



**Examples of Technical Assistance & Materials Used by the
Oregon Pediatric Improvement Partnership to Coach Practices on Using the 96110**

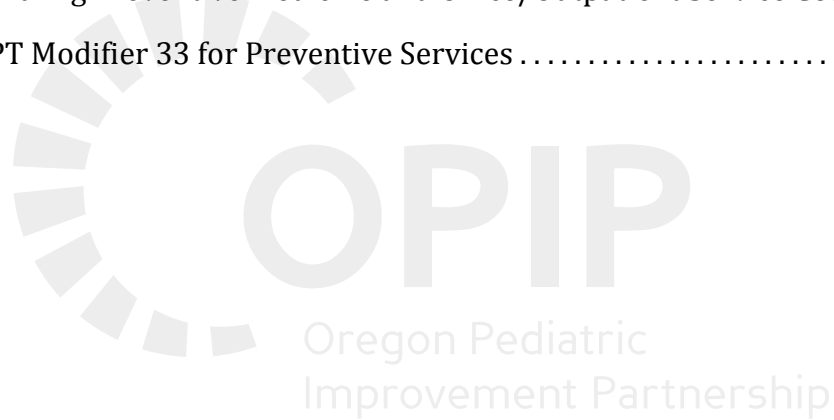
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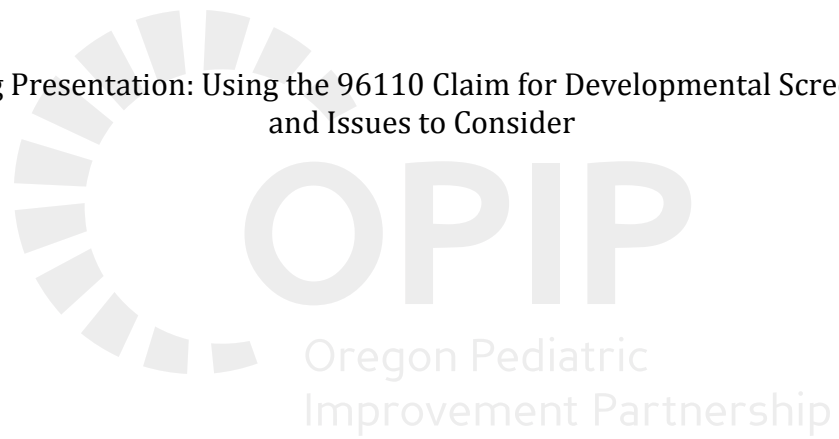
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OPIP Coaching Presentation: Using the 96110 Claim for Developmental Screening” Options
and Issues to Consider





Using the 96110 Claim for Developmental Screening: *Options and Issues to Consider*

Using Claim 96110 for Developmental Screening: General Considerations to Consider

- When deciding on an office billing process, this must be applied equally to all insurance types.
- Different states with different insurance carriers have found some differences in the modifiers required – may need to test.
- The AAP member channel has posted a form letter to use when appealing to plans that deny coverage of 96110.
- Beyond issues of reimbursement, **96110 is used in quality measurement** for ensuring delivery of key pediatric services (developmental screening).
 - CHIPRA Core Measure #8 – Developmental Screening the First Three Years of Life includes specifications that can be derived from 96110
 - Of the state Medicaid/CHIP agencies reporting and using this measure, most are using the claims data given their inability to conduct chart reviews
- There is considerable local variation by state/payer as to what gets recognized/paid.

Issues to Consider When Deciding How to Claim and Use 96110

1. Screening that you are conducting in the office

- Are you just doing developmental screening?
- Are you doing developmental screening and MCHAT screening?
 - Historically, most folks use the same 96110 claim for these two tools
- Specificity of the claims that you want for internal measurement purposes
 - E.g. Do you want to know the difference between developmental and autism screening?

2. Patient Population and Insurance Coverage

- You will find differences in reimbursements and whether patients are charged for screening claims submitted (for Privately and Uninsured patients).

#1: PUBLICLY INSURED

Required to cover it per inclusion in Bright Futures recommendations. Some states include reimbursement as part of the capitated payments.

#2: PRIVATELY INSURED

Variation has been observed in whether private payors cover this claim. In some plans it is covered, but is included as part of the patients' procedural deductibles.

#3: UNINSURED

All claims submitted with a charge will be billed to the patient.

