modifier

1. Attach modifier 50 for procedures that are bilateral and performed during the same visit.

2. Some CPT codes are defined as bilateral procedures (i.e. 99173; screening test of visual acuity, quantitative, bilateral). If the CPT code definition indicates it is a bilateral procedure, you do not use a 50 modifier.

3) When attaching a 50 modifier, use 1 unit. The modifier identifies the code as being done bilaterally, so there is no need for additional units.

Example: 4 YO male, established patient, presents to clinic with complaint of pain in both ears. Upon evaluation by physician/APN, the patient is diagnosed with impacted cerumen in both ears. Cerumen removal with forceps is performed bilaterally.
Report: Code 69210 on 1 line with a 50 modifier attached
Comment: The 50 modifier indicates that the procedure was performed on both ears on the same date of service.

53 Modifier

1. Modifier 53 is used to indicate that a surgical or diagnostic procedure or service was discontinued and not completed.

2. In extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that the procedure was started, but discontinued.

3. Add modifier 53 to the procedure code that was attempted, but discontinued.

Example: 26 year old female established patient presents to the clinic for IUC insertion (code 58300). The patient had a stenotic cervix and the procedure could not be completed.
Report: Code 58300 with modifier 53 attached.
Comment: This modifier allows a discounted reimbursement for time and medical decision making involved in the attempt to provide the service.

SECTION 1: MODIFIERS, cont'd

Date: 11/1/2015; Rev 06/20/2016

59 Modifier

1. The 59 modifier is used to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

2. It is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

3. Do not use modifier 59 with other office visit code. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see previous modifier 25.

4. If a patient is having an injection and vaccine on the same day, a 59 modifier should be attached to the injection.

Example for FQHC CENTERS: 69 year old established Medicare patient presents to the FQHC clinic for diabetes foot problems (FQHC code G0467). He returns later on the same day for an injury due to a fall down the stairs at his home. An additional (FQHC code G0467) would be reported on the same claim with a 59 modifier attached to the second code to explain that the patient returned to the clinic for a different problem on the same date of service.

Report: G0467 for the foot problem. On the same encounter, on a separate line, report another G0467 with 59 modifier attached (for the injury).

Comment: This modifier clarifies that the patient was treated for a problem and left, but the patient returned later that day and received treatment for a different problem.

79 Modifier

1. The 79 modifier is used when an unrelated procedure was provided by the same provider during a post-operative period.
2. The two procedures are performed by the same provider.
3. Used for two services during the post operative period starting the day after the procedure.

Example: 29 year old female established patient presents for genital warts located on the vulva (code 56501) on 9/4/2015. She returns to clinic on 9/12/2015 for follow-up exam (code 99213) for diabetes. There is a 10-day global period assigned to code 56501 which disallows any evaluation and management code from being billed if it relates to the genital warts removal. However, attaching the 79 modifier to the follow-up exam for diabetes will clarify that the other office visit code reported on 9/12/2015 was NOT related to the genital warts removal.

Report: Code 56501 for date of service 9/4/15
Report: Code 99213 with a 79 modifier attached for the follow up exam for diabetes on date of service 9/12/15.

Comment: This modifier clarifies that the other office visit code reported on 9/12/15 was NOT related to the genital warts removal on 9/4/15.

SECTION 1: MODIFIERS, cont'd

11/1/2015; Revised 06/20/2016

91 Modifier

1. The 91 modifier is used when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.

2. This modifier may not be used when tests are rerun to confirm initial results due to testing problems with specimens or equipment.

3. This modifier may only be used for laboratory tests performed more than once on the same day, on the same patient.

Example: 41 year old male presents to clinic for follow up in TB clinic. A peak and trough level is ordered to assess TB drug level. The drug level is drawn when the patient presents for the office visit and the TB drug is administered. The patient returns 3 hours later for the trough level to be drawn. A 91 modifier would be added to the second blood test to explain that two collections on the same date of service are medically necessary.

Report: The appropriate code for the drug that is being monitored (codes 80150 through 80299) would be reported to the lab. Two 36415 codes would be reported on separate lines by the clinic. A 91 modifier would be attached to the second 36415 code.
Comment: This modifier reports that the repeated labs were medically necessary for this patient.

Dual Modifiers

1. Dual modifiers will be reported when an injection and vaccination are completed on the same date of service.

Example: 17 YO female patient presents to clinic for annual EPSDT exam. During the exam she received a HPV vaccine and a Depo injection.

Report: 99394 for the EPSDT (with a 25 modifier attached for the vaccine administration), the appropriate vaccine code, 90460 for the vaccine administration, 96372 (with a 59 modifier attached because a vaccine and injection were provided on the same date of service), and the appropriate code for the Depo.

SECTION 2: INTERPRETER SERVICES

Date: 11/1/2015

SECTION 2: INTERPRETER SERVICES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Interpreter Services (Time Based)		As Appropriate	6	Administrative Purpose	Z02.9	1
Approximately 15 min.	INT1					
Approximately 30 min.	INT2					
Approximately 45 min.	INT3					
Approximately 60 min.	INT4					

COMMENTS:

1) INT1, INT2, INT3 and INT4 reflect use of interpreter in approximately 15-minute increments, up to maximum of 60 minutes. Interpreters may be local health department staff working in other areas. Interpreters may include outside contract personnel, voluntary qualified community interpreters and telephonic language interpreter services.

2) Provider using interpreter should report appropriate INT code based on time the interpreter spent during procedure(s) on encounter form using provider number. The INT code should be used one time per program per visit, even if multiple providers delivered services in that program. Identity of the interpreter or interpretation service used should be written in visit documentation in medical record.

3) If multiple providers in different programs use an interpreter, the INT code may be used more than one time on an encounter by coding to the appropriate program codes. The INT code should not be used for front-desk registration or other activity for which there is no corresponding procedure code, even if an interpreter is involved in the activity.

4) If bilingual provider delivers a service to a patient with limited English proficiency without use of interpreter, code is not used.

5) For community site visits when an interpreter is used or bilingual provider conducts a session in language other than English, code IN in DISPOSITION field for procedure 78059 with appropriate units of time.

SECTION 3: ADMINISTRATIVE SERVICES

Date: 11/1/2015

SECTION 3: COPIES/FAX (Per Page)

Date: 11/1/2015

Use Administrative Encounter Form (PH-3309)

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
"C" Registration (Community Service) (NO Medical Record)	78020	AM	6	Administrative Purpose	Z02.9	# of Pages
	78020A*					# of Pages >40
"L" Registration (Long) (Has Medical Record)	11005					
COMMENTS:						
1) Copies of medical records for patients and worker's compensation have no charge.						
2) For Attorney Request - use 78020A* for each additional page over 40.						

SECTION 3: GENERAL ENVIRONMENTAL SERVICES

Date: 11/1/2015

Use Administrative Encounter Form (PH-3309)

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Temporary Permit (Food Establishments)	78087	FG	6	Administrative Purpose	Z02.9	# of $30.00 Increments to Equal Fee
Permit Fees Per $1.00 Unit	PRMTFEE		6	Administrative Purpose	Z02.9	# of $1.00 Increments to Equal Fee
COMMENTS:						
1) Use code PRMTFEE for Tattoo Parlors temporary permit.						

SECTION 3: GROUND WATER SERVICES

Date: 11/1/2015

Use Administrative Encounter Form (PH-3309)

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
ENV Installers Permit	78026	EN	6	Administrative Purpose	Z02.9	As Appropriate
ENV Pumper Permit	78028					
ENV Inspection Letter	78030					
Certification of Verification	78032					
ENV Water Sample Total	78036					
ENV Water Sample - Fecal Coliform	78036P					
Sewage Disposal, 1000 GAL	78064					
Construction Inspection, Conventional	78064A					
Sewage Disp, Over 1000 GAL	78066					
Alternative Sewage Disp Base	78068					
Construction Inspection, Alternative and Large	78068A					
Experimental Sewage Disposal	78072					
Subdivision Per Lot (2 or Less)	78084A					
Subdivision Per Lot (3 thru 10 Lots)	78084B					
Subdivision Per Lot (11 Lots or more)	78084C					
Large SSD System Plan Review	78090					

SECTION 3: BIRTH CERTIFICATES

Date: 11/1/2015

Use Administrative Encounter Form (PH-3309)

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
"C" Registration, (Community Service) (Has NO Medical Record):						
Birth Certificate	78023A	BR	6	Administrative Purpose	Z02.9	# ISSUED
Birth Certificate	78023B	BC				
Birth Certificate - Veteran	78033	BC				
"L" Registration, (Long) (Has Medical Record)						
Birth Certificate	11053a	BR	6	Administrative Purpose	Z02.9	# ISSUED
Birth Certificate	11053B	BC				
Birth Certificate - Veteran	VETBC	BC				

COMMENTS: PATIENT SEARCH MANDATORY

1) No registration found, use "C" (Community Service) Registration Codes.
2) Registration found, use "L" (LONG) Codes.
3) Code two lines to issue copies of birth certificates.
4) Use program code BR with procedure codes ending with A to deposit the appropriate fee to Vital Records in Nashville
5) Use program code BC with procedure codes ending with B to deposit the appropriate fee to the local health department account.

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
EXAMPLE:						
Birth Certificate (Deposits appropriate portion of fee to Vital Records in Nashville	11053A	BR	6	Administrative Purpose	Z02.9	# ISSUED
Birth Certificate (Deposits appropriate portion of fee to Local Health Department)	11053B	BC	6	Administrative Purpose	Z02.9	# ISSUED

SECTION 3: DEATH CERTIFICATES

Date: 11/1/2015

Use Administrative Encounter Form (PH-3309)

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
"C" Registration, (Community Service) (Has NO Medical Record)		VR	6	Administrative Purpose	Z02.9	# ISSUED
Death Certificate	78022					
Death Certificate - Veteran	78054					
Verify Death Certificate Info	78057					
"L" Registration, (Long) (Has Medical Record)						
Death Certificate	11030					
Death Certificate - Veteran	VETVR					

SECTION 3: CREMATION PERMITS

Date: 11/1/2015

Use Administrative Encounter Form (PH-3309)

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
"C" Registration, (Community Service) (Has NO Medical Record)		VR	6	Administrative Purpose	Z02.9	# Issued
Cremation Permit	CREM					

SECTION 3: VOLUNTARY ACKNOWLEDGEMENT OF PATERNITY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
"L" Registration (Long)	VAOP	AM	6	Administrative Purpose	Z02.9	1

COMMENTS:
1) Encounters should be established using the child record. If the child does not have a PTBMIS record, create one using a Long "L" registration.
2) Key mother's name in Note/Follow field on EN screen.

SECTION 4: TENNCARE ADVOCACY

LEVEL 1 - ACTIVITIES

Date: 11/1/2015

TENNCARE ADVOCACY SHOULD BE ABOVE AND BEYOND WHAT IS NORMALLY PROVIDED TO ANY PATIENT

99401T:
1) Identify and assist patients in completing information to file a TennCare application.
2) Encourage a parent of a TennCare eligible child 0 to 21 years of age to file a TennCare application for the child and refer to the appropriate agency.
3) Provide information about TennCare eligibility and eligibility process.
4) Encourage compliance with clinical appointments.
5) Assist a TennCare enrollee with TennCare transportation arrangements.
6) Provide information about how to access care in the TennCare program (i.e. role of the PCP, how to change MCO and/or PCP).
7) Encourage/educate TennCare enrollees on how to report changes in income, name, address, family size, etc. to the appropriate TennCare Unit.
8) Provide information to TennCare enrollees about patient co-payments for services.
9) Inform and assist a current or prospective TennCare enrollee to appeal decisions about eligibility.
10) Conduct immunization follow-up (excludes mass mailings of immunization notices).

The following activities are Level 1 when the appointment, authorization, or referral is obtained with a phone call requiring no medical justification. When medical justification is needed to obtain the service, the activities automatically transition to Level 2.

1) Inform and assist a patient to appeal MCO decision to deny a service.
2) Identify TennCare participating providers for enrollees.
3) Obtain referrals and authorizations for medical services, including health department services.
4) Make appointments with private providers for patients enrolled in TennCare Presumptive Eligibility (Prenatal or Breast and Cervical).
5) Contact patients by phone if due for EPSDT according to periodicity schedule.
6) Educate TennCare enrollees about EPSDT benefits and need to comply with periodicity schedule.

SECTION 4: TENNCARE ADVOCACY

LEVEL 1 - OVERVIEW

Date: 11/1/2015

99401T - Level 1 - Provider Type:
Any health department employee.

99401T - Level 1 - Coding Guidance:
One 99401T activity may be coded per TennCare recipient per clinic visit or per day; can be coded by any provider. Not required to be coded to highest level of provider.

99401T - Level 1 - Documentation Guidance - DOCUMENT ON ONE OF THE FOLLOWING:
1) TennCare Advocacy Encounter/Log for activities not in connection with a visit for which an encounter has been established; or
2) Place a dated and signed comment in medical record date of service documentation; or
3) TennCare Advocacy Documentation Tool; or
4) SOAP clinical note.

SECTION 4: TENNCARE ADVOCACY

LEVEL 2 - ACTIVITIES

Date: 11/1/2015

99402T - Level 2:
1) Assist with understanding recommended interventions, treatments, medications and/or need for additional appointments.
2) Obtain referrals or prior authorizations for prescribed medications, formulas, medical supplies, durable medical equipment, or specialized medical/dental procedures.
3) Assist TennCare enrollee to appeal an MCO decision about medical care, including pharmacy benefits. Includes justification required from physician or nurse clinician to submit to an MCO for prior authorization of prescription.
4) Assist TennCare enrollee to appeal MCO's lack of timely access to needed services, including provider network inadequacies, inability to obtain a provider appointment within required time frames, etc.
5) Assist TennCare enrollee to appeal MCO decision about provision of transportation to provider appointments.
6) Patient education above/beyond that which is normally provided to all patients.
7) Patient education about appropriate use of Emergency Room Services.

The following activities are Level 2 when medical justification or judgment is needed to obtain the service.
1) Inform and assist a patient to appeal MCO decision to deny a service.
2) Identify TennCare participating providers for enrollees.
3) Obtain referrals and authorizations for medical services, including health department services.
4) Make appointments with private providers for patients enrolled in TennCare Presumptive Eligibility (Prenatal or Breast and Cervical)
5) Contact patients by phone if due for EPSDT according to periodicity schedule.
6) Educate TennCare enrollees about EPSDT benefits and need to comply with periodicity schedule.

SECTION 4: TENNCARE ADVOCACY

LEVEL 2 - OVERVIEW

Date: 11/1/2015

TENNCARE ADVOCACY SHOULD BE ABOVE AND BEYOND WHAT IS NORMALLY PROVIDED TO ANY PATIENT

99402T - Level 2 - Provider Type:
Administrative Staff and Assistant Staff DO NOT provide Level 2 TennCare Advocacy. Level 2 activities involve obtaining health care services and/or resolving difficult access to care problems. Requires assessment, judgment and justification to obtain the TennCare service.

99402T - Level 2 - Coding Guidance:
One 99402T activity may be coded per TennCare recipient per clinic visit or per day.

99402T - Level 2 - Documentation Guidance:
Level 2 activities must be documented as note in patient medical record.

SECTION 4: TENNCARE ADVOCACY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

COMMENTS:
1) Use TennCare Advocacy Log/Encounter Form for Advocacy activities not associated with visit for which an encounter has been established.
2) Multiple providers may provide Advocacy and document on TennCare Advocacy Documentation Tool. Only one provider number can be recorded.
3) 99401T - Code one time per encounter.
4) 99402T - Code one time per encounter.

SECTION 4: TENNCARE ADVOCACY

FIELD SERVICE

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service		TO	6	Administrative Purpose	Z02.9	# 30 Min. Increments
"C" Registration (Community Service) Has NO Medical Record	78059					
"L" Registration (Long) Has Medical Record	3560					

COMMENTS:
1) Use for health fairs, community presentations, dislocated worker presentations

SECTION 5: TENNCARE PRESUMPTIVE ENROLLMENT

OVERVIEW

Date: 11/1/2015

MOVO - Motor Voter Registration:
Used when offering patients the opportunity to register to vote.

MOVO DISPOSITION CODES:
RG - Registered at Health Department today
CR - Currently registered to vote
TF - Took registration form home.
DD - Declined; declination form signed.
NE - Not eligible due to age or lack of citizenship

TCPRES - TennCare Presumptive:
Used when Presumptive Eligibility activity is completed.

COMMENTS:
1) A person who will be at least 18 years old on or before the next election who applies for WIC certification or recertification, CSFP or Presumptive Eligibility, must be offered the opportunity to register to vote. Use the MOVO procedure code and disposition code to indicate patient response.
2) For those who complete and submit the form at the Health Department, the receipt number from the form must be entered in Notes/Follow field at bottom left of encounter screen.
3) Refer to TennCare Prenatal PE Desk Guide for instructions on eligibility and the TennCare Prenatal Eligibility application process.

SECTION 5: TENNCARE PRESUMPTIVE ENROLLMENT

PRENATAL

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
TennCare Presumptive (Prenatal)	TCPRES	CH (Birth thru 20) or WH (21 and over)	6	Administrative Purpose	Z02.9	1

COMMENTS:
1) TCPRES should be used to capture all activities related to TennCare Presumptive Enrollment. Refer to TDH PE Guide.
2) **Do Not Use Advocacy Code 99401T or 99402T in addition to TCPRES.**
3) If pregnancy is determined elsewhere and prenatal counseling is provided, codes 99401 - 99404 may be used. Diagnosis code Z32.01 (positive pregnancy test) may be applied to counseling using CH or WH program codes.
4) The staff person who determines the presumptive eligibility should apply the code.

