Child Health and Disability Prevention program (CHDP): PM 160 Claim forms

Purpose of the PM=-160 (Why bother to get it right?)

Follow-up	The San Mateo CHDP program uses the information submitted on PM-160 claim forms to **follow up identified problems and facilitate referrals.** The program contacts families and provides community resources.
Reimbursement	The clinic is reimbursed for the items we document have been done in clinic. • New patient visits are reimbursed at a higher rate than Routine visits. • Point of Care testing is reimbursed; testing done in the lab is not.
Timing	Incorrectly completed PM-160 forms are returned to the clinic, delaying reimbursement. • The reimbursement rate drops after 6 months from the time of visit. • No reimbursement is provided for claims submitted after 1 year.

Periodicity schedule and how to bill for WCC outside the approved schedule

- The CHDP periodicity schedule determines how often a child can have a Complete Assessment (WCC). More precisely, the schedule determines how often the CHDP program will reimburse the clinic for providing WCCs.
- For older children, the CHDP periodicity schedule does not follow AAP guidelines and leaves long gaps between visits.
- Patients CAN be seen annually – or more often - if the provider documents the rationale for the "out of periodicity" visit in the Comments section of the PM-160 form. (see below)

Common reasons to see patients more frequently than the periodicity schedule dictates:

- Camp, school, preschool entrance exam
- Teens with high risk issues/activities
- Need to provide additional anticipatory guidance to the individual or the parent or legal guardian.
- Abnormal growth or development
- Physically challenged by significant medical condition
- Significant perinatal/neonatal problems e.g. prolonged hospitalization
- Child in foster care
- Abuse, neglect

If you are seeing a child over age 4 for a full WCC that falls out of periodicity – document one of the reasons above in the Comments section of the PM-160.

CHDP PM 160 CLAIM FORM INSTRUCTIONS – Sections to be completed by MDs

FORM SECTION	Notes
CHDP Assessment	Lines 01-12: must be filled out for all patients. Lines 01-05: all items in this section must be done for all patients, including dental assessments for newborns and infants without teeth. Enter check mark if no problem or not done (Column A or B) Enter follow up code for new or known problem (Column C or D). (It is not crucial to accurately identify whether the problem is new or known – either column will work.) If child is unable to cooperate with vision and hearing screening, check Column B. If Hgb is done in clinic (POC): • Enter result on form • Check Column A if normal • Enter follow up code and comment in column C or D if abnormal If patient is sent to lab for Hgb, Check Column B, and write "Lab-Hgb" in comments section.
Comments/Problems	Enter diagnosis for each problem* identified in the Assessment section. *Problems that should be listed include chronic problems (asthma, obesity, failure to thrive, developmental issues) or acute problems *that are likely to require follow-up or referral*.
Referred to:	Enter name of clinic/specialty if patient is being referred (Use follow up code 5 in Assessment column C or D)
Routine Referrals	If patient has been advised to see a dentist, check the dental referral box. If patient has been sent to lab for serum Lead, check the Lead box
Diagnosis Codes	NOT necessary to complete
Tobacco questions	All 3 must be answered
PPD result and assessment/outcome	Mark No Problem Suspected. (Column A) Nurse reading PPD will update as needed when patient returns for PPD reading
Signature	Although forms can be signed by a non-MD/PA provider, CHDP would like to be able to identify the provider who saw the patient in order to facilitate follow-up

Correctly filled out

3-year-old WCC
Diagnosed with constipation, and speech delay during WCC. Unable to cooperate with vision and hearing. Referred to audiology and LPCH speech

DO NOT STAP IN BAR AREA

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (MIDDLE) Code

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

DATE OF SERVICE Mo. Day Year

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM			3		01
02 DENTAL ASSESSMENT/REFERRAL	✔				
03 NUTRITIONAL ASSESSMENT	✔				
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION	✔				
05 DEVELOPMENTAL ASSESSMENT			5		
06 SNELLEN OR EQUIVALENT		✔			06
07 AUDIOMETRIC		✔			07
08 HEMOGLOBIN OR HEMATOCRIT		✔			08
09 URINE DIPSTICK		✔			09
10 COMPLETE URINALYSIS		✔			10
12 TB MANTOUX		✔			12