- Remember: Office billing process must be applied equally to all insurance types (Can't bill Medicaid and not bill for private or uninsured patients)
- Therefore, as a practice you need to assess how many patients fall into each of the categories above may be charged for the screening, your comfort with that, and processes that you may use to address patients who don't want to or can't pay

Important Modifications to 96110

Developmental Testing 96110 Revision

Category I Medicine

Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status, Speech Testing)

- ▲ 96110 Developmental testing screening; limited, (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report, per standardized instrument form
- ▲ 96111 Developmental testing; extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report

Modifiers Generally Being Used

- Modifier to Well-Visit Code
 - **Modifier -25** is used on the well visit code.
 - **Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other**
- Modifier to the 96110 Code (More explanation on next slide)
 - **Modifier -59**
 - **Modifier -33**
 - At AAP coding sessions, it was noted that they have observed that most will get 96110 recognized as stand-alone code or with -59 modifier
 - That said, some have found value in using -33 (see next slide)

Codes Used to Modify 96110: -59 and/or -33

- **Modifier -59**
 - Distinct procedural service.
 - Used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.
- **Modifier -33**
 - Within AK, discussions of this modifier being recommended
 - CPT modifier 33 is applicable for the identification of preventive services without cost-sharing in these four categories:
 1. Services rated “A” or “B” by the US Preventive Services Task Force (USPSTF) (see Table 1) as posted annually on the Agency for Healthcare Research and Quality’s Web site: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;
 2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
 4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

Multiple 96110 Claims

- Some practices are billing multiple 96110 codes in a single visits
 - *Example:* 18 month visit Bright Futures recommendations are a developmental (e.g. ASQ) and Autism Screen (e.g. MCHAT)
 - Some practices choose to submit two 96110 claims for each tool.
 - Under Medicaid, multiple codes may be billed
 - Some rejections noted by private plans, but generally have been paid when appealed

Patients with Public Insurance: Issues to Consider

- Developmental screening part of Bright Futures recommendations.
- Medicaid/CHIP cover 96110 when attached to well visits.
 - Can bill multiple times during a visit if multiple screening tools are employed (e.g. ASQ and MCHAT).
- Bundled payments/Special Encounter Visit Rates may allow for claims to be submitted, but not to be reimbursed (e.g. FQHC, THO)
 - Important to bill 96110 regardless of capitation – even if currently not reimbursed directly.
 - Reimbursement rates under capitation still depend on the services being delivered.
 - Important for the process of quality measurement to include codes for developmental screening.
- Medicaid/CHIP is particularly interested in 96110 rates, as it is a core CHIPRA measure.

Patients with Private Insurance: Issues to Consider

- Coverage of 96110 is variable
 - In Oregon, most plans in our experience cover the code.
- That said, some plans pass on the code to patients' procedural deductibles.
 - So while “covered” the patient still has to pay as it applied to their deductible
- Some plans capitate well visits/use special encounter visit rates and therefore bundle 96110 into the well visit.
 - Important to bill 96110 regardless of capitation – even if currently not reimbursed directly.
 - Reimbursement rates under capitation still depend on the services being delivered.
 - Important for the process of quality measurement to include codes for developmental screening.
- In Oregon, practice-level appeal processes have been successful when plans do not cover multiple codes, or when the code is initially denied.

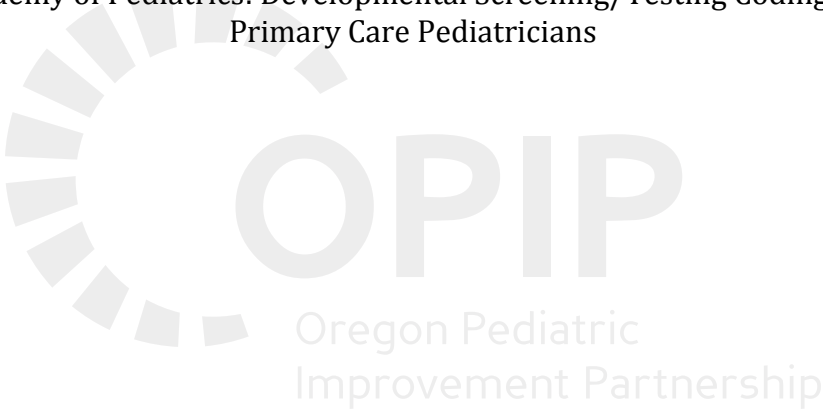
Uninsured Patients: Issues to Consider

- If dealing with a high percentage of uninsured patients, may need to consider a zero bill for all 96110 billings.
 - Remember: Need to bill the same amount regardless of insurance type (to not do this is insurance fraud).
- Practices decide their own policies about patient discounts and write-offs.

Punchline

- 96110 is valuable claim for a practice to use to track developmental screening
- In considering how to use 96110, practices need to consider:
 - If they are submitting one or multiple screenings
 - The mix of insurance coverage for their patients and whether that may impact the practices desire to submit a claim of 96110 with a bill (request of payment)
 - Given that some private insurers may pass the costs of screening on to the patient and this claim involves tool the patient completed, it is an important factor to consider
- Medicaid/CHIP programs in the state may be focusing more on 96110 claims due to its inclusion in the CHIPRA Core measurement set

American Academy of Pediatrics: Developmental Screening/Testing Coding Fact Sheet for
Primary Care Pediatricians





Developmental Screening/Testing **Coding Fact Sheet for Primary Care Pediatricians**

I. CODING

Developmental screening, surveillance, and assessment are often complemented by the use of special tests, which vary in length. This coding fact sheet provides guidance on how pediatricians can appropriately report standardized developmental screening and testing services.

