COMMUNITY FIRST HEALTH PLANS

PROVIDER TIP SHEET

THSteps Vision Screenings

As stated in the Texas Medicaid Provider Procedures Manual: Children's Services Handbook, Section 4.3.12.2.4, a vision screening is required at each THSteps medical checkup.

> Visual acuity tests are required at specific ages defined in the THSteps Periodicity Schedule

> Subjective screenings through Provider observation or informant report are required at other checkups.

Additionally, all patients must undergo screening for any eye abnormalities using a combination of history, observation, and physical exams. If identified as high risk, the patient must be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population. Patients with abnormal visual acuity screening results should also be referred to a Medicaid-enrolled optometrist or ophthalmologist experienced with the pediatric population.

The following vision screening CPT codes are part of THSteps checkups and cannot be reimbursed individually.

> 99177 OCULAR INSTRUMNT SCREEN BIL

> 99174 OCULAR INSTRUMNT SCREEN BIL

> 99173 VISUAL ACUITY SCREEN

> 92553 AUDIOMETRY AIR & BONE

Vision screening for patients who are birth through 20 years of age can be conducted at any primary care provider's office visit, as stated in Section 4.3.3.1, outside of a THSteps Preventive Care Medical Checkup, provided that the following criteria are met:

> Request from a parent

> Referral from a school vision screening program

> Referral from a school nurse

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THSteps Hearing Screenings

As stated in the Texas Medicaid Provider Procedures Manual: Children's Services Handbook, Section 4.3.12.2.4, a hearing screening is a mandatory requirement at every Texas Health Steps (THSteps) checkup for patients between birth and 20 years old.

- After passing their newborn hearing screening, infants' hearing should be monitored in accordance with the THSteps Periodicity Schedule
- Audiometric screenings should be conducted at the ages specified on the THSteps Periodicity Schedule
- Subjective screenings through Provider observation or informant report are required at other checkups.

THSteps checkups incorporate the following CPT codes for Audiometric screenings, which are not reimbursed separately:

- 92551 – Screening test, pure tone, air only
- 92552 – Pure tone audiometry (threshold) air only
- 92553 – Pure tone audiometry (threshold) air and bone

If deemed medically necessary, hearing screens conducted outside of newborn and THSteps medical checkups may be eligible for reimbursement without prior authorization using CPT code 92551.

COMMUNITY FIRST HEALTH PLANS

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THSteps Acute Visits

As stated in the Texas Medicaid Provider Procedures Manual: Children's Services Handbook, Section 4.4.1, an acute visit is defined as the discovery of an acute or chronic condition that requires evaluation and management (E/M) beyond the required components for a THSteps medical checkup.

An acute visit is NOT an insignificant or trivial problem or abnormality that is discovered in the process of performing a checkup and does not require the additional work and performance of the key components of a problem-oriented E/M service.

If an acute or chronic condition that requires E/M beyond the required components for THSteps medical checkup is discovered, a separate E/M procedure code may be considered for reimbursement for the same date of service as a checkup, or the client can be referred for further diagnosis and treatment.

Modifier 25

Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable E/M service by the same physician or other qualified health care professional (QHP) on the same day of the procedure or other service.

> Providers must use modifier 25 to describe circumstances in which an acute care E/M visit was provided at the same time as a THSteps checkup.

> The medical record documentation for the separate EM services must stand on its own for the EM code (acute visit) billed.

> Referencing the chart or portions of the THSteps checkup for any of the key elements (i.e., history, exam, medical decision-making) will not support a separate acute visit billed.

Billing Criteria

1. Appropriate level E/M code (99202-99205) (99212-99215) billed with Modifier 25
2. Documentation that supports medical necessity and the key elements of a separate E/M visit including:
   - Distinct medical history and/or separate examination
   - Medical decision-making
3. Diagnosis related to the acute visit and treatment
4. Separate claim without benefit code EP1

Documentation

> Avoid referencing the THSteps checkup or history for the acute visit.

> Identify and document "new" or "acute" problems separately.

> Document separately treatment or management of "chronic" condition(s) that are "beyond" the THSteps service.

> Document separately the "additional work" performed to support the "acute" visit, apart from the THSteps visit.

CPT Codes for Acute Visits

As of 2021, Evaluation and Management Services (EM) codes are determined by:

> Total time for visit performed on date of encounter, or

> Medical Decision Making (MDM)

The level of history or physical examination does not determine the level of CPT code.

For more information, visit CMS National Correct Coding Initiative Edit (NCCI edits)