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, come 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