A. How To Report Developmental Testing

96110 *Developmental screening, with interpretation and report, per standardized instrument form*

The use of developmental screening instruments of a limited nature (eg, PEDS, Ages and Stages, Vanderbilt ADHD rating scales, Pediatric Symptom Checklist (PSC-17)) is reported using CPT code **96110** (*Developmental screening*). Code **96110** is often reported when performed in the context of preventive medicine services. This code also may be reported when screening is performed with other evaluation and management (E/M) services such as acute illness or follow-up office visits. On the 2013 Medicare Fee Schedule (Resource-Based Relative Value Scale or RBRVS), the Centers for Medicare and Medicaid Services (CMS) published a total relative value unit (RVU) of 0.27 for 96110, which amounts to a Medicare payment of \$9.19 (0.27 x \$34.0230 {Medicare 2013 conversion factor as of 1/1/2013}).

In 2012, the 96110 code descriptor was revised to differentiate it from the “testing” that is referenced under code 96111. *Screening* asks a child’s observer to provide his/her observations of the child’s skills, which are then recorded on a standardized and validated screening instrument. Screening is subjective and only reports the assessment of the patient’s skills through observation by the informal observer. On the other hand, testing measures what the patient is actually able to do on a standardized psychometric instrument at that time. Screening does not imply nor indicate the absence of a diagnosis; only the means by which information is collected on the patient.

Because an office nurse or other trained non-physician personnel typically performs the service, this relative value reflects only the practice expense of the office staff and nurses, the cost of the materials, and professional liability -- there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code **96110** but the time and effort to perform the testing itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When a screening test is performed along with any E/M service (eg, preventive medicine or office outpatient), both the **96110** and the and E/M service should be reported and modifier **25** (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) should be

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appended to the E/M code to show the E/M service was distinct and necessary at the same visit **or** modifier **59** (*distinct procedural service*) should be appended to the screening service code, showing that screening service services were separate and necessary at the same visit.

In 2012, code **96110** was revised in the CPT nomenclature to now differentiate it from the “testing” service, as this code is meant to be reported for a developmental screen. The code was also revised to clarify that the instrument used must be standardized and that the code may be reported more than once during a single date of service. The code descriptor now states “per standardized instrument.” Therefore if you are performing multiple standardized screens on a patient (eg, an M-CHAT and ASQ) then you will report **96110** with 2 units (or on separate line items). Modifier **59** may be required to indicate that the services were distinct.

96111 *Developmental testing (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report*

Developmental testing using standardized instruments (eg, Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition)) are reported using CPT code **96111**. This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the testing (eg, an evaluation and management code for outpatient consultation). A physician or other trained professional typically performs this testing service. Therefore, there are physician work RVUs published on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS) for this code. In 2013, code **96111** has 3.73 total non-facility RVUs, which calculates to a Medicare payment of \$126.91 (3.73 x \$ 34.0230 {Medicare 2013 conversion factor as of 1/1/2013}).

When **96111** is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical exam, and medical decision making) or time for selecting the accompanying E/M code. Just as discussed for **96110**, if the E/M code is reported with **96111**, modifier **25** (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) should be appended to the E/M code **or** modifier **59** (*distinct procedural service*) should be appended to the developmental testing code, showing that the developmental testing services were separate and necessary at the same visit.

In 2005, the CPT code descriptor of **96111** was revised to reflect the deletion of the test examples as well as the "per hour" designation. Thus, effective January 1, 2005, physicians will report the service without regard to time. The typical testing session, including the time to perform the interpretation and report, was found in the American Academy of Pediatrics (AAP) survey used to value the service to be slightly over an hour.

B. When To Report Developmental Testing

96110

The frequency of reporting **96110** (*Developmental screening*) is dependent on the clinical situation. The AAP Bright Futures “Recommendations for Preventive Pediatric Health Care” schedule recommends developmental/behavioral assessment at each preventive medicine visit, and the AAP “Developmental Surveillance and Screening of Infants and Young Children” policy

statement recommends that physicians use validated/standardized developmental screening instruments to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of screening tests of a limited nature seems to enhance the task of developmental assessment typically done in the preventive medicine setting. The exact frequency of testing therefore depends on the clinical setting and the provider's judgment as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history (eg, surveillance), this is not a "test" as such, **and is not separately reportable**. Examples of validated/standardized limited screening instruments along with clinical vignettes are provided below.

96111

Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code **96111** (*Developmental testing*). These tests are typically performed by physicians or psychologists and require upwards of an hour of time. They also are accompanied by an interpretation and formal report, which may be completed at a time other than when the patient is present.

