Tips for ACEs-Related Coding

Getting Started

How should practices account for their time related to ACEs screening, if most payers aren't accepting claims? For now, organizations may want to take a two-pronged strategy in regards to coding for ACEs screening:

1. For tracking purposes, organizations should decide to use one CPT code consistently across an age group, or specific codes for children and for adolescents.
2. For billing purposes, organizations can float a claim to payers to see whether or not the claim will be paid. The payer will indicate if it has enough information to reimburse and/or if the code is accepted. Family medicine physicians would have to bill under the child, not the mother, but clinicians could use the same standardized scores.

Following are some codes to try for both tracking and reporting purposes, as well as links to some resources that can provide you with additional information.

Current Procedural Terminology (CPT) Codes

Current Procedural Terminology (CPT) codes identify interventions that clinicians make after or during a patient visit (e.g., providing anticipatory guidance). The AAP formerly recommended using CPT code 99420 when assessing a child's health risk. However, in 2017, code 99420 was deleted and replaced with code 96160 and code 96161, which address administration and scoring of patient-focused and caregiver-focused assessments, but require the instruments used for screening be standardized and scorable to be reimbursable.

- 96160: Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.
- 96161: Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

A list of commonly reported CPT codes for care for youth who have experienced trauma can be found in the AAP Coding Fact Sheet For Treating Trauma.

ICD-10 Codes

ICD-10 codes refer to the visit itself (what type of visit it was). Although unspecified Z codes always get bounced back by payers, they can be valuable to for tracking purposes/pulling reports.

In California, some ICD-10 codes have been identified as being related to ACEs screening in the state3 (it will vary by state and payer), including:

- Z59.4: Lack of adequate food or safe drinking water
- Z63.0: Relationship problem between spouse or partners
- Z62.819: History of abuse in childhood
- Z63.5: Family disruption due to divorce or legal separation
- Z63.32: Absence of family member

- Z81.9: Family history of mental and behavioral disorder
- Z63.72: Alcoholism and drug addiction in family
- Z63.9: Problem related to primary support group

A list of commonly reported ICD-10 codes for care for youth who have experienced trauma can be found in the AAP Coding Fact Sheet For Treating Trauma.

Payer Guidance

Payer guidance regarding coding for ACEs and trauma screening and treatment is not yet available and will vary across health plans. Reimbursement for ACEs screening will vary from state to state.

The AAP is helping to push the industry to catch up, with an active lobbying group that's seeking support for universal reimbursement for screening. With more consistent efforts and more providers billing with these codes, the thought is we'll see a faster response regarding reimbursement guidance from payers.

1 Coding for Pediatric Preventive Care, 2017. American Academy of Pediatrics. 2017.

2 Policy Statement: Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health, American Academy of Pediatrics. Jan. 2012.

3 Ariane Marie-Mitchell, MD, PhD, MPH. Loma Linda Whole Child Assessment presentation. California Pediatric Symposium 2016.

Developed by the National Pediatric Practice Community on ACEs
NPPC Member website
https://www.nppcacesmembers.org/operational-resources/define-policies/

ACEs Screening Decision Making Inputs Worksheet

You want to implement ACEs screening, but may not know how to get the ball rolling. This worksheet is intended to help you organize your thinking around screening for ACEs in your organization. Take time to talk to others in your practice, consider the questions below and fill out the worksheet (examples to jump-start your thinking included below). When you're finished, you should have answers to some key questions and a good foundation for embarking on a more detailed plan.

Question	Draft your organization's screening protocol	What we know now/what we've heard	What questions we have	Who needs to be involved in making this decision?
What is our rationale for ACEs Screening?				Who holds bottom line responsibility for this decision?
What is the target population? Who will be screened?				
What are our goals for this project? How will we know we have met				

our goals?				
Which clinic(s) will be implementing screening?				
What ACEs screening tool will we use?				
What is the plan for intervention /follow-up?				
Who will be involved in the screening process from a staffing perspective ? (Who will administer? Who will interpret? Who will be responsible for follow up?)	-			

CYW Adverse Childhood Experiences Questionnaire (ACE-Q) Child

To be completed by Parent/Caregiver

Today's Date: _____

Child's Name: _____ *Date of birth:* _____

Your Name: _____ *Relationship to Child:* _____

Many children experience stressful life events that can affect their health and wellbeing. The results from this questionnaire will assist your child's doctor in assessing their health and determining guidance. *Please read the statements below. Count the number of statements that apply to your child and write the total number in the box provided.*

Please DO NOT mark or indicate which specific statements apply to your child.

