Child and Teen Checkups

Answers to Frequently Asked Questions

This Health Plan FAQ was developed by representatives of Blue Plus, HealthPartners, Medica and Ucare health plans. This document is subject to change. To obtain the most recent version of materials referenced throughout this FAQ, please go to the Becker County website or the Minnesota Council of Health Plans Website.

Billing information in this document is specific only to those Medical Assistance and MinnesotaCare recipients enrolled with one of the following health plans: Blue Plus, Medica and UCare.

C&TC billing questions specific to those who are on fee-for-service Medical Assistance (those who are not covered under health plan) should be directed to the Minnesota Department of Human Services. You can also refer to the MHCP Provider Manual which is your primary information source for MHCP coverage policies, rates and billing procedures as it relates to fee-for-service Medical Assistance.

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I. THE CHILD AND TEEN CHECKUPS (C&TC) VISIT

1.) What constitutes a child having a C&TC screening vs. a well-child exam?
A C&TC screening is one level of a well-child/preventative care visit. A preventative care visit is considered a complete C&TC screening when the C&TC periodicity schedule is followed and recommended components are performed at those visits for Minnesota Health Care Program (MCHP) recipients who are under the age of 21.

Many clinics use the C&TC screening guidelines as their standard of care for all children. However, some clinics use the C&TC guidelines for MHCP recipients and a different guideline for individual or commercially insured members.

There are many different guidelines that are used to designate a well-child exam. Your clinic probably uses one of them as their standard of care. The American Academy of Pediatrics (AAP), American Academy of Family Practice (AAFP) and Institute for Clinical Systems Integration (ICSI) all offer different periodicity schedules but each would be considered a complete well-child exam but not a complete C&TC screening.

The current C&TC periodicity schedule must be followed in order for the visit to qualify as a C&TC; following are some resources for you.

- The Minnesota Department of Human Services C&TC Provider Guide
- The C&TC Dental Periodicity Schedule

Please refer to Section V to learn how to bill for a complete C&TC screening.

2.) If a patient is new to our clinic, should we perform a C&TC when he/she first comes to the clinic or should we wait until the next exam is due according to the schedule?
It is recommended that you take advantage of this opportunity to perform a C&TC.

3.) If we perform a C&TC for a child who is not assigned to our clinic, what should we do?
Blue Plus assigns members to a primary care clinic and encourage them to utilize this clinic. If a member presents at the clinic and has a different clinic listed on their member card, they can still be seen for that visit at the clinic as long as the clinic is under contract. The members should be directed to immediately contact Blue Plus or Ucare customer service if he/she wishes to change permanently to the new primary care clinic. This is very important in the coordination of future care for the member.
3.) If we perform a C&TC for a child who is not assigned to our clinic, what should we do? Medica does not require Medica Choice Care and Medica MinnesotaCare members to choose a primary care clinic, so this should not be an issue unless you are a non-network provider.

Ucare encourages members to have a regular doctor who they see routinely but they can also see any network provider. There is no primary clinic identified on member’s card. Any provider contracted with Ucare may bill for the C&TC performed.

4.) If we have a patient that is in the office for a different type of visit, but they are not due for a C&TC, can we still perform a C&TC since they are in the office? If so, will we receive reimbursement?

Yes, we feel it is very important to perform a C&TC screening when you have a patient in the office, even if they are not quite due for a screening according to the periodicity schedule. The health plans will reimburse you for this service.