Like code **96110**, the frequency of reporting code **96111** is dependent on the needs of the patient and the judgment of the physician. When developmental surveillance or screening suggests an abnormality in a particular area of development, more extensive formal objective testing is needed to evaluate the concern. In contrast to adults, the limited ability of children to maintain focused selective attention and testing speed may mean that several sessions are needed to properly evaluate the problem. Code **96111** is reported only once per date of service. There must be an accompanying report describing and interpreting all testing.

Additionally, subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been "significantly low," but who was clearly at risk for maintaining appropriate acquisition of new skills.

II. CLINICAL VIGNETTES

96110 Vignette # 1

At a follow-up visit for bilateral otitis media, the pediatrician notes the patient missed her 12 month well-child visit. He requests and the child's father complete the Ages and Stages Questionnaire (ASQ.) The father endorses no concerns in any developmental domain. The pediatrician reviews the father's completed ASQ and asks him if his daughter is using single words to convey her wants and is using words to label common objects. The father assures him that she is doing this and, in fact, other non-family adults have commented on her clear articulation. No concerns at all are reported and this is consistent with what the pediatrician has observed in the office visits. He tells the father they will continue to monitor for any evidence the child is not acquiring skills at an expected rate. All this is noted in a few sentences in the chart note.

CPT
99392-25* Preventive medicine service;
established patient, age 1-4
(appended with modifier 25)

ICD-9-CM
V20.2 Routine infant or child health check

96110 Developmental screening V20.2 Routine infant or child health check

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the screening service code.

96110 Vignette #2

At a 24-month well child check, the mother describes her toddler as "wild," completes the PEDS (Parent Evaluation of Developmental Status), and responds positively to the question "Do you have concerns about your child's language skills?" The nurse scores the PEDS and places the answer sheet on the front of the chart with a red arrow sticker next to it. When the pediatrician examines the child, he is alerted to ask the mother about her observations of the child's language ability. He then confirms the delay in language, and makes a referral to a local speech pathologist.

CPT

99392-25* Preventive medicine service; established patient, age 1-4 (appended with modifier 25)

ICD-9-CM

V20.2 Routine infant or child health check

**96110 Developmental screening testing; limited V20.2 Routine infant or child health check
315.31 Expressive language disorder**

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the screening service code.

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the **99201-99215** series may be reported using a modifier 25, linked to the appropriate ICD-9-CM code(s) as appropriate (eg, **315.31**, *Expressive language disorder*; **315.32**, *Mixed receptive-expressive language disorder*; **315.39**, *Other developmental speech or language disorder*).

96110 Vignette #3

At a five-year health maintenance visit, a father discusses his daughter's difficulty "getting along with other little girls." "Doctor, she wants friends, but she doesn't know how to make — much less keep — a friend." Further questioning indicates the little girl is already reading and writing postcards to relatives, but has not learned how to ride her small bicycle, is awkward when she runs and she avoids the climbing apparatus at the playground. Her father wondered if her weaker gross motor skills affected her ability to play successfully with other children. She seems very happy to sit and look at books about butterflies — her all consuming interest! The child's physical exam consistently fell in the range of 'normal for age' in previously health maintenance visits. The pediatrician asks her nurse to administer the Australian Scale for Asperger's Syndrome and the father's responses yield 16/24 items with an abnormal score being >3. The pediatrician reviews the form, writes a brief summary, and discusses her observations with the father. A referral is made to a local physical therapist who has a playground activities group and to a local psychologist who has expertise in diagnosing autism spectrum disorders.

CPT

99393-25* Preventive medicine service; established patient, age 5-11 (appended with modifier 25)

ICD-9-CM

V20.2 Routine infant or child health check

96110	Developmental screeningV20.2	Routine infant or child health check 315.4 Developmental coordination disorder 313.9 Unspecified emotional disturbance of childhood
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*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the screening service code.

96110 Vignette # 4

A seven year old boy with previously diagnosed ADHD is being seen for a health maintenance visit. At the end of the visit his mother asks if she can discuss her son’s medication. She hands you 2 Vanderbilt ADHD rating scales completed two weeks ago by his classroom teacher and tutor. You give these to your medical assistant to score while you obtain more interim history from Bobby’s mother. After reviewing the scored teacher Vanderbilt form and discussing the results with Bobby’s mother, you both decide to increase his stimulant medication. A follow-up appointment is scheduled for four weeks.

CPT
99393 25* Preventive medicine service;
 established patient, age 5-11
 (appended with modifier 25)

ICD-9-CM
V20.2 Routine infant or child health check

99213 Office or other outpatient service,
 established patient,
 15 minutes “typical time”

314.01 Attention deficit/hyperactivity disorder,
 combined type

96110 Developmental screening
96110 59

V20.2 Routine infant or child health check
314.01 Attention deficit/hyperactivity disorder,
 combined type

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the screening service code. Some payers may also require the 96110 to be reported in 2 units on one line item.