Motor Voter Registration	MOVO	AM	6	Administrative Purpose	Z02.9	1

MOVO DISPOSITION CODES:
RG - Registered at Health Department today
CR - Currently registered to vote
TF - Took registration form home.
DD - Declined; declination form signed.
NE - Not eligible due to age or lack of citizenship

SECTION 5: TENNCARE PRESUMPTIVE ENROLLMENT

BREAST AND CERVICAL CANCER

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
TennCare Presumptive (Breast and Cervical Cancer)	TCPRES	BCS	6	Administrative Purpose	Z02.9	1

COMMENTS:
1) TCPRES should be used to capture all activities related to TennCare Breast and Cervical Cancer Presumptive Enrollment.
2) **Do Not Use Advocacy Code 99401T or 99402T in addition to TCPRES.**
3) If patient is already enrolled in TBCSP, use code 99080B with TCPRES when activities are performed to collect and transfer data related to procedures performed on patient.
4) The staff person who determines the presumptive eligibility should apply the code.

Motor Voter Registration	MOVO	AM	6	Administrative Purpose	Z02.9	1
MOVO DISPOSITION CODES:						
RG - Registered at Health Department today						
CR - Currently registered to vote						
TF - Took registration form home.						
DD - Declined; declination form signed.						
NE - Not eligible due to age or lack of citizenship						

SECTION 6: LAB

OVERVIEW

Date: 11/1/2015; Rev 07/06/2016

Health departments refer lab specimens to various labs, including the TDH State Lab, the state contracted lab vendor (AEL) and exclusive reference labs for certain insurance plans (example - Quest for TennCare Select and BlueCare).

TDH State Lab - Health departments send specimens to the State Lab through Lab Order Entry (LOE). Refer to LOE TOR Tests for specimens that go to the State Lab.

AEL - State Contracted Lab Vendor. Specimens are sent to AEL for patients when TDH is responsible for payment directly to AEL (payer 6).

Quest - Quest is the exclusive reference lab for BlueCare and TennCare Select. Specimens for health department patients covered by these plans must be sent to Quest.

Check Member Plan for Covered Reference Lab: For patients covered by Medicare Advantage plans and private insurance that TDH does not contract with.

SECTION 6: LAB

LAB - GENERAL

Date: 11/1/2015; Rev 06/20/16

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Code each lab procedure done	As Appropriate	As Appropriate	As Appropriate	As Appropriate	As Appropriate	1
Venipuncture	36415					
Ear, Finger or Heel Stick	36416					
Lab Handling (if outside lab)	99000					

Coding Venipuncture with 99211 Visit:
If a patient receives a venipuncture (36415) in conjunction to a 99211 visit, a 25 modifier should be attached to the 99211 code. This rule only applies to 99211 E/M code. Refer to Section 1: Modifier for additional guidance.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 6: LAB

ELECTRONICALLY ORDERED STATE LAB TESTS

Date: 11/1/2015

Tests ordered electronically on PTBMIS LOE (Lab Order Entry) screen and sent to the State Lab.

CODE	DESCRIPTION
AFBOT	OTHER/AFB SM CULTURE
AFBIS	IND SPUT/AFB SMEAR
AFBNS	NAT SPUT/AFB SMEAR
AFBST	STOOL/AFB SM CULTURE
AFBUR	URINE/AFB SM CULTURE
GENPU	GEN PROBE, URINE
GENPE	GEN PROBE, ENDO
GENPP	GEN PROBE,UROGENTIAL
GENPO	GEN PROBE, THROAT
GENPV	GEN PROBE,SELF-OBTAINED VAGINAL
GENPA	GEN PROBE, ANAL
87389	HIV1/2 AG/AB
87081	GC CULTURE
87045	STOOL CULTURE
87070	BACTERIAL CULTURE
87177	OVA AND PARASITE
86592	RPR (SYPHILIS TEST)
86480	TB BLOOD TEST QUANTEFERON
INFLU	ANTIBODY, INFLUENZA
VIRAL	VIRAL CULTURE
HERP	CULTURE, HERPES

COMMENTS:

1) Once a test is ordered electronically the system automatically populates the test code on the encounter which then creates a place for the electronic result to post.

2) Electronically ordered tests will only accept electronic results. The results cannot be entered manually.

3) Electronic test results are returned to the health department each evening and post into PTBMIS patient records at 6:00 a.m. the following morning.

4) Reflex tests triggered by the result of an electronically ordered test will automatically be run, resulted and posted into PTBMIS. There is no manual intervention in this process.

5) Use venipuncture code 36415 if blood is drawn for lab or 36416 for capillary specimen.

6) Use lab handling 99000 for lab tests sent outside the health department.

SECTION 6: LAB

LAB TESTS ORDERED FROM OUTSIDE VENDOR

Date: 11/1/2015; Rev 07/06/2016

Lab tests are ordered using the appropriate vendor based on patient's third party payer.

Lab tests ordered from outside labs (AEL, Quest, etc.) must also be entered on patient encounter using PTBMIS code for the test.

PTBMIS charge file codes differ from the AEL or Quest test numbers but are shown on the PTBMIS charge record.

EXAMPLE: Screen Shot of PTBMIS Charge File

PTBMIS CODE		QUEST CODE	TEST	AEL EAST TN	AEL CODE MEMPHIS	
Procedure Code: 84550			**Description:** URIC ACID, BLOOD			
			Q 905	905ET	URA	

Effective Date: 02/15/2016 **Thru:** 12/31/2099 **Sent Date:**

Standard Fee: 1.3500 **Max Units/Encounter :** 99

Minimum Fee: **S/S Discountable (Y/N):** Y

RVS: **Sales Taxable (Y/N) :** N

Unit-Based Min (Y/N) :

Copay

Alternate	**Code:**	**Descr:**
(1)	84550	URIC ACID, BLOOD
(2)		
(3)	84550	URIC ACID, BLOOD
(4)		

Financial-Code/Charge

A S 2 5

3-rd Party Reimbursable (Y/N)

M-Care	M-Caid	Ins-1	Ins-2	Ins-3	Ins-4	Ins-5
Y	Y	Y	Y	Y	Y	Y

Service Type : LA **BCRR-Type-1** **F/P Type :**

Accounting (Department/Account) **HIS Action :**

Using the above example to order a URIC Acid, Blood test.

Determine to which Lab **(AEL or Quest)** the test should be sent, based on patient's third party payer.

If test is sent to **AEL,** order test number **905ET or URA in AEL ordering system.**

If test is sent to Quest, order test number **905 in Quest ordering system.**

Enter **PTBMIS procedure/charge code 84550** on the encounter.

SECTION 6: LAB

IN HOUSE LABS

Date: 11/1/2015

In house labs are initiated and resulted within the health department clinic.
In house labs are identified in the PTBMIS charge file with an **IH** in the description field.

EXAMPLE: Screen Shot of PTBMIS Charge File

Procedure Code: 85018 **Description:** HEMOGLOBIN, (HGB) BLOOD COUNT IH

Effective Date: 07/01/2013 **Thru:** 12/31/2099 **Sent Date:**

Standard Fee: 4.2900 **Max Units/Encounter :** 1

Minimum Fee: **S/S Discountable (Y/N):** Y

RVS: **Sales Taxable (Y/N) :** N

Unit-Based Min (Y/N) :

Copay

Alternate (1) **Code:** 85018QW **Descr:** HGB HEMOGLOBIN

(2)

(3) 85018 HGB HEMOGLOBIN

(4)

Financial-Code/Charge

A S 2 5

3-rd Party Reimbursable (Y/N)

M-Care	M-Caid	Ins-1	Ins-2	Ins-3	Ins-4	Ins-5
Y	Y	Y	Y	Y	Y	Y

Service Type : LA **BCRR-Type-1** **F/P Type :**

Accounting (Department/Account) **HIS Action :**

Code 99000, lab handling, **should not be used** when performing an in house lab.

SECTION 7: DENTAL

DEFINITIONS

Date: 11/1/2015

Dental Clinical - Provides comprehensive dental care to children and emergency care for adults

D9430 - Office Visit - Observation, no other services performed.
3734 - Re-check - Assess the status of a previously existing condition of an established patient.
78059 - Field Service - Performed by dental clinical staff providing mass screenings, mass education and health fairs

SECTION 7: DENTAL

DENTAL CLINICAL

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Diagnostic	D0120 - D0330	DN or DT*	Private Ins (5XXX) or Ryan White Program or TennCare (ADDS) or Private Pay 6	Diagnostic and Prevention	Z01.20	As Appropriate
Preventive	D1110 - D1555			All other services excluding emergencies	Z01.21	
Restorative	D2140 - D2954			Emergencies	K08.9	
Endodontic	D3110 - D3330					
Periodontic	D4210 – D4910					
Removable Prosthetics	D5110 - D5851					
Fixed Prosthetics	D6210 - D6930					
Surgical	D7111 - D7971					
Adjunctive General Services	D9110 - D9951					
Office Visit (Observation)	D9430					
Re-check	3734					

COMMENTS:

1) ***DT** - patients seen in the mobile or school-transport program.

2) Private Pay Adult Dental Services -Private pay adult dental services require minimum fee of $5.00 per visit to be paid at time of visit. Before the patient leaves the Health Department, the encounter should be keyed and UPDATED - BUT NOT FINALIZED. If the balance due from the patient for services received is less than $5.00, the command "MINF DN" (MINF space prg DN code) should be entered while on the encounter screen. The difference between the patient's charge(s) for the day's visit and the $5.00 minimum will be calculated by the system and applied to the balance due. The "Update Complete" message will be shown and the encounter can be finalized.

2) Private Pay Adult Dental Services With Lab: Use the appropriate procedure code followed by "A" modifier. Charges full costs of lab to patient.

3) Private Pay Adult Dental Services Without Lab: No modifier is used with appropriate procedure code. Charges will be based on sliding fee scale.

4) EMERGENCY DENTAL SERVICES - use diagnosis code K08.9.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 7: DENTAL

FIELD SERVICE

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service	78059	DN	6	Administrative Purpose	Z02.9	30 Min. Increments

SECTION 8: EARLY PERIODIC SCREENING, DIAGNOSIS and TREATMENT (EPSDT)

TENNCARE - AGES 0 THROUGH 20

Date: 11/1/2015; Rev 06/20/2016

TennCare/Medicaid covers EPSDT services for eligible children 0 through 20 years of age. EPSDT services include 7 components. If a TennCare covered child has private insurance primary and TennCare secondary, the private insurance plan must be billed first.

When performing an EPSDT and a 'significant' problem is found:

Code the preventive exam (99381 - 99395) AND
Code an other office visit (99201 - 99215) for the problem
Add modifier 25 to office visit.

Comment: Refer to Section 1 Modifiers for explanation to report EPSDT and other office visits on the same date of service.

Coding EPSDT with Vaccines:

If vaccines are given with an EPSDT, the EPSDT diagnosis code should be coded first.
A 25 modifier should be attached to the 99381-99395 code.

Coding EPSDT with abnormal screening(s):

If a patient has an abnormal EPSDT screening(s), the entire EPSDT service would be considered abnormal. Report the appropriate "**with abnormal findings"** diagnosis code. Identify the abnormal screen, and attach the appropriate R code as a second diagnosis code to the abnormal screen code.

SECTION 8: EARLY PERIODIC SCREENING, DIAGNOSIS and TREATMENT (EPSDT)

TENNCARE

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient:						
Infant or Child (<1year)	99381	EP	TennCare (AXXX) or Private Ins (5XXX) * or DCS Custodial (5DCS)	Encounter for Health Exam	<8 days - Z00.110	1
1 through 4 years	99382				8 to 28 days - Z00.111	
5 through 11 years	99383				>28 days-17 yrs, abnormal-Z00.121 (Use additional code to identify abnormal findings)	
12 through 17 years	99384				>28 days- 17 yrs, normal - Z00.129	
18 through 20 years	99385				Adult abnormal - Z00.01 (Use additional code to identify abnormal findings)	
					Adult normal - Z00.00	
Established Patient:						
Infant or Child (<1year)	99391	EP	TennCare (AXXX) or Private Ins (5XXX) * or DCS Custodial (5DCS)	Encounter for Health Exam	<8 days - Z00.110	1
1 through 4 years	99392				8 to 28 days - Z00.111	
5 through 11 years	99393				>28 days-17 yrs, abnormal-Z00.121 (Use additional code to identify abnormal findings)	
12 through 17 years	99394				>28 days-17 yrs, normal - Z00.129	
18 through 20 years	99395				Adult abnormal - Z00.01 (Use additional code to identify abnormal findings)	
					Adult normal - Z00.00	
Additional Components Performed, As Appropriate						
Developmental Screen (PEDS and MCHAT)	96110	EP	TennCare (AXXX) or Private Ins (5XXX) * or DCS Custodial (5DCS)	Enc. - Screening developmental disorder	Z00.110-Z00.129 as appropriate; (Use additional code to identify abnormal findings)	Qty = 2 if both performed
Behavioral Screen (PSC-17, Y-PSC, Adolescent)	96127			Enc. - Screening for Other Disorder	Z00.00-Z00.129 as appropriate; if abnormal also report R46.89	Qty = 1 (If more than one behavioral screening is completed, please code additional 96127 with a 59 modifier attached.)
Hearing Screen	92551			Hearing	Z00.00-Z00.129 as appropriate; if abnormal also report R94.120	1
Vision Screen	99173			Vision	Z00.00-Z00.129 as appropriate; if abnormal also report R94.118.	
Immunizations	See Vaccines Immunizations Section			Encounter for Immunization	Z23	
Lead	83655 or 83655IH			Lead Screening	Z13.88	
Ear, Finger or Heel stick	36416			Labs	As Appropriate	
Venipuncture	36415					
Lab Handling	99000					
Fluoride Varnish	D1203N	Refer to Section 10 Page 20 for guidance		Encounter for prophylactic fluoride administration	Z29.3	
Oral Screening	D0190N			Encounter for screening for dental disorders	Z13.84	

SECTION 8: EARLY PERIODIC SCREENING, DIAGNOSIS and TREATMENT (EPSDT)

TENNCARE

Date: 11/1/2015; Rev 10/01/2016

COMMENTS:

1) EPSDT includes:

a. Comprehensive health and development history

b. Comprehensive unclothed physical exam

c. Appropriate immunizations

d. Appropriate laboratory tests

e. Health education

f. Hearing assessment

g. Vision assessment

2) * Bill private insurance first and TennCare second, if applicable.

3) Vision Screen (99173) - Physician, nurse or nursing assistant screens a child during an EPSDT visit for an OBJECTIVE vision screen using a Snellen, Snellen ABC, Tumbling E Chart, Titmus, photo screener or Sure Sight machine. A 25 modifier needs to be attached to the Preventive Visit Code (99381-99395) if a vision screening is completed during visit.

4) Hearing Screen (92551) - Physician, nurse or nursing assistant screens a child during an EPSDT visit for an OBJECTIVE hearing screen using an audioscope, EROscan, or an audiometer.

5) Developmental Screen (96110) - Provide a development screen at each EPSDT preventive exam to a child according to the AAP Periodicity Schedule. The Screening instrument should be the Parents Evaluation of Development Status (PEDS), 0 through 4 years; or Modified Checklist for Autism in Toddlers (M-CHAT), 18 and 24 months. Code quantity of 2 for 96110 when both PEDS and M-CHAT are done at same visit.

6) Behavioral Screen (96127) -Code 96127 in addition to the EPSDT exam code when the PSC-17, Y-PSC or Adolescent Developmental Behavioral Questionnaire is performed. If more than one bahvioral screening is completed, code additional 96127 with a 59 modifier attached.

7) If applicable, the BMI diagnosis code may be reported for ages 2 through 20 years only. Do not report BMI for children under 2 years.

8) An assessment is made when a child is present in clinic (or during a home visit, if appropriate) to determine if the child is due for the EPSDT screen according to the AAP Periodicity Schedule. If the child is present in clinic and due a screen, the child is offered a screen by the discipline that can conduct the screening. If the screening cannot be done that day, an appointment should be scheduled for a later date with the health department or with the child's Primary Care Physician (PCP).

9) Tn Care now reimburses for fluoride varnish for ages 6 months through 5 years of age. Both the fluoride varnish application (D1203N) and oral screening (D0190N) must be coded and the payer for these codes must be changed to ADDS.

10) Refer to Section 1: Modifiers for guidance on reporting vaccines, injections, and venipunctures with other office visits, preventive visits, and/or counseling codes.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 9: VACCINES/IMMUNIZATIONS

OVERVIEW

Date: 11/1/2015; Rev 10/01/2016

Federal Vaccines:
The TDH Immunization Program (TIP) provides federally funded vaccines to county health departments from two programs - Vaccines for Children (VFC) and Section 317 of the Public Health Service Act.
Federal criteria determine who is eligible to receive VFC vaccines and 317 vaccines.
TIP oversees federally funded vaccines and makes them available to county health departments.
Federal vaccines are coded with standard numeric CVX codes.
See Federal Vaccine Code List.

State Purchased Vaccines:
TDH purchases vaccines with state funds and makes them available to county health departments for persons not eligible for federally funded vaccines.
The TDH Director of Pharmacy and Regional Pharmacists order state purchased vaccines for county health departments.
State purchased vaccines are coded with alpha characters.
See State Purchased Vaccine Code List.