II. C&TC ELIGIBILITY

1.) Who is eligible for Child and Teen Checkups (C&TC) or EPSDT (the federal program known as Early and Periodic Screening, Diagnosis and Treatment)?
   • Enrollees under the age of 21 who have coverage under Minnesota Health Care programs.
   • Blue Plus members with group numbers starting with PP0 or PP11
   • Medica Choice Care & Medica MinnesotaCare members (group # starting with 59)
   • All Ucare members

2.) How do I check eligibility – to make sure the patient has coverage?
   • DHS Electronic Verification System (EVS) at 651-431-4399 or 1-800-657-3613
     Coverage can be verified through EVS if you are uncertain as to what health plan the member is enrolled with or if he/she has fee-for-service Medical Assistance. The provider must have an ID code to use EVS. You can also verify recipient eligibility online through MN-ITS. Learn more about MN-ITS and register online at http://mn-its.dhs.state.mn.us

   • To verify directly with the health plan and obtain the member ID#,
     ✓ Blue Plus call 651-662-5200 or 1-800-262-0820 or check Provider Web Self-Service. You can also call customer service for eligibility only at 1-888-711-9862 or 651-662-5545
     ✓ Medica call 952-992-2232 or 1-800-458-5512. You can also verify eligibility for a date of service via WebMD Office, Claimlynx, B2B, etc.
     ✓ Ucare call 612-676-6824 or 1-800-203-7225 or via the Provider Portal at www. Ucare.org
1.) Do we have to use an audiometer for the required hearing screenings?

Children age 3 and older must receive a puretone audiometric test. However, if it is documented in the child’s chart that the child received a hearing screening as a newborn, the puretone audiometer can start at age 4 rather than at age 3. Additionally, for all children, the child, parent or guardian must be asked if there are concerns about the child’s hearing.

2.) If hearing and/or vision screening is done at the school, what type of documentation is needed by the clinic to count as a complete C&TC?

For all three health plans, it is preferred that the health care provider review the results of the screenings performed at the school during the C&TC visit and document accordingly. You can then bill for a completed C&TC screening using code S0302 providing all other recommended components were performed. Again, since the hearing and/or vision screening was not performed, the provider should not bill those specific codes to the health plans.

The provider can choose to perform the hearing and/or vision screening even if it was done at the school. In doing so, the corresponding codes can then be billed to the health plans along with code S0302 providing all other recommended components are performed.

3.) What options are available if we do not have hearing and/or vision screening capabilities?

The Minnesota Department of Health holds sessions each year to train professionals to conduct hearing and vision screenings properly. They also offer Web-based trainings.

You can contact your local public health agency to discuss overcoming the barriers in your clinic. They will work with you to develop processes that meet the C&TC screening criteria.

4.) How do I turn a Sports Physical into a C&TC?

The Minnesota State High School League’s (MSHSL) Sports Qualifying Physical Examination Clearance Form is a very comprehensive exam tool and is only missing a few C&TC components that need to be added to make the sports physical exam count as a complete C&TC. When performing a school sports physical, by also performing and documenting the additional components the exam may be billed as a complete C&TC

- The MSHSL Supplemental Form
- The Minnesota State High School League’s Sports Qualifying Physical Examination Clearance Form
5.) For the Development Component of the C&TC screening, the DDST-II (Denver) has not been a recommended tool for quite some time. Do the health plans recommend any specific developmental screening tool to be used in place of the Denver?
   The list of recommended developmental screening instruments, along with other helpful information about developmental screening, can be found on the Minnesota Department of Health’s website.

6.) Is there a way to compare developmental screening instruments to each other?
   On the navigation bar on the left side of the www.health.state.mn.us/divs/fh/mch/devscrn page you can compare instruments by clicking on:
   - All Instruments At A Glance and
   - Instruments At A Glance for Clinics and Providers

7.) What documentation is required for developmental and/or mental health screenings?
   The minimum documentation requirements call for the name of the screening instrument used, the score and anticipatory guidance related to the screening results. If the screening results are abnormal, documentation must include how this is being addressed.

### IV. BLOOD LEAD TESTING

1.) How am I to bill for a C&TC screening when I do not perform a blood lead test because the child’s medical record has a notice with documentation stating the child was tested two weeks ago at a community testing event and the patient’s lead level was less than 5 micrograms per deciliter?
   You may bill code S0302 (indicator that a complete C&TC screening was performed) providing all other recommended components were performed. You will need to make mention in your C&TC chart documentation the reason why a blood lead test was not performed.