REFERRED TO: Audiology — TELEPHONE NUMBER

REFERRED TO: Speech therapy — TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

01 - Constipation
05 - Speech delay

CODE | OTHER TESTS — PLEASE REFER TO THE CHDP LIST OF TEST CODES — CODE | OTHER TESTS

HEIGHT IN INCHES: 04 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (√): ☐ BLOOD LEAD ✔ DENTAL

PATIENT IS A FOSTER CHILD (√) ☐

DIAGNOSIS CODES

1: 564.00 | 2: 315.39

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ✔ No ☐
2. Tobacco Used by Patient Yes ☐ No ✔
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ✔ No ☐

PATIENT VISIT (√): 1 New Patient or Extended Visit | 2 Routine Visit

TYPE OF SCREEN (√): 1 Initial | 2 Periodic

TOTAL FEES

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY | AID | IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER GPCH/MD DATE 12/12/13

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 INFORMATION ONLY (03/07)

Correctly filled out

2 year-old – Routine WCC – No problems.
Hemoglobin and Lead done in clinic. PPD placed – to be read in 48 hours.
Family advised to schedule first routine dental visit.

Nurses will check PPD in 48 hours and update Assessment section as needed based on result.

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

DO NOT FOLD, STAPLE OR MUTILATE

PLEASE PRINT

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

6-White
7-Other
8-Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM	✔				01
02 DENTAL ASSESSMENT/REFERRAL	✔				
03 NUTRITIONAL ASSESSMENT	✔				
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION	✔				
05 DEVELOPMENTAL ASSESSMENT	✔				
06 SNELLEN OR EQUIVALENT		✔			06
07 AUDIOMETRIC		✔			07
08 HEMOGLOBIN OR HEMATOCRIT	✔				08
09 URINE DIPSTICK		✔			09
10 COMPLETE URINALYSIS		✔			10
12 TB MANTOUX	✔				12

DATE OF SERVICE Mo. Day Year

FOLLOW UP CODES
1. NO DX UNDER
2. QUEST SCHED
3. DX MA

REFERRED TO

REFERRED TO

CODE	OTHER TESTS	CODE	OTHER TESTS

PLEASE REFER TO THE CHDP LIST OF TEST CODES

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
0	4			
HEMOGLOBIN 12.9	HEMATOCRIT .0%		%	BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (√): ☐ BLOOD LEAD ✔ DENTAL

PATIENT IS A FOSTER CHILD (√) ☐

DIAGNOSIS CODES 1 2

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

PATIENT VISIT (√): 1 -New Patient or Extended Visit; 2 -Routine Visit

TYPE OF SCREEN (√): 1 Initial; 2 -Periodic

TOTAL FEES

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ✔
2. Tobacco Used by Patient Yes ☐ No ✔
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ✔