Coding Vaccines and Other Office Visits/Preventive Visits/Counseling:
When an other office visit (99201-99205 and 99212-99215), or preventive visit (99381-99397), counseling (99401-99404), or behavior change intervention (99406-99409) service is provided on the same day as a vaccine, add modifier 25 to the other office visit/preventive/counseling code to explain that both services were provided. Refer to Section 1: Modifiers for additional guidance. If a 99211 level of service has been completed with a vaccine administration, report 99211NC and appropriate vaccine administration code. If vaccines are given with a E/M or EPSDT, the E/M or EPSDT diagnosis code should be reported first. Please note that it is recognized that PTBMIS will not rearrange diagnosis codes in certain circumstances (i.e. when labs are ordered in LOE) . A process is currently being reviewed to resolve this issue.

Coding Vaccines and Other Injectable:
When a vaccine administration code 90460 or 90471 and an injection code 96372 are administered on the same date of service, add modifier 59 to the injection code 96372. Refer to Section 1: Modifiers for additional guidance.

Limits on Vaccine Administrations on the Same Date of Service:					
A Medically Unlikely Edit (MUE) in payer claim systems limits the number of vaccine administrations that can be reimbursed on the same date of service. Vaccine administration code 90460 has a limit of six (6); vaccine administration code 90471 has a limit of one (1). To report vaccine administrations greater than these quantities:					
90460	Quantity = 6	90460 59	Number of units greater than 6		
90471	Quantity = 1	90472	Quantity = 4	90472 59	Number of units greater than 4

SECTION 9: VACCINES/IMMUNIZATIONS

VACCINE CODES - FEDERAL VACCINE (VFC and 317) - ON SITE CLINICS

Date: 11/1/2015; Rev 10/01/2016

VFC Vaccines - Age 0 through 18			
Vaccine	**CVX Code**	**Vaccine**	**CVX Code**
Flucelvax	171	PCV13 – Prevnar-13	133
Quad Flu-IIV4 (Pres. Free)	150	Polio Inactivated IPV	10
Quad Flu-IIV4 MDV	158	Rotavirus RV5 Rotateq	116
Quad Flu - Pediatric (Pres. Free)	161	Rotavirus RV1 Rotarix	119
Hep A Pediatric (child)	83	Varicella – Chickenpox VAR Varivax	21
Hep B Pediatric (child)	08	DT Pediatric	28
Hib - ActHIB or HIBERIX	48	DTaP Infanrix	20
Hib - PedVaxHib	49	DTaP Daptacel	106
HPV4 Gardasil	62	DTaP-IPV-Kinrix	130
HPV9 Gardasil 9	165	DTaP-HepB-IPV Pediarix	110
Meningococcal MCV4 – Menactra	114	DTaP-IPV/Hib – Pentacel	120
Meningococcal MCV4 – Menveo	136	Measles Mumps Rubella MMR	03
Meningococcal B Trumenba	162	MMR+Varicella MMRV ProQuad	94
Meningococcal B, OMV Bexsero	163	Td Decavac or Tenivac	113
PPSV23 Pneumovax	33	Tdap Adacel or Boostrix	115
317 Vaccines - Age 19 and Over			
Vaccine	**CVX Code**	**Vaccine**	**CVX Code**
Trivalent Flu-IIV3 MDV	141	Meningococcal MCV4 – Menactra	114
Trivalent Flu-IIV3 (Pres. Free)	140	Meningococcal MCV4 – Menveo	136
Trivalent Flu- CCIIV3 (Pres. Free)	155	Td Decavac or Tenivac	113
Hep A Adult	52	Tdap Adacel or Boostrix	115
Hep B Adult	43	Varicella – Chickenpox VAR Varivax	21
Measles, Mumps, Rubella (MMR)	03		

SECTION 9: VACCINES/IMMUNIZATIONS

VACCINE CODES - STATE PURCHASED VACCINE - ON SITE CLINICS

Date: 11/1/2015; Rev 10/01/2016

State Purchased Vaccines - 0 through 18 years			
Vaccine	**Code**	**Vaccine**	**Code**
Flu- Multi Dose	FLZ	Polio Inactivated	IPV
Flu-Vac Quad (Pres. Free)	FLX	Rotavirus Rotateq	RTA
Hep A Pediatric	HAS	Rotavirus Rotarix	RV1
Hep B Pediatric	HBS	Varicella - Chickenpox Varivax	VVC
Hep A & B Twinrix (18 years)	HAB	DT Pediatric	DT
Hib Pedvax Hib	HI3	DTaP	DTA
Hib ActHib	HI4	DTaP-IPV-Kinrix	DTI
Human Papillomavirus	HPA	DTaP-HepB-IPV - Pediarix	DHI
HPV9 Gardasil 9	HP9	DTaP-Hib-IPV-Pentacel	DHV
Meningococcal MCV4	MVO	Measles Mumps Rubella	MMA
Meningococcal B Trumenba - full charge, no slide for any patient	TRU	Td	TD
Meningococcal B, OMV Bexsero - full charge, no slide for any patient	BEX	Tdap	TD2
Pneumococcal Polysaccharide	PNE		
PNE Conj. Prevnar 13	P13		

State Purchased Vaccines - 19 years and older			
Vaccine	**Code**	**Vaccine**	**Code**
Flu- Multi Dose	FLZ	Meningococcal MCV4	MVO
Hep A Adult	HAA	Meningococcal B Trumenba - full charge, no slide for any patient	TRU
Hep B Adult	HBB	Meningococcal B, OMV Bexsero - full charge, no slide for any patient	BEX
Hep A & B (18 years and older)	HAB	Pneumococcal Polysaccharide	PNE
Human Papillomavirus	HPA	PNE Conj. Prevnar 13	P13
HPV9 Gardasil 9	HP9	Td	TD
Measles Mumps Rubella	MMA	Tdap	TD2
		Varicella - Chickenpox Varivax	VVC
		Zoster Zostavax - full charge, no slide for any patient	ZOS

SECTION 9: VACCINES/IMMUNIZATIONS

VACCINE ADMINISTRATION

Date: 11/1/2015; Rev 10/01/2016

Code	Definition
90460	Immunization Administration, any route, 0 thru 18 years, with counseling, first or only component of each vaccine
90461	Immunization Administration, any route, 0 thru 18 years, with counseling, each additional component
90471	Immunization Administration (percutaneous, intradermal, subcutaneous, intramuscular injections); 1 vaccine
	DO NOT REPORT 90471 in conjunction with 90473
90472	Immunization Administration (percutaneous, intradermal, subcutaneous, intramuscular injections); each additional vaccine (single or combination)
90473	Immunization Administration (intranasal or oral route); 1 vaccine (single or combination)
	DO NOT REPORT 90473 in conjunction with 90471
90474	Immunization Administration (intranasal or oral route), each additional vaccine (single or combination)
90471CD	Federal vaccine given due to outbreak, PEP or wound
90471NC	Single Immunization Administration, No Charge
G0008	Medicare - Influenza Administration
G0009	Medicare - Pneumococcal Administration

Comments:

1) Refer to Section 1: Modifiers for guidance on reporting vaccines, injections, and venipunctures with other office visits, preventive visits, and/or counseling codes.

2) If a 99211 level of service has been completed with a vaccine administration, report 99211NC and appropriate vaccine administration code.

SECTION 9: VACCINES/IMMUNIZATIONS

Multi Component Vaccine Administration

Date: 06/20/2016

CPT codes 90460 and 90461 require each component of a vaccine to be reported separately. CPT defines a component as all antigens in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components.

- Use code 90460 to report the first (or only) vaccine/toxoid component of each vaccine.
- Use code 90461 to report each additional component of that particular vaccine.

Codes 90460 or 90461 should not be listed on a claim more than once. Repeated administration code(s) will deny as duplicate services.

Example:

Vaccine Code	Descriptor	Number of Components	Code	
90670	Pneumococcal Conjugate Vaccine	1	90460 x 1	
90723	DtaP-HepB-IPV (Pediarix)	5	90460 x 1	90461 x 4
90658	Influenza Virus Vaccine	1	90460 x 1	

Multiple units should be reported as:

90460 x 3 units	The 3 units represent the only component for pneumococcal and influenza and first component for DtaP-HepB-IPV
90461 x 4 units	the 4 units represent each additional component of DtaP-HepB-IPV; no other vaccine has more than one component to report.

Comments:

1) Refer to Section 1: Modifiers for guidance on reporting vaccines with other office visits, preventive visits, and/or counseling codes.
2) 90460, 90471, 90472, and 90473 (vaccine administration) do not report with 99211.

SECTION 9: VACCINES/IMMUNIZATIONS

VACCINE CODES - HISTORY ONLY VACCINES

Date: 11/1/2015

History Only Vaccine	Code	History Only Vaccine	Code
Chickenpox Disease	CPD	Mumps	MUM
Hep B (Dialysis/Immune Suppressed	HPD	Polio, Oral	OPV
Hep B, Adolescent, 2 Dose	HB2	Respiratory Syncytial Virus	RSV
Measles	MEA	Rotavirus - Rotashield	RTV
Measles and Rubella	MR	Rubella	RUB
Measles, Mumps, Rubella Varicella	MMV	Zoster (Shingles)	ZOS

Polio unspecified formulation	89
Rotavirus, history brand unknown	122
DTaP history brand unknown	107
Influenza vaccine formulation unknown	88
Hib history brand unknown	17
Pneumococcal vaccine formulation unknown	109
HPV history brand unknown	137
Meningococcal vaccine formulation unknown	108

COMMENTS:

1) Note: Some history codes are alpha and some are numeric. Alpha codes crosswalk in PTBMIS to CVX numeric codes.

SECTION 9: VACCINES/IMMUNIZATIONS

VACCINE CODES - TRAVEL VACCINES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Hepatitis A Adult (19 and over)	HAA	IT	As Appropriate	Encounter for Immunization	Z23	1
Inactivated Polio	IPV					
Typhoid	TPN					
Yellow Fever, Single Dose	YFS					
Hepatitis A, 1 - 18	HAS					
Hepatitis A & B (Twinrix)	HAB					
Meningococcal	MVO					

SECTION 9: VACCINES/IMMUNIZATIONS

MASS IMMUNIZATION CLINIC

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Flu Vaccine	78088	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	As Appropriate	Encounter for Immunization	Z23	# Given
Hepatitis A Vaccine	78089					
Hepatitis B Vaccine	78094					
Hepatitis B Vaccine - Adult No Charge	78094NC					
Flu Administration	78091F					
Mass Administration - all other vaccines	78091		6			

COMMENTS:
1) Do not use code 78059 for Mass Immunization Clinics.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 9: VACCINES/IMMUNIZATIONS

IMMUNIZATION ONLY VISIT (No Exam)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Vaccines	See Vaccine Codes List	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	As Appropriate	Encounter for Immunization	Z23	

COMMENTS:
1) Vaccine Administration - See Vaccine Administration Code List

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 9: VACCINES/IMMUNIZATIONS

MEDICARE FLU and/or PNEUMONIA VACCINES ONLY VISIT

HEALTH DEPARTMENTS - EXCEPT FQHC

Date: 11/1/2015; Rev 07/06/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Flu	FLZ	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	S	Encounter for Immunization	Z23	1
Flu Administration	G0008					
Pneumonia	PNE or P13					1
Pneumonia Administration	G0009					

COMMENTS:

1) If both Flu and Pneumonia vaccines are given at same visit, enter both administration codes (G0008 and G0009).
2) PNE or P13 must be administered 1 year apart from each other according to Medicare guidelines.

SECTION 9: VACCINES/IMMUNIZATIONS

FIELD SERVICES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service (Audit/Contact/Mass Screening/Mass Education)		IM	6	Administrative Purpose	Z02.9	#30 Min Increments
"C" Registration (Community Service) - Has NO Medical Record	78059					
"L" Registration (Long) - Has Medical Record	3560					

COMMENTS:

1) Field representatives should use 78059 for school and day care audits, 24 month surveys, field visits and mass screenings using facility as "patient" with a "C" registration. Field visits made to individual patients who have a "L" registration should be coded using 3560 to capture the visit. Both 78059 and 3560 are coded in 30 minute increments in quantity column.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

OVERVIEW

Date: 11/1/2015

MOVO:
Use when offering patients the opportunity to register to vote.

3734 - Recheck:

Assess status of previously existing condition of established patient to be used by a licensed provider and/or public health representative.
Nurse Assistant should use venipuncture code 36415 when drawing blood and only the Nurse should use Recheck code 3734..

SECTION 10: CLINIC VISITS

INJECTABLE DRUGS (not VACCINES)

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Injection	96372	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Pay 6 or Private Ins (5XXX) or TennCare (AXXX)	As Appropriate	As Appropriate	1
Recheck Visit	3734		6			

COMMENTS:

1) Code 96372 may be coded with other office visits (99201-99205 and 99212-99215), preventive visits (99381-99397), counseling (99401-99404) and behavior change intervention (99406-99409). Modifier 25 would only be added to the other office (99201-99205 and 99212-99215) visits if billed with 96372. Preventive visits, counseling, and behavior change intervention does not require a 25 modifier.

2) If a 99211 level of service has been completed with an injection (96372), report 99211NC and 96372.

3) Refer to Section 1: Modifiers for reporting injections with other office visits, preventive visits, and/or counseling codes.

4) Injectable drugs are issued from the Pharmacy Module.

SECTION 10: CLINIC VISITS

INJECTION ONLY VISITS - ALLERGY

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Allergen Immunotherapy - one injection OR	95115	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	As Appropriate	As Appropriate	1
Allergen Immunotherapy - multiple injections	95117					1

COMMENTS:
1) Code quantity of 1 for multiple injections, allergen immunotherapy
2) Allergy injections are an elective service given at the discretion of the Medical Director.
3) Refer to Section 1: Modifiers for reporting injections with other office visit, preventive visits, and/or counseling codes.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

BLOOD PRESSURE CHECK ONLY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Recheck Visit	3734	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	6	BP Elevated Without Hypertension	R03.0	1
Blood Pressure Check	5002			Hypertension	I10	
BP - Record in multipurpose field for tracking	BP					

COMMENTS:						
1) Evaluation and management of hypertension should be coded as Office Visit.						
TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

BLOOD PRESSURE CHECK WITH COUNSELING

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Pay 6 or Private Ins (5XXX) or TennCare (AXXX)	Other Specified Counseling	Z71.89	1
Blood Pressure Check	5002					
BP - Record in multipurpose field for tracking	BP					
COMMENTS:						
1) Evaluation and management of hypertension should be coded as Other Office Visit.						
2) Refer to Section 1: Modifiers for reporting counseling with other office visit codes.						
TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

BLOOD WORK ONLY

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Recheck Visit	3734	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	6	As Appropriate	As Appropriate	1
Venipuncture	36415		Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6			
Ear, finger or heel stick	36416					
Labs	See Lab Section					
Lab Handling	99000					
TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

Comments:

1) 3734 is used to assess status of previously existing condition of established patient. Nurse Assistant should use venipuncture code 36415 or ear/finger/heel stick 36416 when drawing blood and Nurse only should use Recheck code 3734.

SECTION 10: CLINIC VISITS

PROBLEM VISIT

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Therapeutic Office Visit:		CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	As Appropriate	As Appropriate	1
New Patient	99201 - 99205					
Established Patient	99211 - 99215					
Venipuncture, if done	36415					
Labs	See Lab Section					
Lab Handling	99000					
Pharmacy	Use Pharmacy Module					
Injection Administration	96372					

COMMENTS:

1) Code 96372 may be coded with other office visits (99201-99205 and 99212-99215). Modifier 25 would be added to these office visit codes if billed with 96372. Refer to Section 1: Modifiers for additional guidance.

2) If a 99211 level of service has been completed with an injection (96372), report 99211NC and 96372.

3) If a patient receives a venipuncture (36415) in conjunction to a 99211 visit, a 25 modifier should be attached to the 99211 code. This rule only applies to 99211 E/M code.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 10: CLINIC VISITS

ANNUAL WELLNESS EXAMS

Date: 11/1/2015; Rev 07/06/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient:						
Infant or Child (<1year)	99381	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins. (5XXX) * or TennCare (AXXX) or Private Pay 6	Encounter for Health Exam	<8 days - Z00.110	1
1 through 4 years	99382				8 to 28 days - Z00.111	
5 through 11 years	99383				>28 days - 17 yrs, abnormal - Z00.121	
12 through 17 years	99384				>28 days - 17 yrs, normal - Z00.129	
18 through 39 years	99385				Adult abnormal - Z00.01	
40 through 64 years	99386				Adult normal - Z00.00	
65 Years and Older	99387					
Established Patient:						
Infant or Child (<1year)	99391					
1 through 4 years	99392					
5 through 11 years	99393					
12 through 17 years	99394					
18 through 39 years	99395					
40 through 64 years	99396					
65 Years and Older	99397					
Additional Components Performed						
Developmental Screen (PEDS and M-CHAT)	96110			Enc. - Screening developmental disorder	Z00.110-Z00.129 as appropriate	Qty = 2 if both performed
Behavioral Screen (PSC-17, Y-PSC, Adolescent)	96127			Enc. - Screening for Other Disorder	Z00.00-Z00.129 as appropriate; if abnormal also report R46.89	Qty= 1 (If more than one behavioral screen is completed, code additional 96127 with 59 modifier attached on the second line.)
Hearing Screen	92551			Hearing	Z00.00-Z00.129 as appropriate; if abnormal also report R94.120	1
Vision Screen	99173			Vision	Z00.00-Z00.129 as appropriate; if abnormal also report R94.118	

SECTION 10: CLINIC VISITS

ANNUAL WELLNESS EXAMS, cont'd

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Lead Screen, if done	83655 or 83655IH (in house)	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins. (5XXX)* or TennCare (AXXX) or Private Pay 6	Lead Screening	Z13.88	1
Finger or heel stick	36416			Labs	As Appropriate	
Venipuncture	36415					
Lab Handling	99000					
Immunizations	See Vaccines/Immunizations Section			Encounter for Immunization	Z23	
Fluoride Varnish	D1203N			Encounter for prophylactic fluoride administration	Z29.3	
Pharmacy Issued	Use Pharmacy Module					

COMMENTS:

1) For Medicare Patient Initial Preventive Physical Exam (IPPE) and Annual Wellness Visit (AWV) - See FQHC Medicare Section.