96111 Vignette #1

An eight-year-old boy with impulsive, overly active behavior and previously assessed "average" intelligence is referred for evaluation of attention deficit disorder. He has by prior history reading and written expression skills at first grade level, and received speech and language therapy during his attendance at Head Start when he was four years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier evaluation and management service appointment. History, physical and neurological examination were also completed at that visit.

On this visit, standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These scores and observations were integrated into a formal report to be used to individualize his education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow up visit to discuss this report and the final diagnosis and treatment plan with the physician.

CPT**96111 Developmental testing****ICD-9-CM****314.0x Attention deficit disorder
x = 0 for no hyperactivity
x = 1 for hyperactivity****96111 Vignette #2**

A 5 4/12 year old boy just beginning kindergarten was seen for developmental testing. At a previous visit, his mother's responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays. After greeting the parent and child and explaining to the child that he and the doctor would do some 'non-school' activities to see how he 'used words to tell others about (his) good ideas', the child and the examiner spent fifty minutes together completing the tasks on the Peabody Picture Vocabulary Test-Third Edition, and the Clinical Evaluation of Language Fundamentals-Fourth Edition. The examiner scored the two tests in five minutes and there was a significant discrepancy detected between the Receptive Language Composite and the Expressive Composite on the CELF-4. Both test scores were abnormal, however, indicating a mixed receptive-expressive language disorder.

CPT**96111 Developmental testing****ICD-9-CM****315.32 Mixed receptive expressive language disorder****96111 Vignette #3:**

A 9 year old girl, being treated for ADHD and receiving language therapy to improve her weak receptive and expressive language skills, comes in for a medication visit. Her mother and teacher both feel the current dosage of her stimulant medication is effective and neither perceives a need for any changes. Your services meet the "limited" level of complexity for the visit. However, while asking about her school performance, the child's mother volunteers, "I know she has been seeing the speech pathologist once a week for 7 months now, but I can't see any signs her vocabulary is increasing." You administer and score the Peabody Picture Vocabulary Test [Fourth Edition]. The performance standard score had increased by one standard deviation from her initial performance eight months ago. You show her mother the improvement and document the test administration, results and interpretation in the medical record.

CPT**99213-25* Office or other outpatient service, established patient
15 minutes "typical time"
(appended with modifier 25)****ICD-9-CM****314.01 Attention deficit disorder, with hyperactivity
315.32 Mixed receptive-expressive language disorder**

**96111 Developmental testing 314.01 Attention deficit disorder, with hyperactivity
315.32 Mixed receptive-expressive language disorder**

*NOTE: Some payers may require alternate reporting wherein the modifier 59 is appended to the developmental testing code.

III. DOCUMENTATION GUIDELINES

Each administered developmental screening and testing instrument is accompanied by an interpretation and report (eg, a score or designation as normal or abnormal). This is often included in the test itself, but these elements may alternatively be documented in the progress

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report of the visit. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

Following are examples of appropriate documentation for some testing tools:

96110

PEDS (Parents' Evaluation of Developmental Status)

This questionnaire is designed to identify any parent/primary caretaker's concerns about a birth through eight-year child's developmental attainment and behavioral/mental health concerns. There are eight specific domain queries and one asking, "please list any concerns about your child's learning, development and behavior" and a final "please list any other concerns." The parent answers are scored into the risk categories of high, moderate, or low. The report form is included with the questionnaire.

ASQ (AGES AND STAGES Questionnaire)

This parent report instrument, covering ages 1 month through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are six questions in each of five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal-Social. All questions are scored on a point system, with summary scores indicating the need for further evaluation. The ASQ also has a non-specific comprehensive section where general concerns are addressed. No score is provided for these answers, but the instrument developers note any "Yes" responses should prompt a referral.

96111

In general, the documentation of developmental testing includes the scoring, interpretation, and the development of the report. This typically includes all or some of the following: identifying data, time and location of testing, the reason for the type of testing being done, and the titles of all instruments offered to/completed by the child; presence (if any) of additional persons during testing, child's level of cooperation and observations of child's behavior during the testing session. Any assistive technology, prosthetics or modifications made to accommodate the child's particular developmental or physical needs should be described, and specific notations should be made if any items offered resulted in a change in the child's level of attention, willingness to participate, apparent ease of task accomplishment. The item results should be scored and the test protocol and any/all scoring sheets should be included in the medical chart (computer scanning may be needed for electronic medical records). A brief interpretation should be recorded and notation should be made for further evaluation or treatment of the patient or family. A legible signature should also appear.

IV. SAMPLE ASSESSMENT/TESTING TOOLS

[NOTE: These are provided as examples only; the AAP implies no endorsement or restriction of code use to these instruments. If you choose to use an instrument not listed below, be sure they are validated/standardized.]