2.) What happens when a child’s lead level comes back elevated?
   Minnesota State Statute requires that facilities performing blood lead analysis must report all results to the Minnesota Department of Health. The Blood Lead Reporting Requirements can be found on the Minnesota Department of Health’s website. When a lead level is elevated, the MDH Lead Unit faxes the lead level and child contact information to the county public health agencies.
   At that time, Case Management Guidelines are followed by the local public health agency which is specific to the elevated level. The Childhood Blood Lead Case Management Guidelines can also be found on the Minnesota Department of Health’s website.
   Additionally, the medical provider is responsible for the medical follow-up of the child. Information in the answer to the following questions will help providers understand current treatment guidelines.
3.) What should clinics do when a lead test is elevated?

The Blood Lead Clinical Treatment Guidelines are available on the Minnesota Department of Health’s website.

4.) How do I bill a blood lead test when the patient has a primary carrier and a secondary carrier?

When a patient has more than one type of health care coverage, the primary carrier must be billed first. Once the primary carrier makes a payment determination, the blood lead claim and the primary carrier’s Explanation of Benefits (EOB) must be submitted to the health plan that is providing the MHCP coverage, even if the primary carrier paid in full. (This also applies to a C&TC screening.) Billing for all of the components reimbursable under the health plan will ensure proper data sharing and follow-up by DHS and/or the county.

Failure to bill the blood lead claim to the health plan that is providing MHCP coverage when the primary carrier has paid in full could result in less dollars going to the clinic by:

a) When the blood lead test is provided during a C&TC screening, the S0302 should also be billed indicating that a complete C&TC screening was performed. Because some health plans provide an additional reimbursement for the S0302 under their Medical Assistance or MinnesotaCare products, failure to bill the health plan can result in lost revenue.

b) Some health plans have a pay-for-performance programs that include blood lead testing as a measurement. When you do not bill the health plan, you do not receive credit for performing the blood lead test.

5.) What is the process for billing blood lead tests done at primary care clinics?

Various factors may affect how clinics or labs bill for blood lead screenings.

- When the clinic bills the health plan, they need to use their NPI provider ID #
- When the hospital bills the health plan, they need to use their own NPI provider ID #
- When the lab bills the health plan, they need to use their own MHCP or NPI provider ID #

**Scenario #1 - The clinic has an onsite lab and the clinic processes blood lead screenings.**

The clinic may bill to the health plan

- CPT 83655 (Lead lab charges)
- 36415 (Venipuncture) or CPT 36416 (Capillary) may also be billed for the blood collection

<table>
<thead>
<tr>
<th>Result of capillary screening test (ug/dL) is:</th>
<th>Perform diagnostics test on venous blood within:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 - 14.9</td>
<td>3 months</td>
</tr>
<tr>
<td>15 - 44.9</td>
<td>1 week</td>
</tr>
<tr>
<td>45 - 59.9</td>
<td>48 hours</td>
</tr>
<tr>
<td>&gt; 60</td>
<td>Immediately (as an emergency lab test)</td>
</tr>
</tbody>
</table>
Scenario #2 – The clinic uses an independent lab or hospital-based lab to process their screenings and their agreement with the lab is that the clinic will bill the health plan for the lab services.

The clinic may bill to the health plan:

- CPT 83655-90 (Lead lab charges)
- CPT 36415 (Venipuncture) or CPT 36416 (Capillary) may be billed for the blood collection

Scenario #3 – The clinic uses a hospital-based lab and their agreement is to have each organization bill the health plan for their services.

The clinic may bill to the health plan:

- 36415 (Venipuncture) or CPT 36416 (Capillary) may also be billed for the blood collection

The hospital-based lab may bill to the health plan

- CPT 83655 with rev code 300 (UB04) (Lead lab charges)

Scenario #4 – The clinic uses an independent lab and their agreement is to have each organization bill the health plan for their services.