2) Patients with private insurance should receive written prescription for any medications needed. When written prescription is not possible, medications issued from TDH drug room should be coded to Payer 5. This includes injectable drugs (Depo).

3) * Bill private insurance first and TennCare second, if applicable.

4) When performing a preventive exam and a 'significant' problem is found:

Code the preventive visit (99381 - 99397) AND

Code an other office visit (99201 - 99215) for the problem

Add modifier 25 to the other office visit

5) When an other office visit service is provided on the same day as a vaccine, injection, or other non-E/M service, add modifier 25 to the other office visit. Refer to Section 1: Modifiers for additional guidance.

6) **If more than one behavioral screen is completed, code additional 96127 with 59 modifier attached on the second line.

7) A 25 modifier needs to be attached to the Preventive Visit Code (99381-99395) if a vision screening is completed during visit.

SECTION 10: CLINIC VISITS

PHYSICALS BY SPECIAL AGREEMENT CONTRACTS ONLY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Special Physicals	3678	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	As Appropriate	According to Exam Type	As Appropriate	1
Venipuncture	36415					
Ear, Finger or Heel Stick	36416					
Labs Completed	See Lab Section					
(Includes routine labs. Adjust off lab procedures included in price of contract.						

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

PHYSICALS - NON-CONTRACT (SCHOOL, CAMP, Etc.)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Preventive Visit - Age Specific		CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	As Appropriate	According to Exam Type	As Appropriate	1
New Patient	99381 - 99387					
Established Patient	99391 - 99397					
Venipuncture	36415					
Ear, Finger or Heel Stick	36416					
Labs	See Lab Section					
Lab Handling (outside labs)	99000					
* School Physical	SCHOOL		6			

COMMENTS:

1) * SCHOOL - Use this code instead of an Office Visit for private pay patients with no third party insurance who need a physical to get into school.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

PEDICULOSIS - INITIAL VISIT

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Therapeutic Office Visit:		CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins. (5XXX) or TennCare (AXXX) or Private Pay 6	Pediculosis - head louse infestation	B85.0	1
New Patient	99201 - 99205			Contact with and exposure to pediculosis	Z20.7	
Established Patient	99211 - 99215					
Pharmacy	Use Pharmacy Module					

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

PEDICULOSIS - SUBSEQUENT VISIT

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Recheck OR	3734	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	6	Pediculosis - head louse infestation	B85.0	1
Office Visit - Established Patient	99211 - 99215		Private Ins. (5XXX) or TennCare (AXXX) or Private Pay 6	Contact with and exposure to pediculosis	Z20.7	

COMMENTS:

1) Code office visit if treatment or prescription is necessary.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 10: CLINIC VISITS

FQHC MEDICARE MEDICAL VISITS

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient Medical Visit	G0466	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	S	As Appropriate	As Appropriate	1
Est. Patient Medical Visit	G0467					
Preventive IPPE or AWV	G0468					
Labs	See Lab Section					
Lab Handling	99000					
Venipuncture	36415					
Pharmacy	Use Pharmacy Module					

COMMENTS:

1) Claims with FQHC Medicare G codes (G0466, G0467, G0468) must contain a qualifying service to qualify for reimbursement from Medicare. Qualifying Services are:
G0466: 99201 - 99205, G0108, 97802, G0101-2, G0442-5 and G0447, Q0091
G0467: 99212-99215, G0108, 97802-97803, G0270, G0101-5 and G0447, Q0091
G0468: G0402, G0438-9

2) Only physicians and Nurse Practitioners should code FQHC G codes. FQHC G codes should be submitted on the encounter. All other services provided should be included on the encounter in addition to the FQHC G codes.

3) Nurse only encounters will not contain FQHC G codes but should be coded to payor 2 (Ex - lab visits).

4) Modifier 59 is attestation that the patient, after leaving the health department, suffered illness or injury that required additional diagnosis or treatment the same day. The subsequent FQHC G code should have the 59 modifier added.

SECTION 10: CLINIC VISITS

PKU, T4, HEMOGLOBINOPATHY and SIMILAR TESTS - INITIAL or REPEAT

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Recheck	3734	CH	6	Encounter for screening for diseases of blood	Z13.0	1
Sickle Cell	85660					
Ear, Finger or Heel Stick	36416NB					
Labs	See Lab Section					
Lab Handling	99000NB					
Newborn Screen	NEWB			Encounter for screening for other metabolic disorders	Z13.228	
Newborn Screen Ear, Finger or Heel Stick	36416NB					
Newborn Screen Lab Handling	99000NB					

COMMENTS:
1) Do not code Office Visit.
2) Newborn screen codes should be used for all initial or repeat Newborn Screening tests and will not generate a charge for the patient.
3) There is no charge for sickle cell 85660.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

PREVENTIVE COUNSELING ONLY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	As Appropriate	As Appropriate	As Appropriate	As Appropriate	1

COMMENTS:

1) Separate encounter for purpose of promoting health and/or preventing illness or injury/risk factor reduction.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 10: CLINIC VISITS

RECHECK VISIT

Date: 11/1/2015; Rev 06/20/16

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Recheck	3734	As Appropriate	6	As Appropriate	As Appropriate	1

COMMENTS:

1) Visit to confirm treatment/service initiated at previous visit was successful, or to complete recent previous visit (i.e., draw fasting blood, give Depo when menses begin).

2) 3734 is used to assess status of previously existing condition of established patient. Nurse Assistant should use venipuncture code 36415 when drawing blood and Nurse should use Recheck code 3734.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 10: CLINIC VISITS

TETANUS - WOUND MANAGEMENT

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient	99201 - 99205	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	As Appropriate	As Appropriate	
Established Patient	99211-99215					
Vaccine Administration	See Vaccine Administration Code List			Encounter for Immunization	Z23	
Vaccine - Federal	113 (Td)					
	115 (Tdap)					
	20 (DTaP)					
	106 (DTaP)					
Vaccine - State	TD					
	TD2					
	DTA					

COMMENTS:

1) When an other office visit (99201-99205 and 99212-99215) service is provided on the same day as a vaccine, add modifier 25 to the other office visit to explain that both services were provided. Refer to Section 1: Modifiers for additional guidance.

2) If a 99211 level of service has been completed with vaccine administration, report 99211NC and appropriate vaccine administration code.

3) For Tetanus Vaccine Only, see Vaccines/Immunizations Section 9.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 10: CLINIC VISITS

EMPLOYEE HEALTH

DEPARTMENT of HEALTH EMPLOYEES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
TB Skin Test	86580	EH	6	TB Skin Test Negative	Z11.1	1
				TB Skin Test Positive	R76.11	
TB Skin Test Read	3734	EH	6	As Appropriate		
X-Ray if indicated						
Prophylactic Treatment for LTBI New Converter						
Hepatitis B Vaccine	HBB			Encounter for Immunization	Z23	
MMR Vaccine	MMA					
Varicella Vaccine	VVC					
HBIG Vaccine	HIG					
Tetanus, Diphtheria, Acellular Pertussis (Tdap) Vaccine	TD2					
Tetanus Vaccine	TD					
Vaccine Administration	90471					

COMMENTS:

1) State purchased vaccine should be used for Employee Health.

2) All other services provided to health department employees will follow CHS Policy, will be coded to Program Codes MH,CH OR WH and billed to the appropriate party.

3) For antibody testing and HIV exposure prophylaxis, refer to Infection Control Manual.

SECTION 10: CLINIC VISITS

TOPICAL APPLICATON of DENTAL FLUORIDE VARNISH

Date: 11/1/2015; Rev 10/01/2016

Non-TennCare Patients and/or Patients greater than 5 years of age

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Fluoride Varnish	D1203N	CH	6	Encounter for prophylactic fluoride administration	Z29.3	1
Screening (oral health assessment)	D0190N			Encounter for screening dental disorders	Z13.84	

TennCare Patients 6 month through 5 years of age

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Fluoride Varnish	D1203N	CH	ADDS	Encounter for prophylactic fluoride administration	Z29.3	1
Screening (oral health assessment)	D0190N			Encounter for screening dental disorders	Z13.84	

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

Comments:

1) TennCare will reimburse for fluoride varnish for children 6 months through 5 years of age. The fluoride varnish and oral screening must be coded to receive reimbursement. Payer for these patients must be changed to ADDS.

SECTION 10: CLINIC VISITS

CERUMEN REMOVAL

Date: 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Removal of impacted cerumen using irrigation/lavage-unilateral	69209	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Impacted Cerumen - Right Ear	H61.21	1
Removal of impacted cerumen using instrumentation - unilateral	69210			Impacted Cerumen - Left Ear	H61.22	
				Impacted Cerumen - Bilateral	H61.23	

COMMENTS:

1) Do not code an E/M when removing impacted cerumen unless the patient was seen in office for other (non-related) conditions. If other (non-related) conditions with additional diagnoses to support an office visit are provided, a 25 Modifier should be added to the E/M code. Refer to Section 1: Modifiers for additional guidance.

2) If cerumen removal is completed in bilateral ears, please use modifier 50.

3) Do not report 69209 in conjunction with 69210 when performed on same ear.

SECTION 10: CLINIC VISITS

PROLONGED CLINICAL SERVICES

Date: 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Prolonged evaluation and management (beyond the typical service time of the primary procedure) in the office setting requiring direct patient contact beyond the usual service; first hour	99354	CH (Birth thru 20) or MH (21 and over) or WH (21 and over)	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	As Appropriate	As Appropriate	1
Prolonged evaluation and management (beyond the typical service time of the primary procedure) in the office requiring direct patient contact beyond the usual service; each additional 30 minutes	99355					

COMMENTS:

1) List separately in addition to code for Other Office Visit codes (99201-99215), or Counseling codes (99241-99245).

SECTION 11: OTHER SERVICES

Date: 11/1/2015

SECTION 11: OTHER SERVICES

MASS SCREENING/EDUCATION - NO CHARGE

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service (Audit, Contact, Mass Screening/Mass Education		As Appropriate	6	As Appropriate OR Other Specified Counseling	Z71.89	#30 Min. Increments
"C" Registration (Community Service) - NO Medical Record	78059			Dietary Counseling	Z71.3	
"L" Registration (Long) - Has Medical Record	3560					

COMMENTS:

1) If multiple providers see the same patient during mass screening, only the highest level provider codes the encounter. If each provider does individual screening, each provider should code on the encounter showing time in 30 minute increments. If multiple presenters provide mass education, each provider should code his/her specific presentation time. If multiple providers share responsibility for mass education but work separately to provide a service (i.e., CPR class divided in groups), each provider should code a line on the encounter showing time spent in 30 minute increments in the QTY column and number of people trained in margin.

2) 78059 and 3560 have same description and should be coded in 30 minute increments in QTY column on encounter form. Number of participants should be written on the encounter. Keyer of encounter should enter number of participants on EN screen in MILE column. If the same service is provided more than one time per day, the total time spent should be entered in QTY column and Grand Total of participants served should be entered on encounter and will be keyed in the MILE column. If at least one group participant is female, use WH Program Code.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 11: OTHER SERVICES

BABY and ME

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Prenatal Counseling	99401BA	CH (Birth thru 20) or WH (21 and over)	6	Administrative Purpose	Z02.9	1
Post Delivery CO2 Testing and Diaper Voucher Issuance (Mother)	BABYPST					
Post Delivery CO2 Testing and Diaper Voucher Issuance (Partner)	BABYPTR					

COMMENTS:

1) The following diagnosis codes related to tobacco use can be assigned if users wish to record a more specific diagnosis:
Z71.6 - Tobacco Abuse Counseling (report additional nicotine dependence code F17.-)
F17.210 - Nicotine dependence, cigarettes, uncomplicated
F17.211 - Nicotine dependence, cigarettes, in remission
F17.213 - Nicotine dependence, cigarettes, with withdrawal
Z72.0 - Tobacco use, unspecified
Z77.22 - Contact with/exposure to second hand tobacco use; passive smoking
Z87.891 - History of tobacco dependence

SECTION 12: BREASTFEEDING

OVERVIEW

Date: 11/1/2015

Code 99350H - Initial Home Visit Includes:
Complete breastfeeding assessment in patient home as related to documented problem or medical diagnosis
Development of Care Plan
Provision of breastfeeding counseling
Any necessary referrals
Documentation in medical record

Code 99349H - Follow up Home Visit Includes:
Update to previous breastfeeding assessment in patient home
Review and update of the Care Plan
Counseling
Documentation in medical record

Code 99348A - Attempted Home Visit:
Unsuccessful home visit attempt. Worker traveled to the participant's residence but was not able to complete the home visit.

Code 78059 - (No medical record) and Code 3560 (has medical record) Field Service:
Provide mass education at health fairs, presentations in the community or workshops for other agencies about the WIC program and its benefits.

Code 1009 - Breastfeeding Peer Counseling Activity
Document all Breastfeeding Peer Counseling activities (individual counseling, breastfeeding survey, breast pump issuance, home visit, hospital visit, or group counseling/classes) done by Breastfeeding Peer Counselor funded with WIC Breastfeeding Peer Counseling Grant. Peer counseling activities must be documented in the patient medical record. Counseling activities may be face-to-face, on-site, off-site or by telephone.

SECTION 12: BREASTFEEDING

COUNSELING

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	BF	6	Dietary Counseling	Z71.3	1

COMMENTS:						
1) Counseling must be documented in the patient medical record.						
2) Counseling may be face-to-face, on-site or off-site.						
3) Counseling must be provided by a health professional trained to do Breastfeeding counseling (i.e., Breastfeeding Coordinator, Nutritionist, Registered Nurse, Nutrition Educator)						
TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 12: BREASTFEEDING

BREAST PUMP ISSUANCE

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Electric Breast Pump Issuance	10708	BF	6	Encounter for care and examination of lactating mother	Z39.1	1
Manual Breast Pump Issuance	10708M					

COMMENTS:
1) Code as "stand alone" procedure when breast pump issuance is only service provided.
2) Do not code counseling.
3) If pump is issued during another type visit, add code **10708** or **10708M** to encounter using **BF** program code.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 12: BREASTFEEDING

BREASTFEEDING INTERVIEW (SURVEY)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Breastfeeding Survey and Counseling	99401 - 99404	BF	6	Dietary Counseling	Z71.3	1

COMMENTS:
1) Face-to-face visit with patient to do breastfeeding survey and determine needs.
2) Provider should be a Registered Nurse, Nutrition Educator, Nutritionist, Breastfeeding Coordinator.
3) May be coded individually or in conjunction with other services.
4) When extensive breastfeeding counseling is done during the same visit that the survey is completed, the appropriate level of counseling code should be used. Example: Late-term prenatal patient who is planning to breastfeed receives counseling to address concerns uncovered in the survey and in-depth counseling on mechanics of breastfeeding.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 12: BREASTFEEDING

BREASTFEEDING HOME VISITS

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Home Visit - Initial Visit	99350H	BF	6	Dietary Counseling	Z71.3	1
Home Visit - Follow-Up Visit	99349H			Encounter for care and examination of lactating mother	Z39.1	
Attempted Home Visit	99348A			Administrative Purpose	Z02.9	

COMMENTS:
1) Change visit setting to reflect off-site location of visit.
2) Provider should be a Registered Nurse, Nutrition Educator, Nutritionist, Breastfeeding Coordinator.
3) Home visits for non-WIC patients should be referred to HUGS Program.

	99401T	TO	6	Administrative Purpose	Z02.9	1
TennCare Advocacy	99402T					
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 12: BREASTFEEDING

BREASTFEEDING GROUP EDUCATION (ON-SITE)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Group Counseling (30 minutes)	99411	BF	6	Dietary Counseling	Z71.3	1
Group Counseling (60 minutes)	99412					

COMMENTS:

1) Establish the appropriate encounter (group or individual) for each educational session and code the appropriate counseling code.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 12: BREASTFEEDING

BREASTFEEDING GROUP EDUCATION (OFF-SITE)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE
Field Service (Audit, Contact/Mass Screening, Mass Education		BF	6	Dietary Counseling	Z71.3
"C" Registration (Community Service) has NO medical record	78059				

COMMENTS:

1) For off-site group presentations use code 78059 in 30 minute increments in QTY column.

2) Write number of participants in group on the encounter form. Number of participants to be keyed in MILES column.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 12: BREASTFEEDING

BREASTFEEDING PEER COUNSELING

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Peer Counseling	1009	BF	6	Administrative Purpose	Z02.9	1

COMMENTS:

1) Breastfeeding Peer Counseling activities should be documented in patient medical record.

2) Record disposition code on the encounter to identify which Breastfeeding Peer Counseling activity has been completed.

3) Enter the disposition code in the disposition field on Encounter screen.

4) Counseling activities may be face-to-face, on-site, off-site, or by telephone.

5) 1009 code should only be used by Breastfeeding Peer Counselor funded by the WIC Breastfeeding Peer Counseling Grant. No other providers should use 1009 code.

DISPOSITION CODE	DESCRIPTION
FS	Breastfeeding Survey
IC	Individual Counseling
BP	Breast Pump Issuance
HV	Home Visit or Hospital Visit
GC	Group Counseling

SECTION 13: FAMILY PLANNING

OVERVIEW

Date: 11/1/2015; Rev 06/20/2016

3734 - Recheck:

Assess status of previously existing condition of established patient. Nurse should use Recheck code 3734, Nurse Assistant should not bill for recheck.

