DSF Expert Work Group Roster		
	Name	**Experience**
Co-Chair(s)	Marian Earls, MD, FAAP	QuIIN Steering Committee Member; helped to lead the PreSIP QuIIN QI project; actively involved on DSF projects including leadership for ABCD 1, 2, 3.
	John Duby, MD, FAAP	President-elect of the Society for Developmental and Behavioral Pediatrics (SDBP); also active in DS/BF Projects.
Pediatricians (DS/BF Leaders)	Paul Lipkin, MD, FAAP	Involved in DPIP – Implementing Developmental Screening and Referrals
	Michelle Macias, MD, FAAP	Involved in DPIP – Implementing Developmental Screening and Referrals. Coding Champion: involved in coding projects related to DB pediatrics. Current President of SDBP.
	Jack Swanson, MD, FAAP	Bright Futures Steering Committee
	Edward S. Curry, MD, FAAP	Bright Futures Steering Committee
	William Stratbucker, MD, FAAP	Involved with PreSIP and other DS projects at AAP
	Mark M. Butterly, MD, FAAP	Pediatric Residency Program Director. See recommendation from Chicago Pediatric Consortium and submitted abstracts.
NAPNAP	Mary Margaret Gottesman, PhD, RN, CPNP	Bright Futures Steering Committee
State of Illinois	Julie B. Doetsch, MA	Manager, Child Health Section Bureau of Maternal and Child Health Promotion
Physician Assistants	Kristy L. Luciano, PA-C	See joint recommendation by American Academy of Physician Assistants and the Society of Physician Assistants in Pediatrics.
Family	Leslie Carroll, MUP	Bright Futures Steering Committee
	Julie Beckett	AAP Parent Advisory Group; Katie Beckett Waiver
	Name	**Experience**
Oregon PIP	Colleen Reuland	Proposed by Dr. Earls. Consulted with the ABCD projects early on, and was one of the developers of the PHDS. Instrumental in developing the CHIPRA CQM ABCD measure. Very knowledgeable about primary care implementation and measurement.

Minnesota ABCD	Glenace Edwall	Proposed by Dr. Earls. Lead on the Minnesota ABCD project; collaborated with MN AAP Chapter; knowledgeable about implementation in primary care and particularly including social-emotional development.
Child/ Adolescent Psychiatrist	Mary Margaret Gleason, MD	Proposed by Dr. Earls. Particular expertise in early child social-emotional development.
Early Intervention	Deborah E. Carroll, Ph.D.	Early Intervention Branch Head
Head Start	Kimberly K. Stice, MA	Manager, Head Start Integrated Initiatives Head Start National Center on Health AAP
CAHMI	Christina Bethell, PhD, MPH, MBA	Director, The Child and Adolescent Health Measurement Initiative
Neurologist	David L. Coulter, MD	Referred by AAP Section on Neurology
Therapies (OT/PT/Speech)	Amy Houtrow, MD, MPH	
Family Medicine - AAFP	Andrew Morris, MD	NCAFP Referral – Faculty - Henderson Family Medicine Residency Program

CHIPRA PMCoE
Developmental Screening & Follow-up (DSF)
Expert Work Group Meeting

Wednesday, February 6, 2013

8:00 AM – 4:00 PM CST
Location: American Academy of Pediatrics
141 Northwest Point Blvd
Elk Grove Village, IL 60009
Dial in #: 1-877-273-4202
Passcode #: 4680256 #

Hosted by the PMCoE DSF Leadership Team: Northwestern University, American Academy of Pediatrics

Co-Chairs: John Duby, Marian Earls

Meeting Materials:

1. Orientation & Overview – PowerPoint presentation
2. Developmental Screening & Follow-up Overview – PowerPoint presentation
3. Literature Review Materials
   a. Existing DSF Measures Table
   b. DSF Guidelines Review
   c. Gaps in Care Summary
   d. Gaps in Measurement Summary
4. Guideline: AAP/Bright Futures Recommendations for Preventive Pediatric Health Care
5. Draft Measurement Set – worksheets, workflow for eMeasure
6. Administrative Claims Overview Materials
   a. PMCoE Developmental Screening Primer
   b. CPT 2013 Psych Codes Revisions
   c. HCPCS Level II Modifiers
   d. HCPCS Application
   e. HCPCS Decision Tree

Agenda

I. Opening/Welcome [8:00-9:00]		
Welcome on behalf of AAP	Fan Tait/Jon Klein	5 minutes
Welcome on behalf of PMCoE	Ramesh Sachdeva	5 minutes
Introductions	All	50 minutes
II. Orientation & Overview [9:00-9:20]	Donna Woods	20 minutes

PMCoE Grant
PCPI Process
Measure Development Goals

1. Public reporting purposes
2. E-measure capability
3. Equity and disparities elements

III. Developmental Screening Overview [9:20-9:50] History and experience of DSF measures Overview of literature and gaps Q&A	John Duby/Marian Earls	30 minutes
Break [9:50-10:00]		
IV. Administrative Claims Overview [10:00-10:45]	Linda Walsh	45 minutes
V. Facilitated Discussion [10:45-12:15] Developmental Screening	All	1 ½ hours
VI. Working Lunch Break [12:15-12:45]	All	30 minutes
VII. Developmental Follow-up Overview [12:45-1:45] National measures Current challenges Continuum of follow-up care	John Duby/Marian Earls	1 hour
VIII. Facilitated Discussion [1:45-3:15] Developmental Follow-up	All	1 ½ hours
IX. Closing Remarks [3:15-4:00] Thank you Next Steps Next Meeting: **Teleconference on Friday, March 1st,** **12:30-2:30pm CST**	John Duby/Marian Earls	45 minutes

Notes

- We will have a working lunch to facilitate movement of the meeting. A short lunch break is allotted for distribution of boxed lunches, but the meeting will continue during the meal.

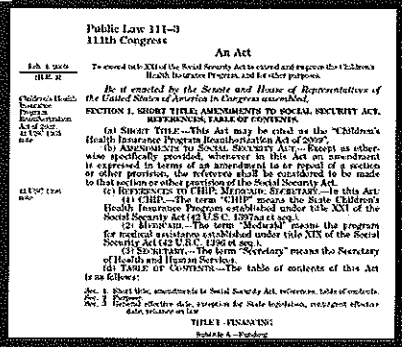
Pediatric Measures – Center of Excellence (PM-CoE)

Agency for Healthcare Research and Quality (AHRQ) Children's Health Insurance Program Reauthorization Act (CHIPRA)
Pediatric Quality Measures Program

MCoW; AMA, PCPI; AAP; ABMS; ABP; NU; TR

Donna Woods, EdM, PhD

CHIPRA



Public Law 111–3
111th Congress

An Act

To amend title XXI of the Social Security Act to extend and improve the Children's Health Insurance Program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Children's Health Insurance Program Reauthorization Act of 2009".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO CHIP; MEDICAID; SECRETARY.—In this Act:

(1) CHIP.—The term "CHIP" means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

(2) MEDICAID.—The term "Medicaid" means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

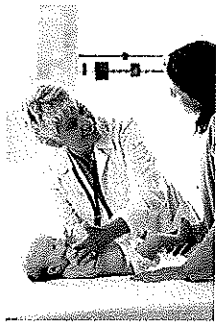
(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

sec. 1. Short title; amendments to Social Security Act; references; table of contents.
sec. 2. Purpose.
sec. 3. Updated effective date; exception for State legislation; contingent effective date; treatment of law.