The clinic may bill to the health plan

- 36415 (Venipuncture) or CPT 36416 (Capillary) may also be billed for the blood collection

The independent lab may bill to the health plan

- CPT 83655 (Lead lab charges)

V. C&TC CODING

Please understand that billing guidelines are subject to change. Follow CPT, ICD-9 and HCPCS coding guidelines or contact the member’s health plan representative with any questions.

1.) Are special codes needed for billing a complete C&TC?

   Yes. To receive credit for a complete C&TC screening, claims must include the appropriate 2 character referral code in the shaded area of box 24A on the CMS 1500. The same referral code is entered on each line. You must also enter Y for “Yes” un-shaded area of Box 24H (EPSDT/Family Planning) on each line when the claim is related to a C&TC.

   The 2 character referral code needs to be places in the mod2 field if billing electronically

2.) Why do we need to include the 2 character referral codes when billing a complete C&TC?

   The referral code is very important because it:
   - Indicates that the exam is a complete C&TC
• Informs DHS and county C&TC outreach staff that a referral was made. Referral follow-up assistance is provided through child’s 10th birthday, as needed to help assure follow-up care is received
• Documents that a complete C&TC screening was performed for enhanced/appropriate reimbursement purposes and
• Fulfills Minnesota’s reporting requirements to the Center for Medicare and Medicaid Services (CMS) on the number of referrals made as a result of C&TC screenings.

3.) Do I have to use a 2 character referral code on every line of the claim?

Yes, but only one 2 character referral code can be used on each claim. HIPAA Code Definitions:

AV Patient refused referral(s)
ST Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screen provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (does not include dental referrals)
S2 Patient is currently under treatment for referred diagnostic or corrective health problem(s)
NU No referral was made

4.) Do I have to use a 2 character referral code if I am referring back to myself?

Yes, you would use referral code ST when you refer back to yourself or another professional due to a concern/abnormality

5.) What happens if I do not include the 2 character referral codes?

• The claim will not be identified as a complete C&TC
• You cannot bill the S0302 to receive maximum reimbursement if you do not complete all of the C&TC components and use the 2 character referral codes.
• The DHS and County C&TC outreach staff will be unaware of the screening and possible concerns/abnormalities and as a result, be unable to offer referral follow-up assistance to the family.
• Minnesota’s reporting requirements to CMS on the number of referrals made as a result of C&TC screenings remain unfulfilled.
• Due to the importance of including these referral codes, as well as new guidance from DHS, some health plans may deny payment on the entire claim or the S0302 if the referral codes are not included on the claim/s.

6.) How does billing staff know what 2 character referral codes to put on the claim?

Please see response to questions V. 3. Clinics need to work out a system to communicate this information to the billing staff. Some clinics use a separate C&TC
Charge Ticket. The providers just circle the appropriate code, based on the Referral Code definitions listed above. Other clinics have coders who review the medical documentation and select the appropriate code.

7.) When is the S0302 code used with a C&TC claim?

All three health plans (Blue Plus, Medica and Ucare) will allow you to bill code S0302 to indicate that a complete C&TC screening was performed and documented. While code S0302 is an informational only code, some health plans link an additional C&TC reimbursement to this procedure code.

8.) What diagnosis code should be used for a fluoride varnish application?

If billing D1206 Topical Fluoride Varnish use

- V 72.2 (dental examination) when only applying fluoride varnish during a visit
- V20.2 when applying fluoride varnish as part of a complete C&TC

More information and an on-line training are available through the University of Minnesota

9.) What codes are used for the Development and Mental Health Screenings?

- For an objective, standardized developmental screening instrument*, use CPT code 96110
- For a standardized mental health screening instrument*, use CPT code 96110 UC
- When a standardized screening instrument is not used for either of the screenings, unable to bill a separate CPT code.