Coding Venipuncture with 99211 Visit:

If a patient receives a venipuncture (36415) in conjunction to a 99211 visit, a 25 modifier should be attached to the 99211 code. This rule only applies to 99211 E/M code. Refer to Section 1: Modifier for additional guidance.

SECTION 13: FAMILY PLANNING

COMMON FAMILY PLANNING DIAGNOSIS CODES

Date: 11/1/2015; Rev 10/01/2016

Diagnosis Code	Description
Z00.00	Encounter for general adult medical examination, normal - male
Z00.01	Encounter for general adult medical examination, abnormal - male
Z30.09	General Counseling on Contraception
Z30.011	Encounter for Initial Prescription of Contraceptive Pills
Z30.012	Encounter for Prescription of Emergency Contraception
Z30.013	Encounter for Initial Prescription of Injectable Contraceptive
Z30.014	Encounter for Initial Prescription of Intrauterine Contraceptive Device
Z30.015	Encounter for Initial Prescription of Vaginal Ring Hormonal Contraceptive
Z30.016	Encounter for Initial Prescription of Transdermal Patch Hormonal Contraceptive Device
Z30.017	Encounter for Initial Prescription of Implantable Subdermal Contraceptive
Z30.018	Encounter for Initial Prescription of Other Contraceptives
Z30.41	Encounter for Surveillance of Contraceptive Pills
Z30.42	Encounter for Surveillance of Injectable Contraceptive
Z30.430	Encounter for Insertion of Intrauterine Contraceptive Device
Z30.431	Encounter for Routine Checking of Intrauterine Contraceptive Device
Z30.432	Encounter for Removal of Intrauterine Contraceptive Device
Z30.44	Encounter for Surveillance of Vaginal Ring Hormonal Contraceptive
Z30.45	Encounter for Surveillance of Transdermal Patch Hormonal Contraceptive Device
Z30.46	Encounter for Surveillance of Implantable Subdermal Contraceptive
Z30.49	Encounter for Surveillance of Other Contraceptives
Z30.433	Encounter for Removal and Reinsertion of Intrauterine Contraceptive Device
Z32.01	Encounter for Pregnancy Test (Positive Result)
Z32.02	Encounter for Pregnancy Test (Negative Result)
Z71.89	Other Specified Counseling
Z20.2	Contact with and (suspected) exposure to infections with predominantly sexual mode of transmission
Z11.3	Encounter for Screening for infections with a predominantly sexual mode of transmission
Z11.51	Screening for Human Papillomavirus
Z11.4	Encounter for Screening for HIV
Z01.419	Encounter for gynecological exam - normal
Z01.411	Encounter for gynecological exam with abnormal findings
Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear
Z12.4	Encounter for screening for malignant neoplasm of cervix
Z12.39	Encounter for other screening for malignant neoplasm of breast
B37.3	Candidiasis of vulva and vagina
N76.0	Acute vaginitis
A59.01	Trichomoniasis vulvovaginitis
Z98.51	Tubal ligation status
Z98.52	Vasectomy Status
Z31.69	Encounter for other general counseling and advice on procreation
Z31.61	Procreative counseling and advice using natural family planning

COMMENT: Refer to ICD10 Diagnosis Code Manual for Other Appropriate Diagnosis Codes

SECTION 13: FAMILY PLANNING

COUNSELING ONLY - NO EXAMINATION

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	See Common Diagnosis List	As Appropriate	1

COMMENTS:						
1) Do not code Counseling Visit for Abnormal Pap Smear follow up when a repeat pap smear is collected.						
2) Use Counseling code only for counseling and referral.						
TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 13: FAMILY PLANNING

INITIAL OR ANNUAL COMPREHENSIVE PREVENTIVE EXAMINATION VISIT FOR MALE OR FEMALE

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Preventive Visit, Age Specific		FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	See Common Diagnosis List	See Common Diagnosis List	1
New Patient	99383 - 99386					
Established Patient	99393 - 99396					
Other Office Visit						
New Patient	99201-99205					
Established Patient	99211-99215					
Additional Services						
Labs	See Lab Section					
Lab Handling	99000					
Pregnancy Test	81025					
Pharmacy Issued	Use Pharmacy Module					
Administration, Injectable Drug (Not Vaccines)	96372					
Liquid based Pap Smear	88142 or *88142NC					
HPV Test	87624					
GenProbe	Order in LOE	ST				
Wet Prep	87210	CH (birth thru 20) or WH (21 and over) or ST				

COMMENTS:

1) Mark "Y" for "Breast Exam Referral" on Family Planning Supplemental when breast exam result requires referral.

2) Pap smears, pregnancy test, hemoglobin (if indicated) and HPV are the only labs assigned to FP. All others should be coded to appropriate program.

3) Use Z01.419 for female annual physical exam, normal or Z01.411 for female annual physical exam, abnormal. Use Z00.00 for male annual physical exam, normal or Z00.01 for male annual physical exam, abnormal.

4) Refer to Section 1: Modifiers for guidance on reporting vaccines, injections, and venipunctures with other office visits, preventive visits, and/or counseling codes.

5) *88142NC should only be used if patient is required to return if the sample is insufficient for testing.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 13: FAMILY PLANNING

QUICK START VISIT

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Encounter for initial prescription of pills	Z30.011	1
Pregnancy Test	81025			Encounter for pregnancy test, neg.	Z32.02	
				Encounter for pregnancy test, pos.	Z32.01	
Administration, inj. drug	96372			Encounter for initial prescription of injectable contraceptive	Z30.013	
Pharmacy Issued	Use Pharmacy Module			Encounter for prescription of emergency contraception	Z30.012	
				Encounter for initial prescription of vaginal ring hormonal contraceptive	Z30.015	
				Encounter for initial prescription of transdermal patch hormonal contraceptive device	Z30.016	
				Encounter for initial prescription of other contraceptives	Z30.018	
Labs	See Lab Section	FP or ST				
Lab Handling	99000			Encounter for screening for infections with sexual mode of transmission	Z11.3	
GenProbe	Order on LOE	ST				

COMMENTS:

1) If medical problem is treated during counseling visit, appropriate other office visit code should be used instead of counseling.

2) Refer to Section 1: Refer to Section 1: Modifiers for guidance on reporting vaccines, injections, and venipunctures with other office visits, preventive visits, and/or counseling codes.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 13: FAMILY PLANNING

SUPPLY VISIT

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Encounter for surveillance of contraceptive pills	Z30.41	1
				Encounter for surveillance of other contraceptives	Z30.49	
				Encounter for surveillance prescription of vaginal ring hormonal contraceptive	Z30.44	
Pregnancy Test	81025			Encounter for surveillance prescription of transdermal patch hormonal contraceptive device	Z30.45	
				Encounter for pregnancy test negative	Z32.02	
Pharmacy Issued	Use Pharmacy Module			Encounter for pregnancy test positive	Z32.01	
Administration, injectable drug	96372			Encounter for surveillance of injectable contraceptive	Z30.42	
Labs	See Lab Section	FP or ST		Encounter for screening for sexual mode of transmission	Z11.3	
Lab Handling	99000					
GenProbe	Order on LOE	ST				

COMMENTS:

1) Refer to Section 1: Modifiers for guidance on reporting vaccines, injections, and venipunctures with other office visits, preventive visits, and/or counseling codes.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 13: FAMILY PLANNING

GYNECOLOGICAL EXAM OR FOLLOW UP VISIT (INCLUDES REPEAT PAP SMEAR OR HPV OR STERILIZATION POST OP)

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Other Office Visit	99201 - 99205 99211 - 99215	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	See Common Diagnosis List	See Common Diagnosis List	1
Liquid based Pap Smear	88142 or *88142NC					
HPV Test	87624					
Labs	See Lab Section					
Lab Handling	99000					
Pharmacy Issued	Use Pharmacy Module	FP				

COMMENTS:

1) Mark "Y" for "Breast Exam Referral" on Family Planning Supplemental when breast exam result requires referral.

2) For Depo User - if woman chooses to wait for menses to occur versus the Quick Start method and returns for initial Depo injection, code Recheck 3734 and injection 96372.

3) *88142NC should only be used if patient is required to return if the sample is insufficient for testing.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 13: FAMILY PLANNING

IMPLANT INSERTION/REMOVAL/MAINTENANCE

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401-99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	See Common Diagnosis List	See Common Diagnosis List	1
Implant Insertion	11981			Encounter for initial prescription of implantable subdermal contraceptive	Z30.017	
Nexplanon	NEXPLAN - Use Pharmacy Module					
Nexplanon (Free) **	NEXPLAF					
Labs	See Lab Section					
Lab Handling	99000					
Implant Removal and Reinsertion *	11983			Encounter for surveillance of implantable subdermal contraceptive	Z30.46	
Implant Removal	11982					
Pharmacy Issued	Use Pharmacy Module					

COMMENTS:
1) * For new patient - code both surveillance and initial prescription.
2) ** Use for Metro Health Departments and Special Patient Assistance Programs only.
3) Counseling should only be reported if medically necessary and counseling expands beyond the normal procedure/device education.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 13: FAMILY PLANNING

IUC INSERTION/REMOVAL/ROUTINE CHECK

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401-99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Initial prescription of IUC without insertion *	Z30.014	1
Labs/Lab Handling	See Lab Section			IUC Insertion only *	Z30.430	
IUC Insertion	58300			Routine Checking of IUC	Z30.431	
IUC Removal	58301			Removal of IUC	Z30.432	
IUC Paragard	IUDP			Removal and reinsertion of IUC	Z30.433	
IUC Mirena	IUDM					
IUC Skyla	SKYLA					
IUC Liletta	LILETTA					
IUC Paragard (Free) **	IUDPF					
IUC Mirena (Free) **	IUDMF					
IUC Liletta (Free) **	LILETAF					
Pharmacy Issued	Use Pharmacy Module					

COMMENTS:

1) Record issuing of IUC in Pharmacy Module.

2) If medical problem is treated during counseling visit, appropriate other office visit code with Modifier 25 should be used instead of counseling code. Refer to Section 1: Modifiers for additional guidance.

3) *Z30.014 should only be used if a patient has their first consultation for the prescription of an IUC, but there was no insertion. Z30.430 should be used if the patient receives the prescription and insertion on the same date of service.

4) **Use for Metro Health Departments and for special patient assistant programs only.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 13: FAMILY PLANNING

PREGNANCY TEST

Date: 11/1/2015; Rev 07/06/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401-99404	FP or CH (birth thru 20) or WH (21 and over)	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Pregnancy Test Positive	Z32.01	1
Pregnancy Test	81025			Pregnancy Test Negative	Z32.02	
				General counseling/advice on procreation	Z31.69	
				Initiate Contraceptive Method	As Appropriate	
				Procreative counseling and advice on procreation using natural family planning	Z31.61	
Labs	See Lab Section					
Lab Handling	99000					
Pharmacy	Use Pharmacy Module					
GenProbe	Order on LOE	ST		Screening STD	Z11.3	

COMMENTS:

1) If pregnancy test is positive and patient is uninsured, see TennCare Prenatal Presumptive Eligibility.

2) Most pregnancy tests are coded to FP; code to CH or WH, as appropriate.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 13: FAMILY PLANNING

EMERGENCY CONTRACEPTIVE PILLS

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401-99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Encounter for emergency contraception	Z30.012	1
Pregnancy Test (if indicated)	81025			Pregnancy Test Negative	Z32.02	
				Pregnancy Test Positive	Z32.01	
Pharmacy	Use Pharmacy Module			Initiate Contraceptive Method	As Appropriate	
Labs	See Lab Section	FP or CH (birth thru 20) or WH (21 and over)				
Lab Handling	99000					
GenProbe	Order on LOE	ST		Screening STD	Z11.3	

COMMENTS:
1) If medical problem is treated during counseling visit, use appropriate other office visit code.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 13: FAMILY PLANNING

COUNSELING AND CONSENT FOR STERILIZATION

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401-99404	FP	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Encounter for other general counseling and advice on contraception	Z30.09	1

COMMENTS:
1) Consent for sterilization must be signed for a minimum of 30 days prior to procedure. Consent expires 180 days after it is signed.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 13: EPSDT Done in Conjunction with Family Planning

TENNCARE

Date: 06/20/2016; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient:						
5 through 11 years	99383	FP	TennCare (AXXX) or Private Ins (5XXX) * or DCS Custodial (5DCS)	Encounter for Health Exam	>28 days-17 yrs, abnormal-Z00.121	1
12 through 17 years	99384				>28 days- 17 yrs, normal - Z00.129	
18 through 20 years	99385				Adult abnormal - Z00.01	
					Adult normal - Z00.00	
Established Patient:						
5 through 11 years	99393				See common diagnosis list for family planning diagnosis codes	
12 through 17 years	99394					
18 through 20 years	99395					
Additional Components Performed, As Appropriate						
Behavioral Screen (PSC-17, Y-PSC, Adolescent)	96127	EP	TennCare (AXXX) or Private Ins (5XXX) * or DCS Custodial (5DCS)	Enc. - Screening for Other Disorder	Z00.00-Z00.129 as appropriate; if abnormal also report R46.89	1**
Hearing Screen	92551			Hearing	Z00.00-Z00.129 as appropriate; if abnormal also report R94.120	
Vision Screen	99173			Vision	Z00.00-Z00.129 as appropriate; if abnormal also report R94.118	
Immunizations	See Vaccines/Immunizations Section			Encounter for Immunization	Z23	
Venipuncture	36415			Labs	As Appropriate	
Finger Stick	36416					
Lab Handling	99000					
Fluoride Varnish	D1203N			Encounter for prophylactic fluoride administration	Z29.3	
Oral Screening	D0190N			Encounter for screening for dental disorders	Z13.84	

SECTION 13: EPSDT Done in Conjunction with Family Planning

TENNCARE

Date: 06/20/2016; Rev; 10/01/2016

COMMENTS:

1) EPSDT includes:

a. Comprehensive health and development history

b. Comprehensive unclothed physical exam

c. Appropriate immunizations

d. Appropriate laboratory tests

e. Health education

f. Hearing assessment

g. Vision assessment

2) * Bill private insurance first and TennCare second, if applicable.

3) Vision Screen (99173) - Physician, nurse or nursing assistant screens a child during an EPSDT visit for an OBJECTIVE vision screen using a Snellen, Snellen ABC, Tumbling E Chart, Titmus, photo screener or Sure Sight machine. A 25 modifier needs to be attached to the Preventive Visit Code (99381-99395) if a vision screening is completed during visit.

4) Hearing Screen (92551) - Physician, nurse or nursing assistant screens a child during an EPSDT visit for an OBJECTIVE hearing screen using an audioscope, Tetratone II, or an audiometer.

5) Behavioral Screen (96127) -Code 96127 in addition to the EPSDT exam code when the PSC-17, Y-PSC or Adolescent Developmental Behavioral Questionnaire is performed. **If more than one behavioral screen is completed, code additional 96127 with 59 modifier attached.

6) If applicable, the BMI diagnosis code may be reported for ages 12 through 20 years only.

7) An assessment is made when a child is present in clinic (or during a home visit, if appropriate) to determine if the child is due for the EPSDT screen according to the AAP Periodicity Schedule. If the child is present in clinic and due a screen, the child is offered a screen by the discipline that can conduct the screening. If the screening cannot be done that day, an appointment should be scheduled for a later date with the health department or with the child's Primary Care Physician (PCP).

8) EPSDT diagnosis codes must be coded first on the encounter form.

9) Refer to Section 1: Modifiers for guidance on reporting vaccines, injections, and venipunctures with other office visits, preventive visits, and/or counseling codes.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 14: BREAST AND CERVICAL CANCER SCREENING PROGRAM

EXPLANATION OF CODES

Date: 11/1/2015

99080A - New Enrollment for BCS includes (used one time only) - FOLLOW PROGRAM GUIDELINES
Verification of eligibility for the service
Completion of data entry for initial screening and lab results
Education about prevention services and particular screening methods that will be used
Authorization and referral for routine or diagnostic services according to protocol
Schedule with the referral provider
Follow-up to assure that patient kept referral appointment
Arrange transportation, if necessary
Arrange for interpreter services, if necessary

99080B - Referral Reports and Documentation (Requires documentation by nurse in patient record; can be used more than one time
Tracking and follow-up with referral provider to collect diagnostic information, results and recommendations
Enter case specific information into PTBMIS in the required data fields
Locate missing information prior to submission to Central Office
Contact patient about next steps for diagnosis and / or treatment
Schedule with provider
Assure that patient kept the referral / treatment appointment

SECTION 14: BREAST AND CERVICAL CANCER SCREENING PROGRAM

COMMON BREAST AND CERVICAL CANCER SCREENING DIAGNOSIS CODES

Date: 11/1/2015

Diagnosis Code	Diagnosis Description
Cervix	
R87.619	AGC cytology
R87.610	ASC-US cytology
R87.611	ASC-H cytology
R87.612	LSIL cytology
R87.613	HSIL cytology
R87.810	High risk HPV-DNA positive
R87.615	Unsatisfactory cytology
R87.616	Lacking transformation zone

Cervical Cytology	
Z01.42	Encounter for cervical pap smear to confirm findings of recent normal smear
Z08	Encounter for follow up examination after completed treatment for malignant neoplasm
Z12.4	Encounter for screening pap smear of cervix
Z85.41	History of cervical cancer

COMMENT: Refer to ICD10 Diagnosis Code Manual for Other Appropriate Diagnosis Codes

SECTION 14: BREAST AND CERVICAL CANCER SCREENING PROGRAM

SCREENING VISIT FOR BREAST AND CERVICAL CANCER

Date: 11/1/2015; Rev: 06/20/16

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
BCS Case Management		BCS	6	Administrative Purpose	Z02.9	1
New Enrollment for BCS	99080A*					
Referral Reports and Documentation	99080B**					
Other Office Visit				Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear	Z01.42	
New Patient	99386			Gyn. Exam, Normal	Z01.419	
Established Patient	99396			Gyn. Exam, Abnormal ***	Z01.411	
Liquid-based Pap Smear	88142 or 88142NC****			Screening pap smear of cervix	Z12.4	
HPV Test, high risk types	87624			Screening breast exam	Z12.39	
Lab Handling	99000			HPV Screening	Z11.51	

COMMENTS:

1) Women must meet Program eligibility guidelines. Screening services (including office visits and lab tests) are not covered by TBSCP for women under 40. Services for women under 40 must be coded to FP, WH or CH depending on age and/or eligibility of woman.