1) Of the statements in Section 1, HOW MANY apply to your child? Write the total number in the box. ☐

Section 1. *At any point since your child was born...*

- Your child's parents or guardians were separated or divorced
- Your child lived with a household member who served time in jail or prison
- Your child lived with a household member who was depressed, mentally ill or attempted suicide
- Your child saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put down your child in a way that scared your child OR a household member acted in a way that made your child afraid that s/he might be physically hurt
- Someone touched your child's private parts or asked your child to touch their private parts in a sexual way
- More than once, your child went without food, clothing, a place to live, or had no one to protect her/him
- Someone pushed, grabbed, slapped or threw something at your child OR your child was hit so hard that your child was injured or had marks
- Your child lived with someone who had a problem with drinking or using drugs
- Your child often felt unsupported, unloved and/or unprotected

2) Of the statements in Section 2, HOW MANY apply to your child? Write the total number in the box. ☐

Section 2. *At any point since your child was born...*

- Your child was in foster care
- Your child experienced harassment or bullying at school
- Your child lived with a parent or guardian who died
- Your child was separated from her/his primary caregiver through deportation or immigration
- Your child had a serious medical procedure or life threatening illness
- Your child often saw or heard violence in the neighborhood or in her/his school neighborhood
- Your child was often treated badly because of race, sexual orientation, place of birth, disability or religion

ACEs Screening Workflow Examples

The purpose of this document is to provide practices with suggested ways to incorporate ACEs screening into the workflow.

A Basic Workflow

Administration of ACEs screening tool	Form completion	Review & score interpretation	Patient & family education and/or referral	Documentation & tracking

Administration of ACEs Screening Tool: A Real-World Example from California Pacific Medical Center's Bayview Child Health Center (BCHC)

Medical Assistant administration of screening tool for well-child visits starting at 9 months and for new patients

1. Medical Assistant greets and welcomes the caregiver and patient.
2. Medical Assistant informs the caregiver that they will need to fill out several forms prior to the child/youth's appointment. The packet is provided on a clipboard. It is recommended that the ACEs screening tool be included earlier in the packet to increase completion rate.
3. Medical Assistant provides a general description of each form in the packet, providing context. She/he informs the caregiver that the Primary Care Provider will review the results with her/him and the child/youth.

Completion of Form

4. The caregiver completes the packet and returns it to the Medical Assistant.
5. For adolescent patients who complete a self-report (in addition to the caregiver report), the completed screen should be returned separately to the Medical Assistant upon completion.

Review & Score Interpretation

6. The packet is provided to the Primary Care Provider for review prior to the appointment.
7. The Primary Care Provider reviews the information prior to meeting with the patient.
8. The Primary Care Provider carries out the standard well-child check-up, and reviews results with the patient and caregiver. If the form is not filled out before the patient and caregiver meet with the Primary Care Provider, the Provider asks the caregiver and/or patient if she/he would like to fill it out today, or save it for another visit. (Typically she/he fills it out then).

Patient & Family Education and/or Referral

9. If the ACEs score is "zero," the Primary Care Provider reiterates that this is a screening tool that is used for all patients, and provides anticipatory guidance explaining what ACEs

are and why this information is important. (Sometimes new patients enter "zero" and then later change the score during a follow-up visit, when they feel more comfortable with theProvider.) The Primary Care Provider may make a note in the patient chart to discuss the screening again at a future visit.