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE/PROVIDER NUMBER

PLACE OF SERVICE

1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

GPCH/MD

SIGNATURE OF PROVIDER

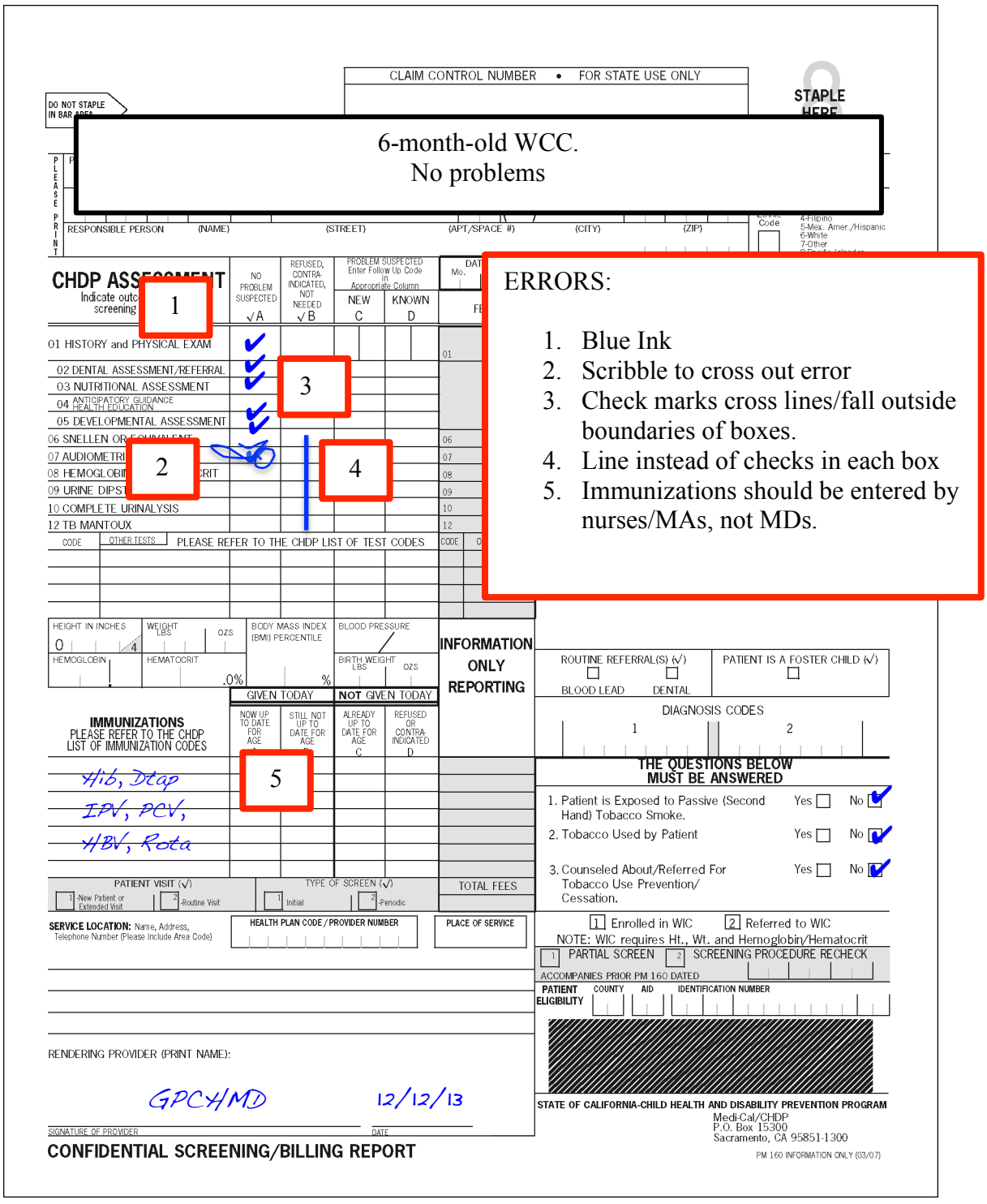
12/12/13

DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

PM 160 INFORMATION ONLY (03/07)