2) TBCSP covers services for eligible women including office visits, pap tests, colposcopies, mammograms and other diagnostic procedures listed on the reimbursement schedule.

3) TBCSP does not pay for treatment; women diagnosed with breast or cervical cancer are referred to TennCare for presumptive eligibility with full Medicaid coverage for 45 days. See TennCare Presumptive Eligibility Section for coding guidance. Other gynecological cancers are not covered by this Medicaid category.

4) * Use 99080A one time only.

5) ** 99080B requires documentation by the nurse in patient record and can be used up to three times within a 60 day period. See Program Guidelines.

6) *** Use additional code to identify abnormal findings.

7) Screening pap smear/HPV can be coded to BCS for patients age 40 - 64.

8) **** 88142NC should only be reported if patient is required to return if the sample is insufficient for testing.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 14: BREAST AND CERVICAL CANCER SCREENING PROGRAM

COLPOSCOPY DYSPLASIA VISIT

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Colposcopy Without Biopsy	57452	WH (21 and over) or BCS (must meet program guidelines)	6	See Common Diagnosis List	See Common Diagnosis List	1
Colposcopy With Biopsy and ECC	57454					
Colposcopy with ECC Only	57456					
Surgical pathology	88305					
Lab Handling	99000					

COMMENTS:

1) Bill TennCare, Medicare or private insurance first. If using Payor 6 code, women must meet general program eligibility guidelines for the BCS program (250% FPL, uninsured or underinsured and 40-64 years of age). The only exception is women under 40 who meet general eligibility guidelines and need cervical diagnostics following a screening Pap test result. These women should be enrolled in BCS for the required diagnostics only. If they need treatment for a pre-cancerous condition, the BCS program will enroll them in presumptive eligibility for TennCare.

2) An office visit cannot be coded on the same day as the colposcopy or on the day prior to the colposcopy.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 15: LEAD

OVERVIEW

Date: 11/1/2015; Rev 06/20/2016

The target population for the Lead Program is children under the age of six (6) and those determined to be high risk from their response to the risk assessment questionnaire.

Coding Venipuncture with 99211 Visit:
If a patient receives a venipuncture (36415) in conjunction to a 99211 visit, a 25 modifier should be attached to the 99211 code. This rule only applies to 99211 code. Refer to Section 1: Modifier for additional guidance.

SECTION 15: LEAD

BLOOD LEAD LEVEL TESTING ONLY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Lead	83655 or 83655IH (in house)	CH	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Encounter for Screening for disorder due to exposure to contaminants	Z13.88	1
Venipuncture	36415			Abnormal lead level in blood	R78.71	
Ear, Finger or Heel Stick	36416					
Labs	See Lab Section					
Lab Handling	99000					
Recheck	3734		6			

COMMENTS:
1) Code office visit or recheck, as appropriate.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 15: LEAD

COUNSELING VISIT ONLY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	CH	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	Encounter for Screening for disorder due to exposure to contaminants	Z13.88	1
TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 15: LEAD

NURSE HOME VISIT

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Home / Off-Site Visit	99350H 99348A	CH	6	Abnormal lead level in blood	R78.71	1
TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 16: CHILDREN'S SPECIAL SERVICES (CSS)

PROGRAM OVERVIEW

Date: 11/1/2015

FUNDING:
Children's Special Services (CSS) is the Federal Title V, MCH Block Grant, Children with Special Health Care Needs (CSHCN) Program offered by the Tennessee Department of Health.

SERVICE SITE:
The primary service site is in the home.

TARGET POPULATION:
Residents of Tennessee, birth to 21 years of age, who have a chronic illness or a medical condition which may affect the independent functioning of a child.

COMMENTS:
Refer to the CSS Policy and Procedure Manual.

SECTION 16: CHILDREN'S SPECIAL SERVICES (CSS)

DEFINITIONS (APPLICATIONS, FOLLOW-UP AND CARE COORDINATION)

Date: 11/1/2015

99350H - Home Visit

Initial, re-certification or other home visits. Home visits are conducted with the patient and/or family member at the participant residence or another site to assess the child and family need for appropriate services, coordination of medical and non-medical services, assistance with appeals for denied services, and providing education and information on diagnosis. Progress and problems are identified and documented per CSS program policy.

99348A - Attempted Home Visit

Unsuccessful home visit attempt. The worker traveled to the participant residence but was not able to complete the home visit. Use this code only one time per day per family.

99403 - Office Visit

Assigned worker meets with a family at the health department or regional office.

99404 - Other Contacts

Assigned worker makes a visit outside his/her office on behalf of the patient. Contacts should include: M-Team/IEP meetings with Department of Education, visits to SSI Office, DHS Office and other face-to-face contact outside the assigned worker office, including private physician office and other clinics “not CSS sponsored”.

1901 through 1910

Use appropriate case closure code. Record has been closed for any reason. May apply to a child that remains on CSS but is transferred to another TDH Region or County.

INTRANS - Initial Transition Plan

Initial transition plan has occurred with a CSS participant age 14 or older. Initial transition plans should be completed within 90 days after the participant’s 14th birthday. Initial transition plans for participants who are 14 years or older should be conducted within 90 days of the initial application signature date. Transition plans are required to ensure that all participants with special health care needs will receive services necessary to make appropriate transitions to adult health care, work and independence.

ANTRANS - Annual Transition Plan

Annual transition plan occurred with a CSS participant age 14 or older. Annual transition plans should be conducted within the 90-day time frame allowed for completion of the recertification application process.

SECTION 16: CHILDREN'S SPECIAL SERVICES (CSS)

APPLICATIONS, FOLLOW-UP, CARE COORDINATION

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Home Visit	99350H	CC	6	Other Specified Counseling OR	As Appropriate *	1
Attempted Home Visit	99348A			Code Assigned by Regional CSS Staff	As Appropriate	
Office Visit	99403					
Other Contacts	99404					
Initial Transition Plan	INTRANS					
Annual Transition Plan	ANTRANS					
CSS Child Had Annual Exam	ANEXAMY					
CSS Child Has Not Had Annual Exam	ANEXAMN					
Case Closure (CSS Case Closure Codes)	1901-1910					

COMMENTS:

1) PROGRAM CODE CC SHOULD BE USED ONLY BY CSS CARE COORDINATORS. If providers other than CSS Care Coordinators use Care Coordination procedure codes listed on this page, they must use program code CS (Children's Special Services).

2) * Diagnosis code should be specific CSS eligible Diagnosis Code.

SECTION 16: CHILDREN'S SPECIAL SERVICES (CSS)

MEDICAL SERVICES ENROLLMENT

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Certification >100% FPL (Federal Poverty Level)	1876A	CS	6	As Appropriate	As Appropriate	1
Certification <100% FPL (Federal Poverty Level	1876B					
Recertification > 100% FPL (Federal Poverty Level)	1878A					
Recertification <100% FPL (Federal Poverty Level	1878B					
SSI Eligible (Supplemental Security Income)	SSI					
Patient Has Private Insurance	PRIVINS					
Patient Has TennCare	TNCARE					
Patient Has No Insurance	NOINS					

COMMENTS:

1) Use appropriate Certification (1876A or 1876B) or Recertification (1878A or 1878B) AND the appropriate code for patient insurance status and/or SSI.

SECTION 16: CHILDREN'S SPECIAL SERVICES (CSS)

CLOSURES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Maximum Treatment	1901	CS	6	As Appropriate	As Appropriate	1
Over Age	1902					
Moved Out of State	1903					
Patient Expired	1904					
Not Diagnostically Eligible	1905					
Registration Error	1906					
Unable to Locate	1907					
Family Not Interested	1908					
Not Financially Eligible	1909					
Moved Within State	1910					

SECTION 17: NUTRITION - NON WIC

Date: 11/1/2015

SECTION 17: NUTRITION - Non-WIC

COUNSELING (REGISTERED DIETITIAN OR NURSE)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Individual Counseling		NU OR As Appropriate	Private Ins. (5XXX) or TennCare (AXXX) or Private Pay 6	Medical Diagnosis OR	As Appropriate	1
Preventive Medicine Counseling - 15 min.	99401			Dietary Counseling	Z71.3	
Preventive Medicine Counseling - 30 min.	99402					
Preventive Medicine Counseling -45 min.	99403					
Preventive Medicine Counseling -60 min.	99404					
Group Counseling						
* 30 minutes (approximately)	99411					
* 60 minutes (approximately)	99412					

COMMENTS:
1) Preventive medical counseling must be coded by Registered Dietitian or Nurse.
2) Do not code Preventive or Therapeutic Office Visit in addition to Counseling.
3) * Group Counseling - use group counseling codes on individual encounter for each participant.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 17: NUTRITION - Non-WIC

MEDICAL NUTRITION THERAPY - REGISTERED DIETITIAN ONLY

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Medical Nutrition Therapy, initial Assessment and Intervention, Individual, each 15 min.	97802	NU OR As Appropriate	Private Ins. (5XXX) or TennCare (AXXX) or Private Pay 6	Medical Diagnosis OR	As Appropriate	As Appropriate
Re-assessment and Intervention, Individual, each 15 min.	97803			Dietary Counseling	Z71.3	
* 30 minutes, Group, 2 or more individuals - Medical Nutrition Therapy, each 30 min.	97804					

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 17: NUTRITION - Non-WIC

NUTRITION EDUCATION

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
"C" Registration (Community Service) - Has NO Medical Record	78059	NU	6	Dietary Counseling	Z71.3	1
"L" Registration (Long) - Has Medical Record	3560					

COMMENTS:

1) For groups, write number of participants on encounter form. Keyer of encounter should enter number of participants in MILE column on EN screen. Can be performed by Nutrition Educator, Registered Dietitian or Nurse.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 17: NUTRITION - Non-WIC

EDUCATION/CONTRACT SERVICES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Education/Contract Services - $1.00 per unit		NU	6	Dietary Counseling	Z71.3	# Units
				Health Related Issues or		
"C" Registration (Community Service) - Has NO Medical Record	78085			As Appropriate		
"L" Registration (Long) - Has Medical Record	10299					

COMMENTS:
1) Code Education/Contract Services $1.00 per unit in addition to procedure code for group session when a fee for service needs to be charged.
2) Show number of units in QTY column to equal contracted fee (i.e., $100.00 contracted fee, show 100 in QTY).

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 17: NUTRITION - Non-WIC

PATIENT SELF MANAGEMENT TRAINING

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Education and Training for Self Management		NU or As Appropriate	Private Ins. (5XXX) or TennCare (AXXX) or Private Pay 6	Medical Diagnosis OR	As Appropriate	# of 30 min. increments
Individual - 30 min.	98960			Dietary Counseling	Z71.3	
2 - 4 patients - 30 min.	98961					
5 - 8 patients - 30 min.	98962					

COMMENTS:
1) Patient must have medical diagnosis.
2) Report educational and training services prescribed by physician and provided by trained staff using established curriculum and guidelines (NOT health educators or nutrition educators).

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 18: COMMUNICABLE DISEASE

OVERVIEW

Date: 11/1/2015; Rev 06/20/2016

99348A - Attempted Home Visit/Off-site:
Performed by Public Health Nurse or Public Health Representative. Used to document an unsuccessful contact investigation attempt. A confidential note may be left for patient to call representative.
Example: Hep A, Meningitis, need to contact pt. within 24-48 hours.

78059 - No medical record, 30 min. increments - Field Service:
Performed by the Public Health Nurse or Public Health Representative providing the following services: Audit of school/day care immunization records, review of medical records, conduct mass education or mass screening. No individual medical record is opened.

3560 - Has medical record, 30 min. increments - Field Service:
Performed by the Public Health Nurse or Public Health Representative. Contact investigation initiated, intelligence gathering field visit.

99350H - Home/Off-site:
Provided by Public Health Nurse or Public Health Representative. Contact investigation initiated, initial interview or re-interview may occur and lab work collected. Appropriate referrals are made, counseling/education and additional information gathered. Approximately 30 - 45 minutes.

3734 - Recheck Office/Home/Off-Site (Bill to Payer 6 and appropriate Program):
3734 is used to assess status of previously existing condition of established patient. Nurse Assistant should use venipuncture code 36415 when drawing blood and Nurse should use Recheck code 3734.
Performed by Public Health Nurse or Public Health Representative for follow-up visit.

Coding Venipuncture with 99211 Visit:
If a patient receives a venipuncture (36415) in conjunction to a 99211 visit, a 25 modifier should be attached to the 99211 code. This rule only applies to 99211 code. Refer to Section 1: Modifier for additional guidance.

SECTION 18: COMMUNICABLE DISEASE

COMMON EPIDEMIOLOGY DIAGNOSIS CODES

Date: 11/1/2015; Rev 10/01/2016

Diagnosis Code	"Definitive" Diagnosis Description	Diagnosis Code	"Contact With" Diagnosis Description
B15.9	Viral hepatitis A without mention of coma	Z20.5	Contact with and exposure to viral hepatitis
B16.9	Viral hepatitis B w/o hepatic coma; acute	Z20.811	Meningococcus; contact with
G00.0 - G03.8	Meningitis		
A39.0	Meningococcal meningitis	Z20.828	Contact with and exposure to other viral communicable diseases (including Zika)
B05.0 - B05.89	Measles; with complication	Z20.3	Contact with and exposure to Rabies
B05.9	Measles; without mention of complication		
B26.0 - B26.89	Mumps with complication	Z20.4	Contact with and exposure to Rubella
B26.9	Mumps without mention of complication		
A77.0	Rocky mountain spotted fever (RMSF)	Z20.09	Contact with and exposure to other intestinal infectious diseases
A37.00	Whooping Cough (B. Pertussis) without pneumonia		
A37.01	Whooping Cough (B. Pertussis) with pneumonia	**Diagnosis Code**	**Screening Diagnosis Description**
A37.10	Whooping Cough (B. parapertussis) without pneumonia	Z11.59	Encounter for screening for other viral diseases (including Zika)
A37.11	Whooping Cough (B. parapertussis) with pneumonia		
A37.80	Whooping Cough due to other Bordetella without pneumonia		
A37.81	Whooping Cough due to other Bordetella with pneumonia		
A82.0 - A82.1	Rabies		
B06.89	German Measles (Rubella) with complications		
B06.9	German Measles (Rubella) without mention of complications		
A02.0 - A02.9	Salmonella infection		
A92.5	Zika Virus Disease		

COMMENT: Refer to ICD10 Diagnosis Code Manual for Other Appropriate Diagnosis Codes

SECTION 18: COMMUNICABLE DISEASE

EPIDEMIOLOGY MEDICAL SERVICES - FOR OUTBREAKS, INVESTIGATIONS

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient	99201 - 99205	EI	Private Pay 6	Other Specified Medical Exam OR	Z00.8	1
Established Patient	99211 - 99215			As Appropriate	As Appropriate	
Labs	See Lab Section					
Lab Handling	99000					
Venipuncture	36415					
Pharmacy	Use Pharmacy Module					
Vaccine/Immunization	See Vaccine/Immunization Section					
Counseling (DO NOT CODE COUNSELING AND OFFICE VISIT)	99401 - 99404					
Recheck Visit	3734					
Home Visit / Off Site Visit	99350H					
Attempted Home Visit	99348A					

COMMENTS:
1) Code Counseling (99401-99404) if providing counseling only.
2) DO NOT use EI for Pediculosis or Scabies. See Clinic Visit Section.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 18: COMMUNICABLE DISEASE

EPIDEMIOLOGY FIELD SERVICES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service (Audit, Mass Screening, Surveillance Contact, Mass Education)		EI	6	Same as Primary Diagnosis **OR**	See Common Diagnosis Code List	# 30 Min Increments
"C" Registration (Community Service) (Has **NO** Medical Record)	78059			Encounter for Other Specified Examinations	Z01.89	
				AND/OR		
				Other Specified Counseling	Z71.89	
"L" Registration (Long) (Has Medical Record)	3560					
COMMENTS:						
1) Insert number of participants on encounter. Person keying encounter should enter number of participants in MILE column on EN screen.						

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 18: COMMUNICABLE DISEASE

AIDS PREVENTION

OVERVIEW

Date: 11/1/2015

Population served is anyone who presents to acquire detailed information regarding HIV prevention. This can take place in health departments, school classrooms and public events (such as health fairs). Services can include patient centered counseling, education, partner notification services and general information about HIV prevention. Use appropriate place of service codes.