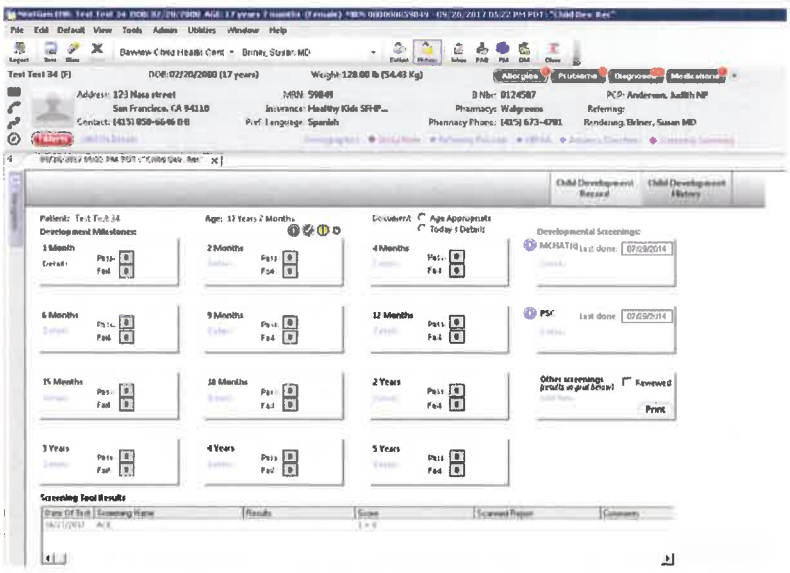
10. If screening reveals an ACE score, the Primary Care Provider explains why ACE screening has been conducted, and carries out next steps according to the established algorithm. Specifically, for a score of 0-3 with no symptoms, the Provider provides patient education. For a score of 1-3 with symptoms (see symptom list), the Provider provides anticipatory guidance. For a score of 4+, the Provider provides the appropriate referral (with a warm hand-off if possible). When a warm hand-off is not possible, the Primary Care Provider explains what resources are available and asks if the caregiver and/or patient would like a referral. Sometimes the caregiver and/or patient would like to think about it, and the Provider can schedule an extra visit to talk further, or coordinate care with an existing therapist, etc.
11. Through conversation with the patient and her/his caregiver, the Primary Care Provider may identify relevant symptoms that should be considered in determining whether a referral for services is clinically indicated. For patients with multiple symptoms, the Primary Care Provider may need to determine what is the most important issue to cover in the time she/he has for the visit; i.e., a child's asthma. Focusing on the most pressing symptom may provide an opening to also talk about interventions like nutrition and exercise, and to schedule future visits to address ACES-related health issues further.

Documentation & Tracking

12. When the Primary Care Provider reviews the ASQ Ages & Stages questionnaire and enters scores and follow-up decisions into the patient record, she/he also adds the ACE score in a specific "free text" field in one of the EHR (NextGen) standard templates.

Standardizing entry of the ACE score across the practice allows the practice to easily pull a monthly report that presents data in an Excel spreadsheet.

Example: Entering ACE score into NextGen at BCHC:



Are You Ready for ACEs Screening?
15 Key Questions to Ask Yourself — and Your Practice

Determining if your practice is ready to implement adverse childhood experiences (ACEs) screening should be a thoughtful, strategic and collaborative process.

First, it's important that you, as the one leading the charge, can clearly demonstrate the importance of ACEs screening and why your practice should implement it. **Second**, take time with your team to consider if your practice has all the necessary staffing, support and resources in place — and/or what you need to put in place — to successfully implement ACEs screening to improve patient outcomes.

Following is a list of exploratory questions to help guide your thought process and research efforts. Once you feel you have satisfactory answers to these basic, foundational questions, you may want to move on to more specific decision-making, using the ACEs Screening Decision Making Inputs Worksheet.

Am I ready?

1. Do I personally have a strong understanding of the background and scientific rationale for screening for ACEs and how this pertains to my practice?
2. Have I practiced explaining ACEs and Toxic Stress to patients?
3. Do I have a practice of self care established?

Is my practice ready?

4. Is there a champion/advocate in the practice (myself or other person) who is committed to leading the effort of integrating ACEs screening into my practice?
5. Is the majority of my practice aligned on the rationale for ACEs screening and why/how it will help our patients and their families? Do I have leadership/managers' support and is there general, overall enthusiasm for making change?
6. Does our practice share an understanding of the rationale for ACEs screening? Do I need to do more education and outreach to clinicians and staff to promote understanding and generate support?