TITLE I—FINANCING

Subtitle A—Funding

State Quality Demonstration Grant



- 15 State Quality Demonstration projects
- Working with the Centers of Excellence
  - Illinois
  - Massachusetts

25 Initial Core Measures

- ❑ Prevention and Health Promotion
  - ❑ Prenatal/Perinatal
  - ❑ Immunizations
  - ❑ Screening
  - ❑ Well-child Care Visits
  - ❑ Dental
- ❑ Management of Acute Conditions
  - ❑ Upper Respiratory-Appropriate Use of Antibiotics
  - ❑ Dental
  - ❑ Emergency Department
  - ❑ Inpatient Safety
- ❑ Management of Chronic Conditions
  - ❑ Asthma
  - ❑ ADHD
  - ❑ Mental Health
  - ❑ Diabetes
- ❑ Family Experiences of Care
  - ❑ Availability

Pediatric Measures – Centers of Excellence

Medical College of Wisconsin

American Medical Association

American Board of Medical Specialties — Higher standards. Better care.

Northwestern University Feinberg School of Medicine

The American Board of Pediatrics

QuIIN

TRUVEN HEALTH ANALYTICS

Chicago Pediatric Quality and Safety Consortium

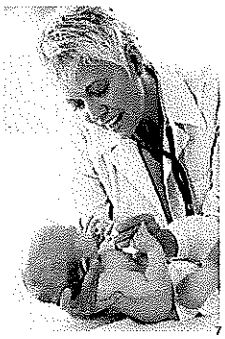
Testing Networks

Chicago Pediatric Quality and Safety Consortium

QuIIN — Quality Improvement and Innovation Network

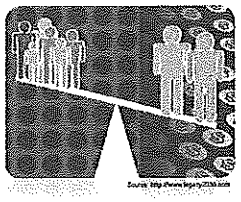
TRUVEN HEALTH ANALYTICS

- Framework includes:
  - Health care quality domains
    - Safe
    - Timely
    - Effective
    - Efficient
    - Patient-centeredness

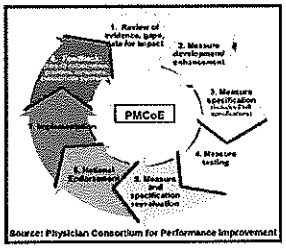


Equity & Disparities

- Assessment of equity, disparities:
  - Race,
  - Ethnicity
  - Insurance status



Methodologies



PROMIS®

Dynamic Tools to Measure Health Outcomes from the Patient Perspective

Role of AHRQ and CMS

AHRQ ⇄ CMS

↓

CHIPRA Centers of Excellence

PMCoE Year 1 Topics

PMCoE Year 1 Topic Assignments

- ❑ Perinatal/prenatal care
- ❑ ADHD diagnosis and follow-up
- ❑ Dental treatment services

PMCoE Year 2 Measure Assignments

- **Developmental Screening & Follow-up**
  - *Co-led by AAP & NU*
    - Focus: Screening Measures
      Follow-up Measures
- **Continuum of Care**
  - *Led by AMA*
- **PICU**
  - *Led by MCW*

Developmental Screening and Follow-up

- **Northwestern**
  - Donna Woods
  - Nicole Muller
  - Lindsay DiMarco
- **AAP**
  - Fan Tait
  - Jon Klein
  - Ramesh Sachdeva
  - Keri Thiessen
  - Melissa Singleton

NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

13

CENTER FOR HEALTHCARE STUDIES

Initial Core Measures Table

DSF Health - Existing Pediatric Measures

CHIPRA Initial Core Set

Measure #	Title	Current Numerator	Current Denominator	Data Source
PHP-33	Rates of screening using standardized screening tools for potential delays in social and emotional development (ABCD)	Number of children screened for social and emotional development with a standardized, documented tool or set of tools as part of a well child or other visit to their primary care provider	Children aged 0-12 months, 12-24 months, or 24-36 months, who had a well child or other primary care visit during the measurement year who were enrollees in Medicaid or CHIP	Administrative Claims and Medical Records

