CODING ADVICE

Date of Completion: 6/2/2022
Patient: Payshent, Sofia
DOB: 01/01/54
EHR ID:

Physician: Williams, Keller
NPI: xxxxxx
Practice: -- NOT FOUND --

Intake Completed by: Admin, Tillie
==========

Primary Billing for AWV and Advanced Directives*

**Advanced Directives has minimum time of 16 minutes to qualify for reimbursement. If work was completed but did not meet the minimum time requirement, no data will display.*

Diagnosis Code: Z00: Encounter with no complaint

Code-Modifier and Language	Duration
G0439: Subsequent Annual Wellness Visit	32 minutes
99497-33: Advanced Care Planning in conjunction with the AWV, 1st 30 minutes	17 minutes

CPTII and Z Codes

CPT II CODES	Z CODES
3028F - Oxygen Saturation recorded	
3036F - Oxygen saturation level greater than 88	Z82.49: Family history of cardiovasular disease
2010F - Vitals recorded	Z82.69: Family history of musculoskeletal system and connective disease
3008F - BMI documented	Z83.79: Family history of other digestive diseases
2001F - Weight recorded	
1055F - Visual function status assessed - bilateral corrected	
2000F - BP measured	Z82.5: Family history asthma or other chronic lower respiratory disease
2014F - Mental status assessed	
1110F - Patient discharged from an inpatient facility (ie, hospital, skilled nursing facility, or rehab facility) within the last 60 days	
1090F - Presence or absence of urinary incontinence assessed	Z83.42: Family history of hypercholesterolemia
1091F - Urinary incontinence characterized	Z82.3: Family history of stroke
1159F - Medication list documented in the medical record	Z82.62: Family history of osteoporosis
3720F - Cognitive impairment or dysfunction assessed	

CODING ADVICE

Date of Completion: 6/2/2022
Patient: Payshent, Sofia
DOB: 01/01/54
EHR ID:

Physician: Williams, Keller
NPI: xxxxxx
Practice: -- NOT FOUND --

Intake Completed by: Admin, Tillie
==========

1175F - Functional status for dementia assessed and results reviewed	Z83.71: Family history of colon polyps
1494F - Cognition assessed and reviewed	
1170F - Functional status assessed using standardized tool	
1003F - Level of activity assessment	
1101F - Patient screened for future fall risk and documentation of no falls in the past year or only one fall without injury in the past year	
6080F - Patient or caregiver queried about falls	
1126F - Pain severity quantified, no pain present	
4290F - Patient screened for injection drug use	
4293F - Patient screened for high-risk sexual behavior	
3351F - Negative screen for depressive symptoms	
1220F - Patient screened for depression	
3725F - Screening for depression performed	
3016F - Patient screened for unhealthy alcohol use	
1000F - Tobacco use assessed	
1033F - Current tobacco non-smoker and not currently exposed to second-hand smoke	
1036F - Current tobacco nonuser	
1030F - Influenza immunization status assessed	
4040F - Pneumococcal vaccine administered or previously received	
1022F - Pneumococcus immunization status assessed	
1026F - Comorbid condition status assessed	
1158F - ACP discussion documented in the medical record	