This drafted policy is open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of what has changed.

HHSC is performing a targeted review of the Texas Health Steps (THSteps) Preventive Care Medical Checkups Policy benefit for Medicaid clients to (1) add Social Determinants of Health (SDOH) screening for clients birth through 20 years of age, (2) add Hepatitis C screening for clients 12 through 20 years of age, and (3) remove vision acuity screening from the 18 year-old checkup and replace it with subjective vision screening.

The following is a summary of changes in scope for this policy review:

* Added policy language relating to reimbursement/billing guidelines and non-mandated documentation requirements for the Social Determinants of Health (SDOH) screening for clients birth through 20 years of age
* Added Hepatitis C screening for clients 12 through 20 years of age as a benefit under laboratory tests
* Removed vision acuity screening from the 18-year checkup and replaced it with subjective vision screening

Some policy language that is out of scope for this review is included in this document for context. New policy language has been added in tracked changes and deleted language has been struck-through to indicate proposed policy changes.

Note: The current language regarding the Texas Health Steps (THSteps) preventive care medical checkups can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Vol 2: Children’s Services Handbook, Sections 4.0 – 4.5. The THSteps Periodicity Schedule can be found on the THSteps website at Medical <https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers>

**Texas Medicaid**

# Texas Health Steps (THSteps) Preventive Care Medical Checkups

## Statement of Benefits

1. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive care benefit for individuals birth through 20 years of age.
2. In Texas, EPSDT is known as Texas Health Steps.
3. Preventive care medical checkups are a benefit of the Texas Health Steps (THSteps) Program at the time of service delivery for clients who are birth through 20 years of age.

## Reimbursement/Billing Guidelines

### Preventive Care Medical Checkups

1. An evidence-based social determinants of health (SDOH) screening tool must be utilized when SDOH screening is completed for clients birth through 20 years of age.
2. Documentation of tool(s) utilized, results, and referral(s) made must be documented in the medical record. The patient or parent/guardian’s preference for assistance must also be documented for all positive screens. Records are subject to retrospective review, and noncompliance is subject to recoupment.
3. The patient or parent/guardian’s preference for assistance must also be documented for all positive screens. Records are subject to retrospective review, and noncompliance is subject to recoupment.
4. Only one SDOH screening using an evidence-based SDOH screening tool will be reimbursed per client birth through 20 years of age, per calendar year, any provider.

### Social Determinants of Health (SDOH) Screening

1. Using the procedure codes listed in the table below providers may receive a separate reimbursement in addition to the preventive care medical checkup or follow-up visit when completing SDOH screening.
2. Providers must use the following procedure codes and appropriate modifier for SDOH screening:

Table A: Procedure Codes—Social Determinants of Health Screening

|  |  |
| --- | --- |
| Procedure Code | Description |
| 96160 | Administration of patient-focused health risk instrument |
| 96161 | Administration of caregiver-focused health risk assessment, for the benefit of the patient |

Table B: Modifier – Social Determinants of Health Screening

|  |  |
| --- | --- |
| Modifier | Description |
| U8 | State defined modifier – Social Determinants of Health (SDOH) screening |

1. SDOH screening must be billed on the same claim form, on the same date of service, by the same provider, as the THSteps checkup or follow-up visit (procedure codes S-99381, S-99382, S-99383, S-99384, S-99385, S-99391, S-99392, S-99393, S-99394, S-99395 or S-99211).
2. SDOH screening (procedure code S-96160 or S-96161 with Modifier U8) is limited to once per calendar year, per client and will be denied unless a checkup, exception to periodicity checkup, or follow-up visit is paid for the same date of service by the same provider.
3. The reimbursement amount for SDOH screening covers any and all SDOH screenings provided during checkups or follow-up visits.
4. Screening is recommended to be completed annually and may be completed more frequently.
5. Only one reimbursement is allowed annually for SDOH screening. Either 96160 or 96161 with Modifier U8 may be reimbursed once per calendar year.
6. If the SDOH screening resulted in a positive screen for a health-related social need(s), the provider must include a corresponding ICD-10-CM Z code on the claim form.

