

Child & Teen Checkups: 7 County Mpls/St. Paul Metro Area Health Plan Answers to Frequently Asked Questions

This Health Plan FAQ was developed by representatives of Blue Plus, HealthPartners, Medica, Metropolitan Health Plan, 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: www.dakotacounty.us/HealthFamily/HealthyLiving/Children/ChildandTeenCheckupsInformationforProviders.htm or www.mnhealthplans.org/tools/health_plans.cfm.

You can also access the following documents on the Dakota County and Minnesota Council of Health Plans Web sites:

- Billing Guidelines
- C&TC Exam Sample Charge Ticket
- Community Newsletter - newsletters targeted to the parent guardian; they focus on different components of C&TC screenings (*most are available in Spanish, Somali, and Russian*)
 - Places of Care
 - Reason to bring 6 - 10 year olds to the clinic
 - Mouth & Teeth Care
 - Adolescent Health
- Health Plan Contacts for Clinic Staff
- Health Plan Guide with County Info
- Metro Action Group (MAG) Provider Newsletters
- Metro Interpreter Vendor List
- One Page C&TC Poster (*available in English, Russian, and Spanish*)
- Perinatal Services Guide
- Refugee Health Assessments - Reference Guide
- Rx for C&TC
- Sports Physical Exam Supplement

Billing information in this document is specific only to those Medica Assistance and MinnesotaCare recipients enrolled with one of the following health plans: Blue Plus, HealthPartners, Medica, Metropolitan Health Plan, and UCare health plans. C&TC billing questions specific to those who are on fee-for-service Medica Assistance should be directed to the Minnesota Department of Human Services.

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

1.) What constitutes a child having a C&TC vs. a well child exam?

C&TC is one level of a well child/preventive care visit. A preventive care visit is considered a complete C&TC when the C&TC periodicity schedule is followed and recommended components are performed at those visits for Minnesota Health Care Program (MHCP) recipients who are under the age of 21.

Many clinics use the C&TC 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 if followed.

The current C&TC periodicity schedule must be followed in order for the visit to qualify as a C&TC.

- The Minnesota Department of Human Services C&TC Provider Guide can be reached by clicking on this link: [C&TC Provider Guide 2007](#)
- The Periodicity Schedule* (most recent update – January, 2005). Can be reached by clicking on this link: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3379-eng>
- The Schedule of Age-Related Dental Standards can be found by clicking on the this link: <http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5544-ENG>

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?

Please contact the appropriate health plan representative identified on the resource sheet that can be reached by clicking on the following link: [Health Plan Contacts for Clinic Staff](#)

Blue Plus & UCare assign 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 member 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.

HealthPartners members choose a primary care clinic and are encouraged to utilize this clinic. If a member presents at the clinic and has a different clinic listed on their member card the member should be directed to immediately contact HealthPartners customer service to

request to change to the new Primary Care clinic. The clinic change request can be processed immediately if the clinic is in the HealthPartners Care network. This is also very important in the coordination of future care for the member.

Medica does not require Medica Choice CareSM and Medica MinnesotaCare members to choose a primary care clinic, so this should not be an issue unless you are a non-network provider.

Metropolitan Health Plan (MHP) members choose a primary clinic as their medical home and are encouraged to utilize this clinic. If a member presents at a clinic that is not identified as their medical home, they can be seen as long as it is a network clinic. The member should be encouraged to contact MHP Member Services to update their choice of medical home,

II. C&TC ELIGIBILITY

1.) Who is eligible for Child & 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
- **HealthPartners Care** members
- **Medica Choice CareSM & Medica MinnesotaCare** members (*group # starting with 59*)
- All **Metropolitan Health Plan (MHP)** members
- 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
 - **HealthPartners** call 952-967-7998 or 1-866-885-8880.
 - **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.
 - **Metropolitan Health Plan (MHP)** call 1-800-620-9090 or verify eligibility via Provider Insight.
 - **UCare** call 612-676-6824 or 1-800-203-7225 or Access UCare

III. C&TC COMPONENTS

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 five health plans, it is preferred that the health care provider review at the time of the C&TC visit, the results of the screening that was performed at the school and document accordingly and bill for a completed C&TC (S0302) providing all other recommended components are performed. Since the hearing and/or vision screening was not performed, the provider should not bill those specific codes to the health plans.