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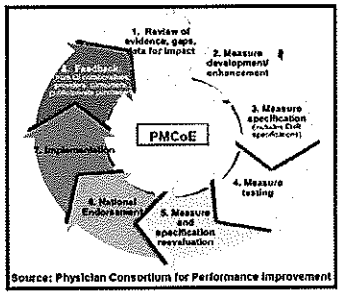
CENTER FOR HEALTHCARE STUDIES

PCPI Wheel



Source: Physician Consortium for Performance Improvement

15

CENTER FOR HEALTHCARE STUDIES

Measure Development

- Structure – Physical equipment and facilities (e.g., CPOE)
- Process – Processes of care (e.g., Percent of asthma patients receiving B-agonist within 30 minutes of ED arrival)
- Outcome – The final product, result (e.g., Mortality, Patient Reported Outcomes)

Patient Safety-Quality Improvement. (2005). Measurement: process and outcome indicators. Retrieved from http://patientsafetyed.duhs.duke.edu/module_a/measurement/measurement.html

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CENTER FOR HEALTHCARE STUDIES

Measure Development for Quality Improvement & Accountability

What makes a measure suitable for accountability uses? (P4P, MOC, etc.)

- Strength of evidence base
- "Data integrity"
  - Well-defined measure specifications (incl. exclusions)
  - Feasibility of data collection
  - Data reliability
  - Adequate sample size; risk adjustment
- Degree of control ("actionability")
  - Is the process/outcome under the control of the clinician or entity assessed?

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CENTER FOR HEALTHCARE STUDIES

Exceptions

Categories & sub-categories for designating measure exceptions:

Medical reason(s)

- Contraindicated (patient allergic history, potential adverse drug interaction, other)
- Not indicated (absence of organ/limb, already received/ performed, other)
- Intolerant (therapy was tried and the patient was intolerant)
- Other medical reason(s)

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CENTER FOR HEALTHCARE STUDIES

Exceptions

Categories & sub-categories for designating measure exceptions (continued):

Patient reason(s)
- Patient preference
  - Social reason(s)
  - Religious reason(s)
  - Other patient reason(s)

System reason(s)
- Resources to perform the services not available
- Insurance coverage/payor-related limitations
- Financial reason(s)
- Uninsured
- Service/treatment to be provided by another physician
- Other reasons attributable to health care delivery system

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Measure Development

Considerations for Development & Testing

- Workflow
  - Administrative claims data
  - Electronic health records data
- Feasibility
  - Are there codes that represent the quality of care to be assessed
  - Are the measure elements available in queriable fields
- Reliability
- Meaningful Use

20

Stage 2 Meaningful Use

Eligible professionals must meet 17 core objectives and 3 menu objectives selected from a list of 6; or a total of 20 core objectives

Repod on all 17 Core Objectives:
1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
2. Generate and transmit permissible prescriptions electronically (eRx)
3. Record demographic information
4. Record and chart changes in vital signs
5. Record smoking status for patients 13 years old or older
6. Use clinical decision support to improve performance on high-priority health conditions
7. Provide patients the ability to view online, download and transmit their health information
8. Provide clinical summaries for patients for each office visit
9. Protect electronic health information created or maintained by the Certified EHR Technology
10. Incorporate clinical lab-test results into Certified EHR Technology
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
13. Use certified EHR technology to identify patient-specific education resources
14. Perform medication reconciliation
15. Provide summary of care record for each transition of care or referral
16. Submit electronic data to immunization registries
17. Use secure electronic messaging to communicate with patients on relevant health information

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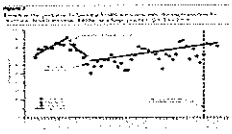
Stage 2 Meaningful Use

* **Has the capacity to capture and query information relevant to health care quality** *



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It's a New day!