### Vision Screening

1. Vision screening must be performed at each checkup. A visual acuity test must be performed at ages indicated on the periodicity schedule. Subjective screening through provider observation or informant report must be completed at ages indicated on the periodicity schedule.
2. Vision screening should be performed in accordance with the Texas Department of State Health Services (DSHS) Vision and Hearing Screening Program’s vision screening requirements.

### Laboratory Tests

1. The client must be screened for Hepatitis C (procedure code 5-86803) as indicated on the periodicity schedule. The specimen may be sent to the DSHS Laboratory, or the client or specimen may be sent to the laboratory of the provider’s choice.
2. Additional testing for certain conditions may be completed based on an identified risk or at the provider’s discretion:
   1. Dyslipidemia
   2. Type 2 Diabetes
   3. Sexually transmitted disease/infection:
      1. Syphilis
      2. Chlamydia
      3. Gonorrhea
   4. Hepatitis C (Hep C)
   5. Human immunodeficiency virus (HIV)

**NOTE:** Inform the client that the HIV test is routinely available, confidential, and completely anonymous.

## Documentation Requirements

### Non-Mandated Components

#### Social Determinants of Health Screening and Referral Services

1. Social determinants of health (SDOH) are the non-medical factors that affect health outcomes. They are conditions in the environment where individuals are born, grow, live, work and age. Social determinants of health affect the physical and mental health, well-being and quality of life of children.
2. The five core health-related social determinants of health include:
   1. Housing/Living situation
   2. Food
   3. Transportation
   4. Utilities
   5. Safety/Personal safety
3. The American Academy of Pediatrics (AAP) recommends screening for social determinants of health at each well child visit.
4. Screening for social determinants of health is not a required component of a checkup however, THSteps providers are encouraged to screen all children birth through 20 years of age at least annually and provide appropriate action, including referral for any identified health-related social need(s).
5. SDOH requires the use of an evidence-based SDOH screening tool.
6. In order for SDOH screening to be considered for reimbursement, screening must be completed using an evidence-based SDOH screening tool(s). Evidence-based screening tools include but are not limited to:
   1. Hunger Vital Sign
   2. Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE)
   3. EveryONE Project Social Needs Screening Tool (EveryONE)
   4. Health Leads Screening Toolkit
   5. Well Child Care Evaluation, Community, Resources, Advocacy, Referral, Education (WE CARE)
   6. Health-Related Social Needs Screening Tool (HRSN)

#### Positive Screenings: Referrals and Follow Up

1. All positive screenings for social determinants of health require the THSteps provider to discuss with the patient or parent/caregiver the positive screen including the identified health-related social need(s) and the patient or parent/caregiver’s preference for assistance with the identified health-related social need(s).
2. Patients or parents/caregivers who report wanting assistance with the identified health-related social need(s) should be referred or linked to needed services and resources within the community. Patients or parents/caregivers who report that they do not want assistance should be advised they can always access resources in the future.
3. Community services and resources for addressing identified health-related social needs may include but are not limited to:
   1. local food banks
   2. federal assistance programs such as the Women’s Infants and Children (WIC) Program and the Supplemental Nutrition Assistance Program (SNAP)
   3. financial assistance organizations
   4. educational organization
   5. health care organizations
   6. faith-based organizations
   7. Medicaid NonEmergency Medical Transportation (NEMT)
   8. other community-based services
4. As best practice THSteps encourages all providers to develop a list of local referral resources and provide it to patients or parents/guardians who report wanting assistance with identified health-related social needs.
5. THSteps highly encourages all THSteps providers to follow up on all positive screens for health-related social needs prior to the next checkup or follow-up visit.

## Prior Authorization Requirements

1. Screening for SDOH during a THSteps checkup or follow-up visit does not require prior authorization.

### Documentation Requirements

1. Documentation in the patient’s medical record must include the date the screening was completed, the name of the SDOH screening tool(s) used and the results of the screening.
   1. If the SDOH screening resulted in a positive screen for a health-related social need(s), the provider must also document the patient or parent/guardian’s preference for assistance, information provided, and any action taken including any referrals for appropriate SDOH services and resources provided to the patient or parent/caregiver.
   2. If the SDOH screening resulted in a positive screen for a health-related social need(s), the provider must include a corresponding ICD-10-CM Z code on the claim form.
2. Documentation in the patient’s medical record should also include any health education or anticipatory guidance provided, along with the time period recommended for the next appointment.