96110

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Ages and Stages Questionnaire-Second Edition (ASQ) and Ages and States Questionnaire: Social-Emotional (ASQ:SE) (Brookes Publishing: Jane Squires, PhD and Diane Bricker, PhD, et. al)

Australian Scale for Asperger's Syndrome (ASAS) (Michelle Garnett, Master's Clinical Psychology and Anthony Attwood, PhD)

Behavior Assessment Scale for Children-Second Edition (BASC-II) (American Guidance Service: Cecil Reynolds and Randy Kanphaus)

Behavioral Rating Inventory of Executive Functioning (BRIEF) (Psychological Assessment Resources, Inc.: Gerald Gioia, PhD, Kimberly Espy, PhD, and Peter Isquith, PhD)

Modified Checklist for Autism in Toddlers (M-CHAT) (Robins, Fein, & Barton, 1999)

Parents' Evaluation of Developmental Status (PEDS) (Ellsworth and Vandermeer Press, LLC: Frances Page Glascoe, PhD)

Pediatric Symptom Checklist: A Primary Care Screening Tool to Identify Psychosocial Problems (PSC) (<http://psc.partners.org>: Michael Jellinek, MD, and J. Michael Murphy, PhD)

Vanderbilt Rating Scales (Mark L. Wolraich, MD)

96111

Beery-Buktenica Developmental Test of Visual-Motor Integration-Fourth Edition, Revised (VMI) (Modern Curriculum Press: Keith E. Beery, PhD)

Clinical Evaluation of Language Fundamentals-Fourth Edition (The Psychological Corporation: Eleanor Semel, PhD, CCC-SLP, Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP)

Clinical Evaluation of Language Fundamentals-Preschool Version-Second Edition (Psychological Corporation: Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP, and Eleanor Semel, PhD, CCC-SLP)

Comprehensive Test of Nonverbal Intelligence (Pro-Ed: Donald Hammill, Nils Pearson, and J. Lee Wiederholt.)

Developmental Test of Visual Perception-Second Edition (Pro-Ed: Donald Hammill, Nils Pearson, Judith Voress)

Kaufman Brief Intelligence Test-Second Edition (American Guidance Service: Alan Kaufman and Nadeen Kaufman)

Peabody Picture Vocabulary Test-Fourth Edition (American Guidance Service: Lloyd M. Dunn and Leola M. Dunn)

Test of Auditory-Perceptual Skills-Revised (Psychological and Educational Publications: Morrison Gardner)

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Test of Language Competence-Expanded Edition (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Test of Nonverbal Intelligence-Third Edition (Pro-Ed Publishing: Linda Brown, Rita Sherbenou, Susan Johnsen)

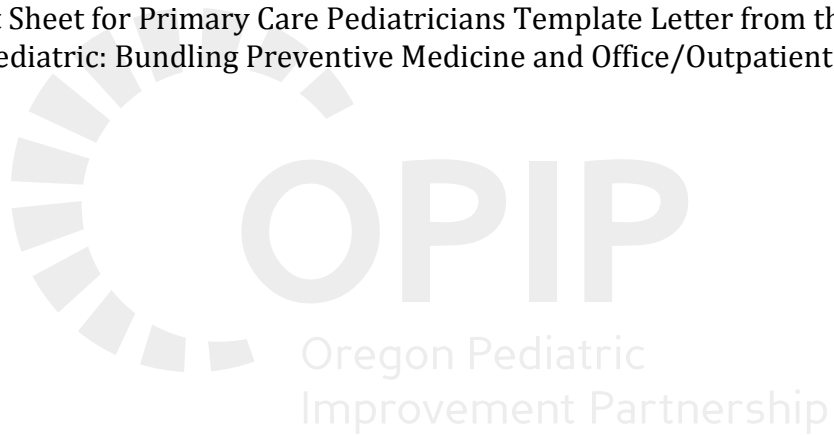
Test of Problem Solving 3: Elementary Version (LinguiSystems, Inc: Linda Zachman, Rosemary Huisingh, Mark Barrett, Jane Orman, Carolyn LoGiudice)

Test of Word Knowledge (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

Woodcock-Johnson Test of Cognitive Abilities-Third Edition (Riverside Publishing: Richard W. Woodcock, PhD, Kevin S. McGrew, PhD, and Nancy Mather, PhD)



Coding Fact Sheet for Primary Care Pediatricians Template Letter from the American Academy of Pediatric: Bundling Preventive Medicine and Office/Outpatient Service Codes



Template Letter: Bundling Preventive Medicine and Office/Outpatient Service Codes

2010

American Academy of Pediatrics

Date:

Insurance Carrier Claims Review Department address or
Insurance Carrier Medical Director and address

Dear:

RE: Claim #:

I am writing regarding the aforementioned claim and (Insurance Carrier Name)’s practice of bundling preventive medicine service codes and office/outpatient service codes. CPT guidelines indicate that in certain cases, it is appropriate to report a preventive medicine service code (99381-99397) in conjunction with an office/outpatient service code (99201-99215) on the same date of service.