CONFIDENTIAL SCREENING/BILLING REPORT


CLAIM CONTROL NUMBER • FOR STATE USE ONLY
STAPLE HERE
DO NOT STAPLE IN BAR AREA
6-month-old WCC.
No problems
PLEASE PRINT
RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)
CHDP ASSESSMENT
NO PROBLEM SUSPECTED √A
REFUSED, CONTRA-INDICATED, NOT NEEDED √B
PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column
NEW C
KNOWN D
01 HISTORY and PHYSICAL EXAM
02 DENTAL ASSESSMENT/REFERRAL
03 NUTRITIONAL ASSESSMENT
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION
05 DEVELOPMENTAL ASSESSMENT
06 SNELLEN OR EQUIVALENT
07 AUDIOMETRI
08 HEMOGLOBI CRIT
09 URINE DIPST
10 COMPLETE URINALYSIS
12 TB MANTOUX
CODE OTHER TESTS PLEASE REFER TO THE CHDP LIST OF TEST CODES
HEIGHT IN INCHES
WEIGHT LBS OZS
BODY MASS INDEX (BMI) PERCENTILE
BLOOD PRESSURE
HEMOGLOBIN
HEMATOCRIT .0%
BIRTH WEIGHT LBS OZS
INFORMATION ONLY REPORTING
ROUTINE REFERRAL(S) (√)
BLOOD LEAD
DENTAL
PATIENT IS A FOSTER CHILD (√)
DIAGNOSIS CODES
GIVEN TODAY
NOT GIVEN TODAY
IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES
NOW UP TO DATE FOR AGE A
STILL NOT UP TO DATE FOR AGE B
ALREADY UP TO DATE FOR AGE C
REFUSED OR CONTRA-INDICATED D
Hib, Dtap
IPV, PCV,
HBV, Rota
THE QUESTIONS BELOW MUST BE ANSWERED
1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes No
2. Tobacco Used by Patient Yes No
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes No
PATIENT VISIT (√) 1-New Patient or Extended Visit 2-Routine Visit
TYPE OF SCREEN (√) 1 Initial 2-Periodic
TOTAL FEES
SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)
HEALTH PLAN CODE / PROVIDER NUMBER
PLACE OF SERVICE
1 Enrolled in WIC 2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit
1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED
PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER
RENDERING PROVIDER (PRINT NAME):
GPCH/MD
12/12/13
SIGNATURE OF PROVIDER
DATE
CONFIDENTIAL SCREENING/BILLING REPORT
STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM
Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300
PM 160 INFORMATION ONLY (03/07)
1
2
3
4
5
ERRORS:
1. Blue Ink
2. Scribble to cross out error
3. Check marks cross lines/fall outside boundaries of boxes.
4. Line instead of checks in each box
5. Immunizations should be entered by nurses/MAs, not MDs.

6year-old WCC.
Known to be overweight – discussed during visit.
Diagnosed with tinea capitis during WCC and started on griseofulvin.

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

DO NOT IN BAR

PLEASE PRINT

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code
4-Filipino
5-Mex. Amer./Hispanic
6-White
7-Other
8-Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED √A	REFUSED, CONTRA-INDICATED, NOT NEEDED √B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM			✔		01 6
02 DENTAL ASSESSMENT/REFERRAL	✔				02
03 NUTRITIONAL ASSESSMENT				✔	03
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION	✔				04
05 DEVELOPMENTAL ASSESSMENT					05 7
06 SNELLEN OR EQUIVALENT	✔				06
07 AUDIOMETRIC	✔				07
08 HEMOGLOBIN OR HEMATOCRIT		✔			08
09 URINE DIPSTICK		✔			09
10 COMPLETE URINALYSIS		✔			10
12 TB MANTOUX		✔			12

CODE | OTHER TESTS | PLEASE REFER TO THE CHDP LIST OF TEST CODES | CODE | OTHER TESTS

DATE OF SERVICE Mo. Day Year

FOLLOW UP CODES

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

Tinea capitis
Obesity

ERRORS:

6. Checks instead of follow up codes for identified problems
7. Developmental assessment not documented (all 12 items in the assessment must be documented)
8. 2 of 3 smoking questions not filled out

ROUTINE REFERRAL(S) (√) ☐ BLOOD LEAD ✔ DENTAL

PATIENT IS A FOSTER CHILD (√) ☐

DIAGNOSIS CODES 1 2

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ✔
2. Tobacco Used by Patien 8 Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

☐1 Enrolled in WIC ☐2 Referred to WIC
NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

☐1 PARTIAL SCREEN ☐2 SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY | COUNTY | AID | IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

GPCH/MD

SIGNATURE OF PROVIDER

12/12/13

DATE

CONFIDENTIAL SCREENING/BILLING REPORT

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