Screening & Operational Logistics

7. Do we have a protocol for the integration of ACEs screening into our workflow?
   - Who will we assess (e.g., universal screening, certain age groups, symptomatic, parents, etc.)?
   - How will we screen (e.g., questionnaire, interview, etc.)? What tools will we use? What staff will be involved in ACEs screening (e.g., administration, collecting and managing ACEs data) and can they do it with appropriate confidentiality and professionalism?
   - How will we collect and track data on ACEs screening results (e.g., in EMR, paper records, etc.) and how will we aggregate data to report and evaluate results?
   - Have we identified a range of clinical and non-clinical responses to ACEs screen results
8. Do our clinical policies and procedures provide adequate guidance relevant to ACEs screening?
9. When/how often will we review and evaluate results?Patient support & follow-up

10. Can our practice support patients with a range of responses/interventions once ACEs have been identified (e.g., patient and caregiver education, mental and behavioral health services, nutrition services, care coordination, home visiting, etc.)?
    - Do we know the evidence-based and promising interventions?
    - Do we know what types of resources our families want?
    - Have we prepared our internal responses/interventions to receive patients based on ACEs screening results?
    - Do we have resources to handle any acute issues that might arise as a result of the screen when it's administered?
    - Do we have the right resource partnerships in place? Are they high quality and ACEs-informed? Can they handle a potential influx of new patients?
11. Will families be able to access resources relatively quickly? Can we facilitate warm handoffs? If there is a delay in getting support from resources, are we prepared to help families identify coping strategies while waiting to be referred to appropriate services?

Staff preparation & support

12. Have we discussed and addressed clinician and staff concerns regarding ACEs screening?
13. Does our practice have the financial resources to support staffing, staff training, and staff support?
14. How and when will staff be trained about trauma-informed care, ACEs screening (e.g., trauma-informed care, vicarious trauma, conflict resolution, and mandated reporting)?
15. Is our practice set up to support staff around challenging cases and burnout?

Developed by the National Pediatric Practice Community on ACEs
NPPC Member website
https://www.nppcacesmembers.org/knowledge-base/determine-your-course/are-you-ready-for-aces-screening-15-key-questions-to-ask-yourself/

Pick the Questionnaire

NAME	TYPES OF ITEMS ASSESSED	ALIGNED WITH ACE STUDY ITEMS	TARGET POPULATION	WHO COMPLETES IT
Adverse Childhood Experience Questionnaire	ACEs	Yes	18+	Self (adolescent); Parent
Beyond ACE Questionnaire	ACEs	Yes	Parent; Child; Adolescent	Service provider
Center for Youth Wellness ACE Questionnaire	ACEs + Other adversity	Yes	0-19	Self (adolescent); Parent
Child Abuse and Trauma Scale	ACEs + Other adversity	No	Child; Adolescent; Adult	Self; Parent
Child and Adolescent Needs and Strengths-Trauma Comprehensive (CANS Trauma)	ACEs + Other adversity + Resilience	Yes	3-18	Clinician or service provider
Childhood Trauma Questionnaire (CTQ)	ACEs + Resilience	Yes	12+	Self
Childhood Trust Events Survey	ACEs + Resilience + Resilience	Yes	0-18	Self; Parent
Children's Trauma Assessment Center Trauma Screening Checklist	ACEs	Yes	0-18	Clinician or service provider
Connor-Davidson Resilience Scale (CD-RISC©)	Resilience	No	10-18; Adults	
Elsie Allen Health Center ACE Survey	ACEs + Other adversity	Yes		Self
Juvenile Victimization Questionnaire – 2nd Revision	ACEs + Other adversity	Yes	8-17; Adult	Service provider or self
Loma Linda University Whole Child Assessment	ACEs + Other adversity + Resilience	Yes	0-17	Self (adolescent) Parent
Parental ACE Questionnaire	ACEs + Other adversity	Yes	Parent	Self

NAME	TYPES OF ITEMS ASSESSED	ALIGNED WITH ACE STUDY ITEMS	TARGET POPULATION	WHO COMPLETES IT
Philadelphia ACE Project and Health Federation of Philadelphia Expanded ACE Survey	ACEs + Other adversity	Yes	18+	Self
SEEK Parent Questionnaire (PSQ): A Safe Environment for Every Kid	Other adversity	No	Parent of 0-5 year old	Self
THEARC's Adverse Childhood Experiences (ACEs) Questionnaire	ACEs + Other adversity	Yes	0-3	Parent
Trauma History Profile from the UCLA PTSD Reaction Index	ACEs + Other adversity	No	7+; Parent	Clinician
WHO ACE-International Questionnaire (ACEs Family Health History and Health Appraisal Questionnaire)	ACEs	Yes	18+	Interviewer
Yale-Vermont Adversity in Childhood Scale (Y-VACS)	ACEs + Other adversity	Yes	0-20	Self, Parent, Clinician

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NPPC Member website
https://www.nppcacesmembers.org/screening-resources/pick-the-questionnaire/
Screening Resources ---> Pick the Questionnaire

About National Pediatric Practice Community on Adverse Childhood Experiences (ACEs) Overview

The National Pediatric Practice Community on Adverse Childhood Experiences (NPPC) is a network of pioneering pediatric-serving medical practitioners interested in integrating ACEs screening into their workflow and using a toxic stress framework to enhance the quality of patient care and health outcomes. NPPC members are leaders in advancing and disseminating knowledge in the field of ACEs and toxic stress in primary care. The NPPC is led by the Center for Youth Wellness with funding from the JPB Foundation, Genentech, Packard Foundation, and Google.org.