According to the American Medical Association’s CPT guidelines, “if an abnormality(ies) is encountered or a preexisting problem is addressed in the process of performing a preventive medicine evaluation and management service, and if the problem/abnormality(ies) is significant enough to require additional work to perform the key components of a problem-oriented service, then the appropriate office/outpatient code should also be reported. Modifier 25 should be added to the office/outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported”(page 31, *CPT 2010* {professional edition}). These statements clearly indicate that both a “well” and a “sick” visit should be recognized as separate services when reported on the same day.

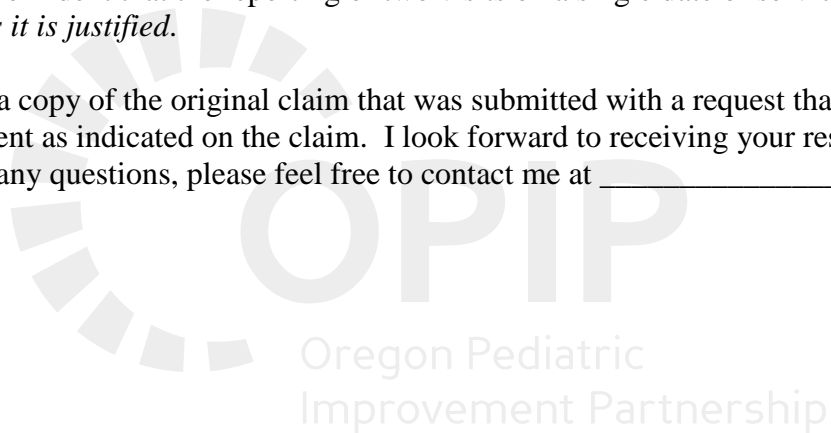
Unfortunately, many carriers are not familiar with the CPT guidelines that allow for the reporting of a two visits on the same day of service by use of the modifier 25. Further, there are no diagnosis (ICD-9-CM) requirements tied to the use of modifier 25. In fact, “the descriptor for modifier 25 was revised to clarify that since the E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided, different diagnoses are not required to report the E/M services on the same date” (*CPT Assistant*, May 2000, Volume 10, Issue 5). This basic tenet of CPT coding underscores the fact that it is *inherently incorrect for carriers to place restrictions on the number, type, or order of diagnoses associated with the reporting of two visits on the same day*.

There are also some carriers who, through failure to recognize all services provided during a single patient session, potentially increase the number of visits necessary to address a patient's concerns. If a patient is seen for a preventive medicine visit and the physician discovers that the patient has symptoms of otitis media during the examination, clinical protocol and common sense would dictate that the physician take care of both the well child exam and the treatment of the otitis media during that single patient visit. Unfortunately, the fact that some carriers fail to fairly reimburse the physician for providing both services will motivate providers to address only the acute problem and have the patient/parent return at a later date for the preventive medicine visit. This situation is frustrating for everyone involved, but especially for the insureds.

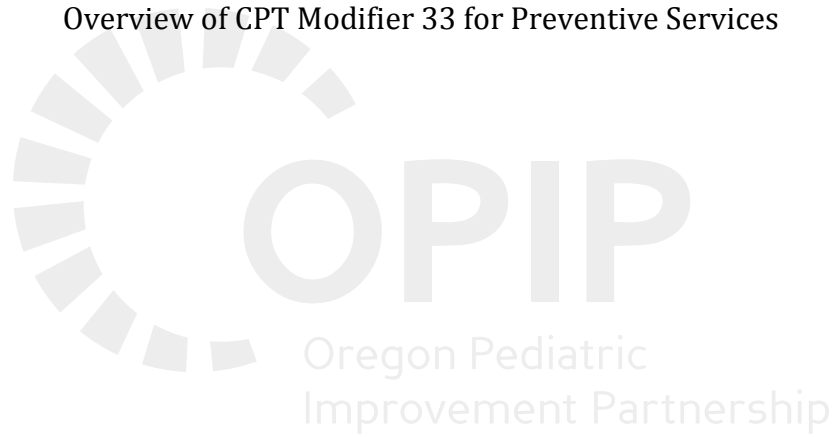
While there is no legal mandate requiring private carriers to adhere to the aforementioned CPT guidelines, it is considered a 'good faith' gesture for them to do so, given that the guidelines are the current standard within organized medicine. Since providers are clearly instructed that an office/outpatient "sick" visit cannot be reported unless it represents a significant, separately identifiable service beyond the preventive medicine service, carriers should feel confident that the reporting of two visits on a single date of service *will not occur unless it is justified*.

Enclosed is a copy of the original claim that was submitted with a request that you process reimbursement as indicated on the claim. I look forward to receiving your response. If you have any questions, please feel free to contact me at _____.