SECTION 18: COMMUNICABLE DISEASE

COMMON AIDS DIAGNOSIS CODES

Date: 11/1/2015

Diagnosis Code	For "Definitive" Diagnosis	Diagnosis Code	AIDS Related Conditions
Z21	Asymptomatic HIV	B00.0 - B00.8	Herpes Simplex viruses (chronic) specific codes
B20	HIV Disease (includes AIDS, ARC, Symptomatic HIV infection)	*R64	Wasting syndrome
*B97.35	HIV 2		
R75	Inconclusive laboratory evidence of HIV		
*Z72.51	High risk heterosexual behavior		
Z72.52	High risk homosexual behavior		
Z72.53	High risk bisexual behavior		
Z71.7	HIV Counseling		
*Z72.89	Other problems related to lifestyle (self-damaging)	**Diagnosis Code**	**For "Contact/Exposure to"**
Z11.4	Encounter for Screening for HIV/AIDS	Z20.6	Contact to and suspected exposure to HIV/AIDS
Diagnosis Code	**AIDS Related Conditions**	**Diagnosis Code**	**Misc. Diagnosis Codes**
*B37.81	Candidiasis - Esophageal	*Z91.19	Noncompliance with medical treatment, against medical advice
*B37.1	Candidiasis - Lungs, bronchi & trachea	Z79.01 - Z79.899	Long term (current) use of medication
*B37.0	Candidiasis – Oral (Thrush)	*Z76.0	Encounter for issue of repeat prescription
B25.0 - B25.8	Cytomegalovirus specific codes		
*B00.9	Herpes simplex viruses (chronic), unspecified		
C46.0 - C46.7	Kaposi Sarcoma specific codes		
*B59	Pneumocystis pneumonia (PCP)		
*A31.0	Mycobacterium avium complex (MAC or MAI)		
B58.0 - B58.8	Toxoplasmosis (Toxo), specific codes		
*A15.0	Tuberculosis (TB) of Lung		
A15.4 - A19.9	Tuberulosis specific codes for other sites		

COMMENTS:

1) * These conditions should be reported as secondary diagnosis only. Code also any drug level monitoring (Z51.81).

2) Refer to ICD10 Diagnosis Code Manual for Other Appropriate Diagnosis Codes

SECTION 18: COMMUNICABLE DISEASE

AIDS PREVENTION - HIV COUNSELING AND TESTING

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	AP	6	Counseling HIV	Z71.7	1
Labs	See Lab Section			Screening HIV	Z11.4	
Lab Handling	99000			Contact to and suspected exposure to HIV/AIDS	Z20.6	
Antibody, HIV-1 and HIV-2 Serum	Code Per LOE			See Common Diagnosis Code List	As Appropriate	
OraSure Test Antibody, HIV-1, Oral Swab (saliva)	ORASURE ORAQUIK					
Venipuncture	36415					

COMMENTS:

1) If patient presents for ST and requests HIV testing, code the HIV test and any HIV counseling to the AP Program and the ST services to ST. Code only one (1) venipuncture and one (1) lab handling fee.

2) Do not code counseling for negative HIV results given to patient by telephone.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

AIDS PREVENTION - RETURN VISIT FOR TEST RESULTS

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401 - 99404	AP	6	Counseling HIV (for counseling)	Z71.7	1

COMMENTS:

1) Counseling Codes 99401-99404 should be used for face-to-face post-test counseling and can be used with Program AP and Private Pay 6 in conjunction with other program office visits. There is no charge to the patient with the AP Program code.

2) If a patient presents for ST and requests HIV testing, code HIV test and HIV counseling to the AP Program and the ST services to ST. Code only one (1) lab handling fee.

3) Do not code counseling for negative HIV results given to patient by telephone.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

AIDS FIELD SERVICES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Services (Audit, Contact, Mass Screening, Mass Education)		AP	6	Contact with and suspected exposure to HIV/AIDS	Z20.6	# 30 Minute Increments
				AND/OR		
"C" Registration (Community Service) (Has **NO** Medical Record)	78059			HIV Counseling	Z71.7	
"L" Registration (Long) (Has Medical Record)	3560					

COMMENTS:

1) Insert number of participants on encounter. Person keying encounter should enter number of participants in MILE column on EN screen.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

AIDS RYAN WHITE – MEDICAL SERVICES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Office Visit		AR	Private Pay 6	See Common Diagnosis Code List	See Common Diagnosis Code List	1
New Patient	99201 - 99205					
Established Patient	99211 - 99215					
Patient Home Nursing Assessment						
New Patient	99341					
Established Patient	99347					
Nutrition Services						
Initial Visit, Office or Home	99404					
Other Office or Home Visit	99403					
Labs	See Lab Section					
Lab Handling	99000					
Venipuncture	36415					
Ear, Finger or Heel Stick	36416					
Pharmacy	Issue from Pharmacy Module					

COMMENTS:

1) Visit for Evaluation and Management of HIV positive patients. Patient must be Tennessee resident, must be clinically tested as HIV positive and not have any third party insurance that will provide for specific service needed. AR Program Code should not be used on encounters generated during HIV clinics unless the patient meets Ryan White eligibility criteria. Use ST Program Code for HIV clinics when patient does not qualify for Ryan White. An Office Visit and a Nutrition Counseling Visit may be coded during the same office visit based on Ryan White guidelines.

2) Program Guidelines: **See AIDS Support Fee Schedule for description of services. Providers should use Code 99347 for subsequent home visits to provide care coordination after billable visits are exhausted.**

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

STD PROGRAM CODE DEFINITIONS

Date: 11/1/2015

99348A -- Attempted Home Visit/Off-site:

Performed by Public Health Nurse or Public Health Representative. Used to document an unsuccessful contact investigation attempt. Confidential note may be left for patient to call representative.

78059 -- No medical record, 30 minute increments - Field Service:

Performed by Public Health Nurse or Public Health Representative providing mass education or mass screening. No individual medical record opened.

Lab Monitoring/Surveillance: Performed by the Public Health Representative to private labs to educate and troubleshoot any problems in reporting of STD positive results.

3560 -- Has medical record, 30 minute increments - Field Service:

Performed by Public Health Nurse or Public Health Representative. Contact investigation initiated, intelligence gathering field visit.

99350H - Home/Off-site:

Service provided by Public Health Nurse or Public Health Representative. Contact investigation initiated, initial interview or re-interview may occur. Referrals made, counseling/education and additional information gathered. Approximately 30 to 45 minutes. Arranging for or providing transportation. May collect lab work. If interview, re-interview, counseling/education provided and/or elicitation of contacts the time may increase 30-120 minutes.

3734 - Recheck Office/Home/Off Site

Performed by Public Health Nurse or Public Health Representative for follow-up visit. Example: Follow-up blood work to see if therapy effective.

SECTION 18: COMMUNICABLE DISEASE

COMMON STD DIAGNOSIS CODES

Date: 11/1/2015 Rev 06/20/2016

Diagnosis Code	"Definitive" Diagnosis	Diagnosis Code	"Contact/Exposure to"
B20	AIDS (confirmed)	Z20.2	Contact with/exposure to infection with sexual mode of transmission
Z21	HIV (Asymptomatic)	Z20.6	Contact with/exposure to HIV
A53.0	Syphilis, Latent	Z11.6	Contact with/exposure to Trichomoniasis
A51.0	Syphilis, Primary (Genital)	Z11.59	Contact with/exposure to Genital herpes
A54.31	Syphilis, Secondary (of skin or mucous - condyloma latum)	Z20.828	Contact with/exposure to other communicable diseases
A51.2	Syphilis, Other 'Specified' Site	**Diagnosis Code**	**Special Screenings**
A51.3	Syphilis, Secondary (skin or mucous - syphilitic alopecia)	Z11.51	Special screening examination for Human papillomavirus (HPV)
A54.00	Gonorrhea (Acute lower genitourinary)	Z11.3	Screening for infections with a predominantly sexual mode of transmission
A54.01	Gonorrhea (cystitis and urethritis)	Z11.4	Special screening examination for HIV
A54.02	Gonorrhea (vulvovaginitis)		
A54.03	Gonorrhea (vaginitis)	R00 - R99	**Diagnostic Testing for Symptomatic Patients (code to signs/symptoms)**
A54.09	Gonorrhea (other 'specified' infection lower genitourinary site)		
A54.5	Gonorrhea (pharyngitis)	Z69 - Z72.9	**Counseling for STD, HIV and Sexual Related Issues**
A54.6	Gonorrhea (anus and rectum)	**COMMENT**: Refer to ICD10 Diagnosis Code Manual for Other Appropriate Diagnosis Codes	
A56.00	Chlamydia (Unspecified urinary site)		
A56.01	Chlamydia (cystitis and urethritis)		
A56.02	Chlamydia (vulvovaginitis)		
A56.09	Chlamydia, other specified lower genitourinary tract		
A56.3	Chlamydia (anus and rectum)		
A56.8	Chlamydia, sexually transmitted, Other 'Specified' Site		

SECTION 18: COMMUNICABLE DISEASE

STD MEDICAL SERVICES

Date: 11/1/2015; Rev: 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Office Visit		ST	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	See Most Common Diagnosis List	See Most Common Diagnosis List	1
New Patient	99201 - 99205					
Established Patient	99211 - 99215					
Venipuncture	36415					
Labs	See Lab Section					
Lab Handling	99000					
Injection Administration	96372					
Pharmacy	Issue from Pharmacy Module					
Recheck Visit	3734		6			
Home / Off Site Visit	99350H or 99350					
Attempted Home Visit	99348A					
Counseling	99401 - 99404	AP				

COMMENTS:

1) Use ST Program Code for HIV clinic when patient does not meet Ryan White eligibility criteria. Use AR (AIDS Ryan White) Program Code for HIV clinic only if patient qualifies for Ryan White.

2) Highest level provider should code visit. **EXCEPTION: If patient requests HIV testing in addition to ST visit, the provider who does HIV testing and counseling should code the appropriate counseling code using AP (AIDS Prevention) and HIV test and Private Pay 6.** Do not code condoms dispensed.

3)Third party pay sources may be billed for clinical services provided to patients under the ST Program.

4) **For Home/Off-Site Visits to contacts, use source case record to establish the encounter. If source case has no record, open one.** When the contact presents to clinic, open record on contact.

5) Code treatment for both reportable and non-reportable sexually transmitted diseases using program code ST.

6) If a 99211 level of service has been completed with an injection (96372), report 99211NC and 96372.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

STD - FIELD SERVICE

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service (Audit, Mass Screening, Contact, Mass		ST	6	See Common Diagnosis List	See Common Diagnosis List	# 30 Min Increments
"C" Registration (Community Service) (Has **NO** Medical Record)	78059					
"L" Registration (Long) (Has Medical Record)	3560					

COMMENTS:
1) Use code 3560 for "L", long registration, or 78059 for "C", community service, registration.
2) Insert number of participants on encounter. Person keying encounter should enter number of participants in MILE column on EN screen.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

TUBERCULOSIS PROGRAM

OVERVIEW

Date: 11/1/2015

TBS Health Department or Off-site:

Performed by Public Health Nurse or other trained health department personnel.

Screening individual for TB utilizing TB/LTBI Assessment Tool (TB RAT)

99348A Attempted Home Visit/Off-site:

Performed by Public Health Nurse or Public Health Representative. This code is used to document an unsuccessful contact investigation attempt.

A confidential note may be left for patient to call representative.

99350H Home/Off-site:

Performed by Public Health Nurse or other trained health department personnel.

Monthly follow-up visit, interval history, drug monitoring, biochemical monitoring, screening co-existing disease, DOT, delivery of monthly supply.

May include referrals, review of test results, counseling and education, gathering additional information.

3734 Recheck Office/Home/Off-Site:

Performed by Public Health Nurse or Public Health Representative for follow-up visit.

Example: Follow-up visit for skin test reading or IGRA results.

99347H Health Department or Off-site; DOT or Delivering Monthly Supply:

Limited contact with patient to provide medications with assessment for signs and symptoms of toxicity; no other services provided.

1516 Case Closure:

Close out patient. Use appropriate disposition code.

SECTION 18: COMMUNICABLE DISEASE

COMMON TUBERCULOSIS DIAGNOSIS CODES

Date: 11/1/2015; Rev 06/20/2016

TB Skin Test		QFT-GIT Testing	
Z11.1	TB Skin Test Negative	Z11.1	QFT - GIT Negative
R76.11	TB Skin Test Positive	R76.12	QFT-GIT Positive
T-Spot Testing		R76.8	QFT-GIT Indeterminate
Z11.1	T-Spot Negative	R76.9	QFT-GIT Unsatisfactory
R76.12	T-Spot Positive	Z53.8	QFT-GIT Not Performed
R76.8	T-Spot Borderline	**TB Infection**	
R76.9	T-Spot Invalid	R76.11	TB Skin Test Positive
Z53.8	T-Spot Not Performed	R76.12	QFT-GIT Positive
		R76.12	T-Spot Positive

TB Suspect (without symptoms)	TB Suspect (with symptoms)	TB Contact	TB Inactive (Healed)	Personal History of TB	B-notification Evaluation
Z03.89	Use symptoms code(s)	Z20.1	B90.9 (code first the condition resulting from 'sequela' from TB)	Z86.11	Z02.89

Symptoms			
R04.2	Hemoptysis	R05	Cough
R06.02	Shortness of breath	R50.9	Fever
R61	Night sweats	R63.4	Abnormal weight loss

Adverse Reaction to Medication	Therapeutic Drug Monitoring (Drug Levels)
Code for Adverse Effect of Specific Medication	Z51.81

Administrative Purpose	HIV Testing as Part of QFT-GIT Draw
Z02.9	Z11.4
COMMENT: Refer to ICD10 Diagnosis Code Manual for Other Appropriate Diagnosis Codes	

SECTION 18: COMMUNICABLE DISEASE

COMMON TUBERCULOSIS DIAGNOSIS CODES, page 2

Date: 11/1/2015

Vision Screening			
Z01.00	Encounter for exam of eyes and vision without abnormal findings	Z01.01	Encounter for exam of eyes and vision with abnormal findings (use additional code to identify abnormal findings)

Hearing Screening			
Z01.10	Encounter for exam of ears and hearing without abnormal findings	Z01.11 (use an additional code for abnormal findings)	Encounter for exam of ears and hearing with abnormal findings

Pregnancy Testing			
Z32.02	Encounter for pregnancy test, negative	Z32.01	Encounter for pregnancy test, positive

Drug Resistance	
Z16.341	Resistance to single antimycobacterial drug (mono-resistance)
Z16.342	Resistance to multiple antimycobacterial drugs (use for MDR and XDR)
Z16.35	Resistance to multiple antimycobacterial drugs (poly-resistance not MDR or XDR)
Z16.23	Resistance to quinolones or fluoroquinolones

A15: Respiratory Tuberculosis			
A15.0	TB of lung	A15.4	TB of intrathoracic lymph nodes
A15.5	TB of bronchus	A15.6	TB pleurisy
A15.7	Primary respiratory TB	A15.8	Other respiratory TB

A17: TB of the Nervous System			
A17.0	TB meningitis	A17.1	Tuberculoma of meninges
A17.81	Tuberculoma of brain and spinal cord	A17.82	Tuberculous myelitis
A17.83	Tuberculous mononeuropathy	A17.89	Other TB of nervous system

SECTION 18: COMMUNICABLE DISEASE

COMMON TUBERCULOSIS DIAGNOSIS CODES, page 3

Date: 11/1/2015; Rev 06/20/2016

TB of Other Organs			
A18.01	TB of spine	A18.02	TB of hip and knee
A18.03	TB of other bones	A18.09	Other musculoskeletal TB
A18.11	TB of kidney and ureter	A18.12	TB of bladder
A18.13	TB of other urinary organs	A18.14	TB of prostate
A18.15	TB of other male genital organs	A18.16	TB of cervix
A18.17	TB of female pelvic inflammatory disease	A18.18	TB of other female genital organs
A18.31	TB peritonitis	A18.32	TB enteritis
A18.39	Retroperitoneal tuberculosis	A18.4	TB of skin and subcutaneous tissue
A18.51	TB episcleritis	A18.52	TB keratitis
A18.53	TB chorioetinitis	A18.54	TB iridocyclitis
A18.59	Other TB of eye	A18.6	TB of inner/middle ear
A18.7	TB of adrenal glands	A18.81	TB of thyroid
A18.82	TB of other endocrine glands	A18.83	TB of digestive tract organs
A18.84	TB of heart	A18.85	TB of spleen
A18.89	TB of other sites	A18.2	Tuberculous peripheral lymphadenopathy
A19: Miliary TB			
A19.0	Acute miliary TB single site	A19.1	Acute miliary TB multiple sites
A19.8	Other specified miliary TB		

Adverse Effects of Medication *			
Drug	**Code**	**Drug**	**Code**
Amikacin	T36.5X5	Moxifloxacin	T37.8X5
Capreomycin	T36.8X5	PAS	T37.1X5
Clofazimine	T37.1X5	Pyrazinamide	T37.1X5
Cycloserine	T37.1X5	Rifabutin	T36.6X5
Ethambutol	T37.1X5	Rifamate	T37.1X5
Ethionamide	T37.1X5	Rifampin	T36.6X5
Isoniazid	T37.1X5	Rifapentine	T36.6X5
Kanamycin	T36.5X5	Streptomycin	T36.5X5
Levofloxacin	T37.8X5		

* Appropriate 7th character is to be added to each code: A-initial encounter, D-subsequent encounter, S-sequela

SECTION 18: COMMUNICABLE DISEASE

TB PROGRAM FIELD SERVICE CODE DEFINITIONS

Date: 11/1/2015

Contact Investigation:	
99350H	**Contact Investigation, Initial Visit OR Follow-up Visit(s), Any Off Site Location (including jails, prisons, etc. Use appropriate place of service codes).**
	Initial Visit - Initial contact investigation, conduct initial interview, collects lab work; administer TB skin test, if appropriate. Public Health Nurse or other trained health professional.
	Follow-up Visit - Monthly follow-up visit, interval history, drug monitoring, biochemical monitoring, screening co-existing disease. May include Directly Observed Therapy (DOT) OR delivery of monthly re-supply. May include referrals, reviews of test results, counseling and education, gathering additional information. Performed by Public Health Nurse or other trained health department personnel.
99348A	**Attempted Visit, Any Off Site Location**:
	Attempted visit for DOT, delivery of monthly re-supply, contact investigation, follow-up lab work; patient not located or contacted. Performed by Public Health Nurse or other trained health department personnel.
3560	**Field Service Visit, Off Site (other than Health Department) - Patient has medical record:**
	Gather information from patient or initiate contact investigation. Performed by Public Health Nurse or Public Health Representative. No medical service provided. Number of units should reflect 30-minute increments. (Example: field service visit, 60 minutes equals 2 units).
Community Site/Targeted Testing:	
78059	**Community Site - Educational Counseling Visit:**
	Preventive education and counseling of individual community, business leaders or groups of clients. May be performed by Public Health Nurse or other trained TB personnel; time spent should be documented in 30 minute increments.
78059TP	**Community Site – Total Population:**
	Total population of community site where TB screening, preventive education and testing for TB infection occurs; enter total number of persons in group, regardless of whether they are individually contacted.
78059SP	**Community Site – Total Screened Population:**
	Total number of persons screened individually with the TB/LTBI Risk Assessment Tool (RAT).
78059IN	**Community Site – Use of Interpreter:**
	Number of individuals screened (with TB/LTBI Risk Assessment Tool) in a language other than English; interpreter is used.
78059HR	**Community Site – High Risk:**
	Number of individuals identified as High Risk among those screened with the TB/LBTI Risk Assessment Tool.

