

Make Every Annual Physical Exam Count

Use annual physical exams to identify risks, close care gaps, address chronic conditions and ensure complete documentation and coding.

Annual physical exams are an opportunity to improve patient outcomes, close preventive care gaps and ensure complete documentation, accurate coding, and submission of claims and encounter data. Complete documentation and coding support quality measurement, risk adjustment, continuity of care and appropriate reimbursement.



Key actions during annual physical exams

- Review medical, family and social history.
- Complete age- and risk-appropriate screenings.
- Review immunization status and administer or recommend vaccines as appropriate.
- Assess behavioral health and social needs.
- Address chronic and acute conditions.
- Document all findings, diagnoses and services provided.
- Submit complete and accurate claims and encounter data.



Check for open care gaps before the visit ends

Before the visit ends, check Cozeva[®] for open HEDIS^{®1} care gaps. Complete applicable screenings, tests, immunizations and preventive services during the visit when appropriate. If you do not have access to Cozeva, contact Health Net*.

Preventive care opportunities



Children and adolescents

Assess for:

- Immunizations needed or missed.
- Developmental, behavioral and social concerns.
- Oral health, need for fluoride varnish or supplementation.
- Vision and hearing problems.
- Lead exposure and tuberculosis (TB) risk, when indicated.
- Age-appropriate sexual health risks.
- Social determinants of health (SDOH).



Adults

Assess for:

- High blood pressure, cardiovascular risk, diabetes and lipid disorders.
- Age- and risk-appropriate cancers.
- Behavioral health, substance use and social risk factors.
- Oral health, preventive dental care.
- Sexual health risks.
- SDOH.



All patients

Provide:

- Recommended child, adolescent and adult immunizations.
- Counseling on vaccines, nutrition, physical activity, skin cancer prevention, tobacco, alcohol and substance use prevention and cessation, and healthy habits/lifestyle, including:
 - **Children and adolescents:** Injury prevention and safety, oral health and behavioral health.
 - **Adults:** Weight management and obesity.

Note: Services may vary based on age, sex, medical history, risk factors and current clinical guidelines.

(continued)



Documentation requirements

Ensure the medical record supports all services billed and diagnoses reported.

During the visit:

- Clearly document all findings, assessments, diagnoses, care plans, orders and referrals.
- Address and document all conditions that affect patient care, including conditions that do not require added workup.
- Code diagnoses and procedures to the highest level of specificity using current ICD-10-CM and CPT² coding guidelines.
- Submit complete, accurate and timely claims and encounter data for all services rendered.
- Consider CPT Category II codes to support quality measurement and performance reporting.



Coding guidance

Report preventive visit, evaluation and management (E/M) and diagnosis codes as appropriate, based on services provided and conditions addressed during the visit.



Preventive visit CPT codes

Report preventive visit CPT codes based on the patient's age and whether the exam is an initial or subsequent preventive visit.

Age	New patient	Established patient
Under 1 year	99381	99391
1–4 years	99382	99392
5–11 years	99383	99393
12–17 years	99384	99394
18–39 years	99385	99395
40–64 years	99386	99396
65+ years	99387	99397

Separate E/M services

Report a separately identifiable E/M service when significant additional work is performed to evaluate or manage acute concerns, chronic conditions, symptoms or abnormal findings beyond the preventive visit.

- Use CPT codes 99202–99215 with modifier 25.
- If a preventive visit is performed on same date, report CPT codes 99381–99387, 99391–99397, as appropriate.
- Select the E/M level based on medical decision-making or total time.
- Report CPT code 99211 for clinical staff services provided under appropriate supervision.

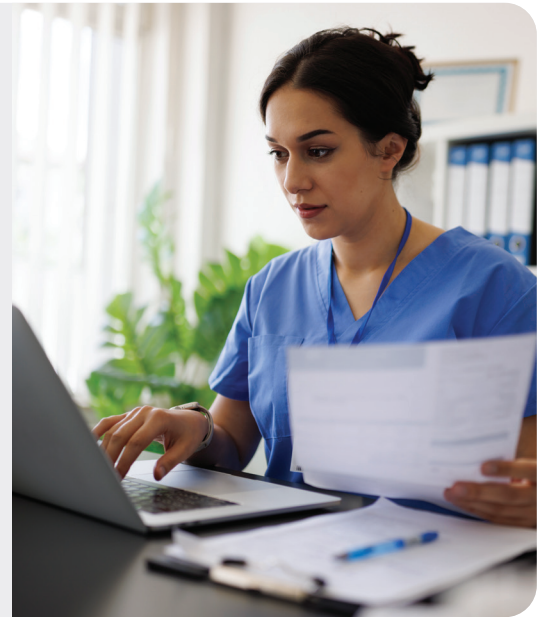
ICD-10-CM annual exam codes

Use the preventive visit diagnosis code and report all conditions addressed during the visit.

Code	Description	Use when
Z00.110	Newborn exam, under 8 days	Routine health supervision for newborns younger than 8 days.
Z00.111	Newborn exam, 8–28 days	Routine health supervision for newborns 8–28 days.
Z00.129	Child exam, normal findings	Preventive exam with no abnormal findings. Report additional codes for chronic conditions addressed during the visit.
Z00.121	Child exam, abnormal findings	Preventive exam with abnormal findings. Report additional codes for all chronic conditions addressed during the visit.
Z00.00	Adult exam, normal findings	Preventive exam with no abnormal findings. Report additional codes for chronic conditions addressed during the visit.
Z00.01	Adult exam, abnormal findings	Preventive exam with abnormal findings. Report additional codes for all conditions addressed during the visit.

Clinical and coding resources

- California Department of Public Health (CDPH)
- U.S. Preventive Services Task Force (USPSTF)
- American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule
- American Academy of Pediatrics (AAP) Childhood Immunization Schedule
- American Academy of Family Physicians (AAFP)
- National Committee for Quality Assurance (NCQA)
- Current CPT, ICD-10-CM and Healthcare Common Procedure Coding System (HCPCS) guidelines
- Health Net Provider Portal and Provider Operations Manual for HMO and PPO



¹Healthcare Effectiveness Data and Information Set.

²CPT Copyright 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

*Health Net of California, Inc. and Health Net Community Solutions, Inc. are subsidiaries of Health Net, LLC and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.