*Both screenings may be billed on the same date of service and on the same claim.

10.) How do I bill a C&TC or blood lead test when the patient has a primary carrier and a secondary carrier?

When a patient has more than one type of health care coverage, the primary carrier must be billed first. Once the primary carrier makes a payment determination, the C&TC claim and the primary carrier’s Explanation of Benefits (EOB) must be submitted to the health plan that is providing the MHCP coverage, even if the primary carrier paid in full. (This also applies to blood lead testing if you provide the test at a time other than at the C&TC visit.) Billing for all of the components reimbursable under the health plan will ensure proper data sharing and follow-up by DHS and/or the county.

11.) How do I code for an immunization obtained Minnesota Vaccines for Children (MnVFC)?

Use the modifier SL which indicates that the vaccine has been provided free of charge through MnVFC.
VI. C&TC BILLING

1.) Can a component of the C&TC be deferred to a later date? If so, what dates should be used to bill and should each procedure be billed together or separate?
   Components can be deferred if needed. However, we recommend that the 2nd visit be as close to the first date as possible.

   The billing for all the C&TC components that were performed on different days should be sent on one claim once all components are completed. The dates on the claim should reflect the actual date services were provided.

2.) Can we bill for both a C&TC visit and an acute visit on the same date of service/claim form? (For example, the child comes for a C&TC and immunizations but is found to have an ear infection and receives an otitis media diagnosis).
   Blue Plus, Medica and Ucare allow for the billing of a sick and a C&TC visit that occurs on the same date. Most plans require the use of a 25 modifier. Please follow each of the health plans’ policies.

3.) How do I bill for the C&TC “Sports Physical”?
   When you perform a school sports physical and also perform and document the additional C&TC components that are not requested on the MSHSL Sports Qualifying Physical Examination Clearance Form, you may bill as a complete C&TC (see our response to question 4 in section III for additional guidance).

4.) How do I bill for labs services conducted offsite?
   For a member of an MCO, bill lab services as usual (use the modifier 90 when an independent lab or hospital-based lab is used to process the lab work and the clinic agreement with the lab is that the clinic will bill the health plan for the lab services).

   For FFS members, per the MCHP Provider Manual:

   Effective for the dates of services on and after January 1, 2015, in conjunction with Section 1902(a)(32) of the Social Security Act MHCP must only reimburse a provider who personally performed a service. Providers will no longer be reimbursed for lab test they did not complete. Tests submitted with modifier 90 will be denied. Do not include lab services you did not complete on your claim. When a specimen is sent to another provider, the ordering provider must also send all necessary information required for that provider to claim for the service.

   This policy applies only to lab services where the costs are paid fee-for-service. This policy applies to all services reported on claim format 837P. Lab services that are part of an all-inclusive inpatient hospital DRG or nursing facility rate are not affected.
VII. INTERPRETER SERVICES

1.) Are clinics responsible for paying interpreters if a client does not speak English?
   o **Blue Plus**  For Public Programs members, Blue Plus contracts with interpretive services agencies to provide interpretation for our members. The agencies are reimbursed by Blue Plus for the services that are provided. Members or providers should contact member services to arrange for an interpreter to accompany them to a scheduled visit. Call 651-662-5545 or 1-800-711-9862.
   
   o **Medica**  For those covered under the Medica Choice Care and Medica MinnesotaCare products, Medica reimburses the interpreter vendor directly. Members contact customer service 2 – 5 days prior to their health care appointment so that the health plan can make arrangements for the interpreter to meet the member at the appointment. Call 952-992-2292 or 1-800-601-1805.
   
   o **UCare**  For those covered under Minnesota Health Care programs, UCare contracts with interpretive services agencies to provide interpretation for our members. Members or providers should contact member services to arrange for an interpreter to accompany the member to a scheduled visit. Call 612-676-3200 or 1-800-203-7225.