

# Annual Physical Exam Guide



**Annual Physical Exams include an appropriate history/exam with risk counseling and/or quality intervention.**

**A successful Annual Physical Exam will:**

- ▶ Identify patients who need disease management or intervention.
- ▶ Improve meaningful data exchanges between health plan and providers.
- ▶ Improve quality of care provided and patient health outcomes.

**The medical record must support all diagnoses and all services billed on the claim.**

- ▶ Address all conditions that require or affect patient care, treatment, or management.
- ▶ Thoroughly document the specific diagnoses and care plan.
- ▶ Code to the highest specificity using ICD-10 Guidelines.
- ▶ Consider including CPT II® codes to provide additional details.
- ▶ Submit claim/encounter data for each service rendered.
- ▶ Ensure all claim/encounter data is accurate and submitted in a timely manner.

## Coding & Documentation

Exam Type	Initial CPT®	Subsequent CPT
Age 0	99381	99391
Age 1-4	99382	99392
Age 5-11	99383	99393
Age 12-17	99384	99394
Age 18-39	99385	99395
Age 40-64	99386	99396
Age 60+	99387	99397

### Separate Evaluation and Management<sup>1</sup>

- ▶ Provider may perform separately identifiable services 99202-99215, 99381-99387, 99391-99397, on the same day.
- ▶ The components of both the Annual Wellness Visit and the Routine Physical Exam must be met and documented.
- ▶ Report E/M and routine physical with modifier-25 when performed on the same date.
- ▶ If the provider's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.
- ▶ A separately identifiable E/M service may be reported if prompted by symptoms or chronic conditions assessed during the annual physical. Select the appropriate level of E/M services based on the following:
  1. The level of the medical decision making as defined for each service; **or**
  2. The total time for E/M services performed on the date of the encounter.

### Focused on modifiable risk factors and disease prevention

- ▶ No chief complaint/not due to present illness
- ▶ Complete systems review
- ▶ Past medical, social, and family history
- ▶ Pertinent risk factors
- ▶ Risk factor and age-appropriate counseling, screening, labs, tests, and vaccines

### Documentation should include:

- ▶ Status of chronic conditions that are not significant enough to require additional work-up
- ▶ Description and care plan for minor problems that do not require additional work-up
- ▶ Orders and/or referrals

<sup>1</sup><https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

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## Additional Services | Refer to the current CPT Coding Manual

Included With Exam	Covered Separately		
<ul style="list-style-type: none"> <li>▶ Preventive Medicine Counseling, Individual</li> <li>▶ Smoking/Tobacco Cessation</li> <li>▶ Alcohol/Substance Abuse Screening and Intervention</li> <li>▶ Other Additional Preventive Services</li> </ul>	<b>Screenings</b> <ul style="list-style-type: none"> <li>▶ Vision</li> <li>▶ Hearing</li> <li>▶ Developmental</li> </ul>	<b>Vaccines</b> <ul style="list-style-type: none"> <li>▶ Toxoid Administration</li> <li>▶ Risk/Benefit Counseling</li> </ul>	<b>Ancillary Studies</b> <ul style="list-style-type: none"> <li>▶ Laboratory</li> <li>▶ Radiology</li> <li>▶ Other Procedures</li> </ul>

## ICD-10: Encounter for general medical exam

Report the documented reason for the encounter as the primary diagnosis code and assign additional diagnosis codes if applicable. Follow the current year's Official ICD-10-CM Guidelines for Coding and Reporting.

<b>...infant exam 7 days and younger, Z00.110</b>	Use when identifying health supervision for newborn under 8 days old.
<b>...infant exam 8 to 28 days, Z00.111</b>	Use when identifying health supervision for newborn 8 to 28 days old.
<b>...child exam with normal findings, Z00.129</b>	Use when conditions are stable or improving. Report additional codes for chronic conditions.
<b>...child exam with abnormal findings, Z00.121</b>	Use when any abnormality is found during the visit. Report additional codes for all existing conditions.
<b>...adult exam with normal findings, Z00.00</b>	Use when conditions are stable or improving. Report additional codes for chronic conditions.
<b>...adult exam with abnormal findings, Z00.01</b>	Use when any abnormality is found during the visit. Report additional codes for all existing conditions.

## HEDIS® Measures

Prevention/Visits	Scheduled Screenings	Diabetes	Medication Management
<ul style="list-style-type: none"> <li>▶ Blood Pressure Control</li> <li>▶ Immunizations</li> <li>▶ Well-Child Visit</li> <li>▶ Weight Assessment and Counseling for Children &amp; Adolescents</li> </ul>	<ul style="list-style-type: none"> <li>▶ Colorectal Cancer</li> <li>▶ Breast Cancer</li> <li>▶ Cervical Cancer</li> <li>▶ Diabetic Eye Exam</li> <li>▶ Annual Dental Visit</li> </ul>	<ul style="list-style-type: none"> <li>▶ HbA1c and Glucose Testing &amp; Control</li> <li>▶ Kidney Health Evaluation</li> <li>▶ Nephropathy Screening</li> </ul>	<ul style="list-style-type: none"> <li>▶ Asthma</li> <li>▶ Antidepressants</li> <li>▶ ACE/ARB</li> <li>▶ Statins</li> <li>▶ Diabetes medications</li> </ul>

For additional resources, contact our Provider Relations team at [Providers@ARHealthWellness.com](mailto:Providers@ARHealthWellness.com)

NOTE: Follow ICD-10-CM/CPT/HCPS Guidelines for Coding and Reporting at <https://www.cms.gov>.  
HEDIS measures can be found at <https://www.ncqa.org>.