Sincerely,



Overview of CPT Modifier 33 for Preventive Services



New CPT Modifier for Preventive Services

The implementation of health care reform regulations has begun with a significant change involving preventive services. The Patient Protection and Affordable Care Act (PPACA) requires all health care insurance plans to begin covering preventive services and immunizations without any cost sharing, ie, they must provide first-dollar-coverage for certain specified preventive services. The timing of this being implemented is dependent on when health insurance plans renew or change. The regulations specify that plans cannot impose cost-sharing requirements, such as co-pays, coinsurance, or deductibles with respect to specified preventive services in which preventive services are billed separately. When these services are part of an office visit, the office visit may not have cost-sharing if the **primary** reason for the visit is to receive preventive services. However, cost-sharing is permitted for an office visit when the office visit and covered preventive services are billed separately, and the primary purpose of the office visit is *not* delivery of the covered preventive services.

In addition, insurance plans are permitted to impose cost-sharing (*or choose not to provide coverage*) for recommended preventive services if they are provided out-of-network. Not all services that some or many clinicians consider as preventive are included in the law. For preventive services not covered in the statute and regulations, plans are permitted to require cost-sharing. The new mandate may also affect payer coverage or payment policies for services listed in the Counseling Risk Factor Reduction and Behavior Change Intervention section of CPT (99401-99429).

In response to this PPACA requirement, CPT modifier 33 has been created to allow providers to identify to insurance payers and providers that the service was preventive under applicable laws, and that patient cost-sharing does not apply. This modifier assists in the identification of preventive services in payer-processing-systems to indicate where it is appropriate to waive the deductible associated with copay or coinsurance and may be used when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service. The most notable example of this is screening colonoscopy (code 45378), which results in a polypectomy (code 45383).

Note that Medicare has created HCPCS II codes for some of these preventive medicine services. CPT modifier 33 is effective after January 1, 2011, and should be appended to codes representing the preventive services, unless the service is inherently preventive, eg, a screening mammography or immunization recognized by the Advisory Committee on Immunization Practices (ACIP). If multiple preventive medicine services are provided on the same day,

the modifier is appended to the codes for each preventive service rendered on that day.

The CPT modifier's descriptor has additional non-Affordable Care Act (ACA)-specific language for states or other mandates that have similar insurance benefit requirements for other services than those covered in the federal law. For example, if a state mandates first-dollar-coverage for PSA screening, the modifier would be appropriate to use for insureds with plans affected by the mandate. It is hoped that the modifier will create less reliance on combining complex procedures and diagnosis codes without diminishing the importance of correct diagnostic coding.

Modifier 33, Preventive Service: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending **modifier 33, Preventive Service**, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.

CPT modifier 33 is applicable for the identification of preventive services without cost-sharing in these four categories:

1. Services rated "A" or "B" by the US Preventive Services Task Force (USPSTF) (see Table 1) as posted annually on the Agency for Healthcare Research and Quality's Web site: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;
2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

Services with 'A' or 'B' ratings by the USPSTF are services that are recommended to be offered or provided. Services that are graded with an 'A' rating have been judged to have a high certainty that the net benefit is substantial. Services that are graded with a 'B' rating have been judged to have a high certainty of moderate to substantial net benefit.

continued on page 19

Table 1. USPSTF A and B Recommendations for Preventive Services

The following is a list of preventive services that have a rating of **A** or **B** from the US Preventive Services Task Force (USPSTF) that are relevant for implementing the Affordable Care Act (ACA).

Topic	Description	Grade	Date in Effect
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.	B	February 2005
Alcohol misuse counseling	The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.	B	April 2004
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent CVD: men	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent CVD: women	The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening	The USPSTF recommends screening for high blood pressure in adults aged 18 and older.	A	December 2007
BRCA screening, counseling about	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.	B	September 2005
Breast cancer preventive medication	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.	B	July 2002
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.	B	September 2002*†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.	A	January 2003
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.	A	June 2007
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.	B	June 2007
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.	A	June 2008

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Table 1. (cont.)

Topic	Description	Grade	Date in Effect
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries chemoprevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.	B	April 2004
Depression screening: adolescents	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gonorrhea prophylactic medication: newborns	The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.	A	May 2005
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).	B	May 2005
Healthy diet counseling	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.	B	January 2003
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009

Table 1. (cont.)

Topic	Description	Grade	Date in Effect
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.	A	July 2005
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Obesity screening and counseling: adults	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.	B	December 2003
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.	B	September 2002
PKU screening: newborns	The USPSTF recommends screening for phenylketonuria (PKU) in newborns.	A	March 2008
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24-28 weeks gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
STIs counseling	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.	B	October 2008
Tobacco use counseling and interventions: non-pregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.	B	May 2004

*The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the US Preventive Services Task Force.

†Denotes coinsurance/deductible is not waived for this service in calendar year 2011.