SECTION 18: COMMUNICABLE DISEASE

TB SCREENING, TESTING AND COUNSELING FOR INDIVIDUALS

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
TB Skin Intradermal Test	86580	TB	6	See Common Diagnosis List	See Common Diagnosis List	1
TB Screening (RAT Tool)	TBS					
QFT-GIT	Code per LOE					
HIV 1- HIV 2	Code per LOE	AP				
TB Skin Test Read	3734	TB	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6			
Venipuncture	36415					
Labs	See Lab Section					
Lab Handling	99000					
TB Skin Test Read With Counseling (Without counseling - not a billable service)	99211					
Follow-up for QFT-GIT Results	99211					
T-Spot Test	86480					
Follow-up for T-Spot Results	99211					
New Patient	99201 - 99205					
Established Patient	99211 - 99215					
Counseling	99401 - 99404					

Comments:

1) TB/LTBI Risk Assessment Tool is used to determine whether a patient is at high or low risk of TB infection. High-risk patients will be counseled and offered a TB skin test or IGRA. Low-risk clients will be given further counseling or testing when appropriate. If patient has a positive TB skin test or an IGRA result that is not negative, use appropriate counseling or office visit code and appropriate payer code.

2) Other diagnosis codes for LTBI and active TB are determined by TB physician or nurse practitioner at the time of treatment.

3) Any IGRA test result that is not negative will require the patient to have a follow-up in clinic.

4) Refer to Section 1: Modifiers for guidance on counseling with other office visit encounter.

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

TB MEDICAL SERVICES

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
New Patient	99201 - 99205	TB	Private Ins (5XXX) or TennCare (AXXX) or Private Pay 6	See Common Diagnosis List	See Common Diagnosis List	1
Established Patient	99211 - 99215					
Labs	See Lab Section					
Lab Handling	99000					
Venipuncture	36415					
TB Sputum Induction	94640					
DOT/Monthly Resupply	99347H		6			
Attempted Home Visit	99348H					
Home Visit Off Site	99350H					
Pharmacy	Issue from Pharmacy Module					
Case Closure	1516					
Comments:						
1) Use 99350H only when additional services over and above DOT/monthly re-supply are provided. Use 99347H if only DOT or monthly resupply is done. Patient with a new positive TB test or IGRA must have a chest X-Ray and be seen by a physician or NP to rule out active TB.						
2) For home visit, change the visit setting on encounter to"02".						
3) When patient completes, leaves, or does not start treatment the case should be closed using 1516 procedure code and a disposition code. The disposition code should note reason for the closure and be entered in the disposition field. See TB Disposition Codes.						
TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.						

SECTION 18: COMMUNICABLE DISEASE

TB TREATMENT DISPOSITION CODES

Date: 11/1/2015

Disposition Codes			
Code	**Description**	**Code**	**Description**
AC	Active TB developed	**PD**	Provider decision
AE	Adverse effect of medicines	**PL**	Patient lost to follow-up
AT	Already Treated	**PM**	Patient moved, follow-up unknown
DA	Patient moved to Davidson Co	**PT**	Patient chose to stop
DE	Death	**RE**	Refused Evaluation for TB
ET	Patient moved to East Tennessee Region	**RI**	Refused IGRA test
HA	Patient moved to Hamilton Co.	**RM**	Refused medication / treatment
JM	Patient moved to Madison Co	**RT**	Refused skin test
KN	Patient moved to Knox Co.	**S3**	Patient moved to Southeast Region
MC	Patient moved to Mid Cumberland Region	**S6**	Patient moved to South Central Region
MS	Patient moved to Shelby Co	**SU**	Patient moved to Sullivan Co.
NT	No TB found	**TC**	Treatment completed
N1	Patient moved to Northeast Region	**UC**	Patient moved to Upper Cumberland Region
OS	Patient moved out of state	**WT**	Patient moved to West Tennessee Region

SECTION 18: COMMUNICABLE DISEASE

TB CONTACT INVESTIGATION, ANY SITE

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
TB Skin Intradermal Test	86580	TB	6	See Common Diagnosis List	See Common Diagnosis List	1
TB Screening (RAT Tool)	TBS					
QFT-GIT	Code per LOE					
Venipuncture	36415					
Labs	See Lab Section					
Lab Handling	99000					
TB Skin Test Read	3734					
TB Skin Test Follow-up Visit (with counseling)	99211					
Follow up Visit for QFT-GIT	99211					
T- Spot Test	86480					
Follow up Visit for T-Spot Test	99211					
Counseling (do not code counseling and 99211 on same encounter)	99401 - 99404					
Initial or Follow up Visit	99350H					
Field Service Visit, Limited	3560					

COMMENTS:

1) Staff may link contact to source case by putting case source patient ID on encounter form and in note/follow-up field on encounter screen.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.

SECTION 18: COMMUNICABLE DISEASE

TB COMMUNITY SITE/TARGETED TESTING

Date: 11/1/2015; Rev 06/20/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Community Service Encounter:						
Community Site Educational Counseling Visit	78059*	TB	6	Administrative Purpose	Z02.9	# 30 Min Increments
Total Population At Site	78059TP					# In Population
Total Screened Population At Site	78059SP					# Screened
High-Risk Among Screened Population	78059HR					# Identified As High Risk
Use of Interpreter	78059IN					# Screened Language Other than English
COMMENTS:						
1) *For community site visits when interpreter is used or bilingual provider conducts session in language other than English, code "IN" in DISPOSITION field for procedure 78059 with appropriate units of time. If patient has positive TB skin test or IGRA, appropriate counseling or office visit code can be used.						
Individual Encounter:						
TB Skin test Read	3734	TB	6	TB Skin Test Negative	Z11.1	1
TB Skin test Read	3734			TB Skin Test Positive or Latent	R76.11	
QFT-GIT	Code per LOE			QFT-GIT Negative	Z11.1	
				QFT-GIT Positive or Latent	R76.12	
Venipuncture	36415			QFT-GIT Indeterminate	R76.8	
T-Spot Test	86480			T-Spot Negative	Z11.1	
				T-Spot Positive or Latent	R76.12	
Labs	See Lab Section			T-Spot Borderline	R76.8	
Lab Handling	99000			T-Spot Invalid	R76.9	
Case Closure	1516			T-Spot Test Not Performed	Z53.8	
COMMENTS:						
1) Record on individual encounter and link in the Notes field to screening site by placing community site patient ID number in the notes/follow-up field on the encounter screen.						
TennCare Advocacy	99401T					
	99402T					
Advocacy may be coded as appropriate. Refer to TennCare Advocacy Section.		TO	6	Administrative Purpose	Z02.9	1

SECTION 19: TOBACCO CESSATION

OVERVIEW

Date: 11/1/2015

Tobacco Cessation Program:

The Department of Health Tobacco Cessation Program was implemented to assess and assist in cessation of tobacco use. The population is all health department patients age 13 and older who receive clinical services.

Patient Tobacco Survey - for Regions with FQHC Sites:

Standardized assessment tool to determine patient's level of tobacco use and need for intervention. All health department patients age 13 and older receiving clinical services are asked two questions regarding current and former tobacco us. If either question is answered "yes", the patient will be offered the patient tobacco survey. The patient receives evaluation and tobacco cessation counseling, if requested.

SECTION 19: TOBACCO CESSATION

EXAMINATION VISIT

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Office Visit, New Patient	99201 - 99205	CH (13 thru 20) or MH (21 and over) or WH (21 and over)	As Appropriate	History of Tobacco Use (not pregnant)	Z87.891	**1**
Office Visit, Established Patient	99211 - 99215			Tobacco Use Complicating Pregnancy	O99.330 - O99.345	
				Tobacco Use	Z72.0	
Patient Tobacco Survey	TSA	QT	6	History of Tobacco Dependence	Z87.891	
Counseling	99401QT			Nicotine Dependence	F17.20 - F17.299	
	99402QT					
	99403QT					
	99404QT					

COMMENTS:

1) For visits including primary care or other services AND tobacco, code for other programs first (WH, MH, CH, WIC, FP, etc.).

2) If the visit is for tobacco ONLY, use program code QT.

3) Interpreter Codes (INT1-INT4) can be used with QT program

SECTION 19: TOBACCO CESSATION

COUNSELING ONLY

Date: 11/1/2015; Rev 10/01/2016

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Counseling	99401QT	QT	6	History of Tobacco Use (not pregnant) OR	Z87.891	1
	99402QT			Tobacco Use Complicating Pregnancy	O99.330 - O99.345	
	99403QT					
	99404QT					
				Tobacco Abuse Counseling	Z71.6	
				Nicotine Dependence	F17.20 - F17.299	

COMMENTS:

1) When coding Tobacco Abuse Counseling Z71.6, also code accordingly for Nicotine Dependence F17.20-F17.299.

SECTION 20: WIC

OVERVIEW

Date: 11/1/2015

1004- Voucher issuance:

Issue an encounter, updating the WICQ screen
Print vouchers and receipt
Obtain participant signatures on vouchers and receipt
Explain use of vouchers
Void vouchers if printed in error and reissuing corrected vouchers

1000 - WIC Certification:

Obtain certification measures (height and weight, and hemoglobin according to current WIC Program Guidelines)
Plot measures on growth chart
Take medical history
Complete nutrition assessment
Determine risk criteria
Complete the encounter form

1002 - WIC Mid Certification:

Obtain measures (height and weight, and hemoglobin according to current WIC Program Guidelines)
Plot measures on growth chart
Complete nutrition assessment; update medical diagnosis and/or new concerns
Complete the encounter form

78059 (No Medical Record) and 3560 (Has Medical Record) Field Service:

Provide mass education at health fairs, community or workshops presentations for other agencies about WIC Program and its benefits

99350H - Initial Home Visit:

Complete nutritional assessment in patient home, relating to documented problem or medical diagnosis; develop plan of care
Provide nutritional counseling and make necessary referrals
Document in medical record

99349H- Follow up Home Visit:

Update previous nutrition assessment in patient home
Review and update plan of care
Provide nutritional counseling
Document in medical record

SECTION 20: WIC

OVERVIEW, cont'd

11/1/2015

99348A - Attempted Home Visit:

Document unsuccessful home visit attempt. Traveled to participant's residence but was not able to complete visit.

MOVO - Motor Voter Registration:

1) A person who will be at least 18 years old on or before the next election who applies for WIC certification or recertification, CSFP or Presumptive Eligibility, must be offered the opportunity to register to vote. Use the MOVO procedure code and disposition code to indicate patient response. For those who complete and submit the form at the Health Department, the receipt number from the form must be entered in Notes/Follow field at bottom left of encounter screen.

DISPOSITION CODES:

RG - Registered at Health Department today
CR - Currently registered to vote
TF - Took registration form home
DD - Declined; declination form signed
NE - Not eligible due to age or lack of citizenship

SECTION 20: WIC

CERTIFICATION /MID CERTIFICATION/ RECERTIFICATION

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
WIC Certification Visit	1000	WI	6	Administrative Purpose	Z02.9	1
WIC Mid Certification	1002					
Voucher Issuance	1004					
Hemoglobin *	85018					
Ear, Finger or Heel Stick	36416					
Nutrition Counseling	99401-99404			Dietary Counseling	Z71.3	

COMMENTS:
1) * For treatment of abnormal hemoglobin levels, code per guidance in Problem Visit - Clinic Visit Section.

Motor Voter Registration	MOVO	AM	6	Administrative Purpose	Z02.9	1

MOVO DISPOSITION CODES:
RG - Registered at Health Department today
CR - Currently registered to vote
TF - Took registration form home.
DD - Declined; declination form signed.
NE - Not eligible due to age or lack of citizenship

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 20: WIC

VOUCHER PICKUP

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Voucher Issuance	1004	WI	6	Administrative Purpose	Z02.9	1
Nutrition Counseling (if provided)	99401-99404			Dietary Counseling	Z71.3	
COMMENTS:						
1) Counseling must be documented in patient medical record. Provider must be a nurse, nutritionist, or nutrition educator.						
TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 20: WIC

GROUP NUTRITION EDUCATION (DURING WIC VOUCHER PICKUP ONLY)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Group Education **AND**	99411	WI	6	Dietary Counseling	Z71.3	1
Voucher Issuance (Code On Each Individual Participant's Encounter Form)	1004			Administrative Purpose	Z02.9	

COMMENTS:

1) Establish the appropriate encounter (group or individual) for each educational session and code the appropriate counseling code.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 20: WIC

ISSUE VOC CARD

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
WIC VOC Card Issuance	1004	WI	6	Administrative Purpose	Z02.9	1
TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 20: WIC

NUTRITION COUNSELING

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Group Education	99411	WI	6	Dietary Counseling	Z71.3	1
Individual Education	99401 - 99404					
Home / Off-Site Visit						
Initial Visit	99350H					
Follow-up Visit	99349H					

COMMENTS:

1) Use when counseling only is provided and no vouchers are issued. Establish the appropriate encounter (group or individual) for each educational session and code the appropriate counseling code. For home visits, change Visit Setting to 02.

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					

Advocacy may be coded as appropriate. See TennCare Advocacy Section.

SECTION 20: WIC

HIGH RISK NUTRITIONAL COUNSELING (REGISTERED DIETITIAN ONLY)

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Preventive Medicine Counseling - 15 minutes	99401	WI	6	Dietary Counseling	Z71.3	1
Preventive Medicine Counseling - 30 minutes	99402					
Preventive Medicine Counseling - 45 minutes	99403					
Preventive Medicine Counseling - 60 minutes	99404					

TennCare Advocacy	99401T	TO	6	Administrative Purpose	Z02.9	1
	99402T					
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 20: WIC

FIELD SERVICE - COMMUNITY ACTIVITIES

Date: 11/1/2015

PROCEDURE	CODE	PROGRAM	RE	DIAGNOSIS	CODE	QTY
Field Service (Audit, Mass Screening, Mass Education)		WI	6	Dietary Counseling	Z71.3	# 30 Min Increments
"C" Registration (Community Service) (Has **NO** Medical Record)	78059					
"L" Registration (Long) (Has Medical Record)	3560					
COMMENTS:						
1) Contact with local agencies/groups to promote the WIC Program and inform the public about WIC.						
2) Person who keys encounter should key number of participants in MILE column on EN screen.						

TennCare Advocacy	99401T 99402T	TO	6	Administrative Purpose	Z02.9	1
Advocacy may be coded as appropriate. See TennCare Advocacy Section.						

SECTION 21: PTBMIS PROGRAM CODES

Date: 11/1/2015

CODE	PROGRAM	CODE	PROGRAM	CODE	PROGRAM
AD	CHAD	**FG**	Food and General Sanitation (GEH)	**VR**	Vital Records (Death Certificates)
AM	Administration	**FP**	Family Planning	**WH**	Women's Health (Age 21 and over)
AP	Aids Prevention	**HP**	Health Promotion	**WI**	WIC
AR	Aids Ryan White	**HU**	HUGS (Help Us Grow Successfully)	**WO**	WIC Over Charges (Vendor Reclaims)
BC	Birth Certificates (Local health)	**IM**	Immunization		
BF	Breastfeeding	**IN**	Insurance		
BR	Birth Certificates (Vital Records)	**IT**	International Travel		
BCS	Breast and Cervical Cancer Screening Program	**MH**	Men's Health (Age 21 and over)		
CC	Care Coordination (CS Only)	**NU**	Nutrition		
CH	Child Health (birth through 20)	**OT**	Other		
CS	Children's Special Services	**PN**	Prenatal (Full Prenatal Clinics Only)		
DN	Dental Clinic	**PPI**	Primary Prevention Initiative		
DP	Dental Prevention	**QT**	Tobacco Cessation (formerly Smoking Cessation)		
DT	Dental Transport	**RP**	Rape Prevention		
EH	Employee Health	**SF**	CSFP (Commodity Surplus Food Program)		
EI	Epidemiology	**ST**	Sexually Transmitted Diseases		
EN	Environmental (Ground Water)	**TB**	Tuberculosis		
EP	EPSDT (Early Periodic Screening, Diagnosis & Treatment)	**TO**	TennCare Advocacy		