If the parent/guardian doesn't bring the results to the C&TC visit and state that they refuse to have the component repeated, the provider can document accordingly and bill for a completed C&TC (S0302) providing all other recommended components are 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 chose 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 the 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. 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 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. The Child & Teen Checkups Metro Action Group created a supplemental documentation sheet with the necessary components. 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 supplemental form can be found by clicking on the following link [Sports Physical Supplement](#)
- The Minnesota State High School League's (MSHSL) Sports Qualifying Physical Examination Clearance Form can be downloaded at <http://www.mshsl/publications.asp#5>.

5.) 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?

In 2004, an interagency task force formed to review & recommend available developmental and mental health screening instruments for use in the C&TC program for children birth through 16 years of age. The task force had representation from the Minnesota Departments of Health, Human Services and Education, which includes

- Minnesota's Early Childhood Screening program
- Head Start
- University of Minnesota Center for Early Education and Development

The list of recommended developmental screening instruments, along with other helpful information about developmental screening, can be found at www.health.state.mn.us/divs/fh/mch/devscrn.

6.) Is there a way to compare developmental screening instruments to each other?

On the navigation bar on the left side of 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 and the score to be retained in the child's medical record.

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 records has a notice 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 the S0302 (indicator that a complete C&TC was performed) providing all other recommended components were performed. You will need to make mention in your C&TC chart documentation the reason why no blood lead test was performed.

2.) What happens when a child's lead level comes back elevated?

Lead level information for all children is shared with the Minnesota Department of Health's (MDH) Lead Unit by lab facilities. When a lead level is elevated, the MDH Lead Unit faxes the lead level and child contact information to county public health agency.

At that time, *Case Management Guidelines* are followed by the local public health agency which are specific to the elevated level. Most public health agencies follow-up on any lead levels. If a level is greater than 15mg/dl, a home visit to assess the environment and provide face-to-face education is recommended. The MDH Lead Unit or your county will also send a lead assessor when elevated levels occur. This is done to identify potential sources of the lead exposure.

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?

FOLLOW-UP CARE	
If result of capillary screening test (µg/dL) is:	Perform diagnostic test on venous blood within:
10-14.9	3 months
15-44.9	1 week
45-59.9	48 hours
≥ 60	Immediately (as an emergency lab test)

Information on *Clinical Treatment Guidelines* to help providers with further testing and follow-up, recommendations are available at: <http://www.health.state.mn.us/divs/eh/lead/index.html>

Information on clinical treatment guidelines are available at:
<http://www.health.state.mn.us/divs/eh/lead/reports/treatment/treatmentchildren.pdf>

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

- 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
- 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 (UB92) (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, 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 placed 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 as needed to help assure follow-up care is received,
- documents that a *complete* Child & Teen Checkups screening was performed for enhanced/appropriate reimbursement purposes, and
- fulfills Minnesota's reporting requirements to the Centers 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 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, and
- Minnesota's reporting requirements to CMS on the number of referrals made as a result of C&TC screenings remain unfulfilled.

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

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.

- The Child & Teen Checkups Metro Action Group's sample C&TC Charge Ticket can be reached by clicking on [C&TC Exam Charge Ticket](#).

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

All 5 health plans (Blue Plus, HealthPartners, Medica, MHP, and UCare) will allow you to bill S0302 to indicate that a complete C&TC screening was performed and documented. While the

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 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, go to: <http://www.meded.umn.edu/apps/pediatrics/FluorideVarnish/index.cfm>.

9.) What codes are used for the Developmental 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.

Failure to bill the C&TC 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:

- c. The S0302 should also be billed indicating that a complete C&TC screening was performed. Some health plans provide an additional reimbursement for the S0302 under their Medical Assistance or MinnesotaCare products. The S0302 code is not reimbursable for individual or commercially insured members.
- d. Some health plans have pay-for-performance programs that include C&TC screenings as a measurement. When you do not bill the health plan, you do not receive credit for performing the C&TC screening.

V. 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 visit 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 dates the 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, HealthPartners, Medica, MHP & UCare allow for the billing of a sick & well child 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.

VII. INTERPRETER SERVICES

1.) Are clinics responsible for paying for interpreters if a client does not speak English?

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.

HealthPartners HealthPartners contracts with interpretive services agencies to provide interpretation for our HealthPartners Care members. The provider should use the "Spoken Language Interpreter Work Order" form provided by HealthPartners to order an interpreter. Members or providers should call 952-967-7998 or 1-866-885-8880.

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.

MHP For Public Program members, MHP contracts with interpretive services agencies to provide interpretation for our members. Members should contact interpreter services at 612-596-0740 to arrange for an interpreter to accompany them to a scheduled visit. Providers can contact an MHP contracted interpreter agency directly to arrange for an interpreter. For a list of providers, call 612-596-0740 or 1-800-620-9090.

UCare 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.