Why an NPPC?

The science on ACEs and toxic stress is advancing rapidly, providing the field with greater clarity on the physiological mechanisms that explain the relationships between adversity and health outcomes, and how adversity may interact with current standards of medical care. There is increased interest and demand for information about how to integrate an ACEs, toxic stress, and trauma-informed framework into pediatric medical care, and how to effectively integrate screening and its results into patient health care management. The NPPC will help prepare medical practices to adopt these innovations, provide practitioners with information and training on relevant subject matter, and engage its members to inform future research based on clinical experiences.Over three years, the NPPC's goal is to support 1,000 pediatric medical providers in making ACEs screening and intervention part of their routine clinical practice. This project operates on two levels:

The NPPC Virtual Network

At the broadest level, NPPC is a *virtual network* with a comprehensive member website that serves as a hub for information, tools, shared learning opportunities, peer information exchange, and resources to ultimately help facilitate the process of ACEs screening implementation in medical practices. The NPPC aims to:

- Disseminate emerging and evidence-based practices related to ACEs, toxic stress, and trauma-informed pediatric medical care.
- Provide virtual coaching and training opportunities that allow members to learn from experts in the field and each other.
- Foster collaborative learning and gather lessons learned as part of a process to better understand the impact of ACEs screening on medical practice.

NPPC Pilot Site Engagement

As a sub-project to the virtual NPPC network, we are working with and providing tailored support to a select number of *Pilot Sites,* which are medical practices representing diverse healthcare delivery models that have not yet adopted an ACEs screening protocol. Pilot sites work with the NPPC coach, a clinical quality improvement (CQI) specialist, and receive tailored clinical quality improvement coaching to facilitate the adoption of an ACEs screening protocol relevant to the site's delivery model and patient population. Pilot sites will work in partnership with the NPPC team to collect, analyze, and utilize data to ensure a deep level of learning about clinical transformation and adoption of ACEs screening, and share lessons and resources developed learned with the broader NPPC membership.

What are the benefits of being a Pilot Site?

- Support in achieving buy-in across the medical practice.
- Facilitation of readiness assessment and workplan development.
- Tailored coaching and trainings.
- Access to relevant high-quality and innovative content through virtual and in-person convenings.
- $15,000 stipend (self-funding sites may not receive a stipend.)

What are the benefits of joining NPPC?

- Being a pioneer in advancing practice and knowledge around ACEs screening
- Enhanced quality of patient care
- Access to virtual and in-person professional development for providers and staff (possibly offering CMEs)
- Virtual technical assistance from the Center for Youth Wellness ACEs coach and staff
- Access to a network of providers who are at varying stages of ACEs screening protocol development
- Monthly communications on relevant topics and access to a resource library
- Reduced registration fee for conferences held by the Center for Youth Wellness

Who can join NPPC?

The NPPC is a learning community focused on medical practice. It is open to all pediatric-focused primary care medical providers, including physicians, nurse practitioners, nurses, medical assistants, and supporting teams that have direct responsibility over clinical quality improvement. Members can be at any stage of implementation of ACEs screening and intervention. We intentionally looking to recruit practitioners with varying levels of experience in as this will allow for a rich learning environment among members. The implementation team at each Pilot Site is automatically enrolled in the NPPC, but additional providers/team members at each practice are also welcome to join as individuals.

How do I join NPPC?

You can indicate your interest in enrolling during the NPPC Pilot Site training. To enroll after the training, please visit www.NPPCaces.org and click **JOIN NOW** in the top navigation bar. To enroll, complete the registration information, baseline questionnaire, and accept the terms of the participant agreement. A confirmation email will be sent to the address provided along with information on how to access the member site. For more information, please contact Leena Singh: lsingh@centerforyouthwellness.org