- EHRs preferred primary data source
  - EHRs recognized as a critical component to achieving improved quality
  - Enable data collection to measure—and inform-improvement in health outcomes
  - eSpecification
  - eMeasure

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eSpecification/eMeasure

- eSpecification -generic term used to describe a performance measure specification—includes information to facilitate use of measures into EHRs
- eMeasure -XML version of e-specification; renders the measure "computable" when used in an EHR

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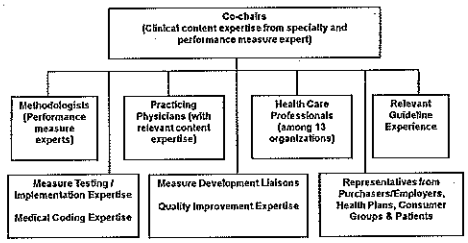
eSpecification Elements

- Includes:
  - Text descriptions of information
  - **Data Elements**
  - Representation of measure logic with data element attributes, Boolean logic and constraints
  - Mathematical expression to calculate measure
  - **Value Sets (aka: code list)**
    SNOMED, LOINC, RxNorm

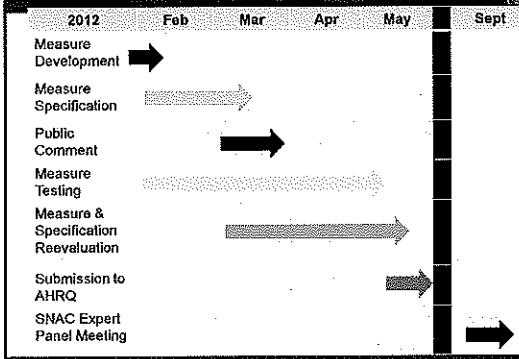
New eMeasures

- Determine appropriate data source(s)
  - eSpecifications for new measures
  - Incorporating nationally recognized standards
    - Clinical vocabularies vs administrative code sets
      SNOMED CT vs ICD9 & 10
  - Developed in context of EHRs
- Changing measure documentation
  - Workflow Documents and Templates

Multi-Specialty & Multi-Disciplinary Composition of Work Groups



Timeline



Thank You

Questions? Comments?

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Lindsay.dimarco@northwestern.edu

PMCoEDSF

Developmental
Screening
Overview

February 6, 2013

National Trends for Screening and Surveillance

- ABCD (Assuring Better Child Health & Development) Commonwealth Fund Initiatives since 2000:
  - ABCD I (2000–2003)
  - ABCD II (2003–2006)
  - Setting the Stage for Success (2006–2007)
  - ABCD Screening Academy (July 2007)—involving 23 states
  - ABCD III (2009-2012)
- AAP: 2001 & 2006 Policy Statements, Task Force on Mental Health, Bright Futures, 2007 Autism Screening Guidelines
- Rethinking Well-Child Care (AAP and Commonwealth)
- Tiered Well-Child Care (Commonwealth)
- SAMHSA—screening for social-emotional development
- Early Childhood Comprehensive Systems Grants (MCHB)
- Medical Home (AAP)

Early, Periodic, Screening, Diagnosis, & Treatment (EPSDT):

Omnibus Budget Reconciliation Act of 1989 (OBRA 89)

Social Security Act, section 1905(r)...

"Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by screening services"

EPSDT Continued....

Federal Requirements

- **Screening components**
  - Comprehensive health and developmental history
    Physical health development assessment
    Mental health development assessment
  - Comprehensive unclothed physical exam
  - Immunizations
  - Lab tests, including lead toxicity screening
  - Health education, including anticipatory guidance
- **Vision, hearing, and dental screens and services**
- **Other needed care discovered by the screenings**

State Medicaid Requirements and Reimbursement Policies On Developmental Screening, April 2011[1]

Red: State Medicaid program requires standardized developmental screening as part of well-child exams and pays an additional fee for it, and the usual well-child exam reimbursement for this screening. (9)

Blue: State Medicaid program requires standardized developmental screening as part of well-child exams, but does not pay an additional fee for it and the usual well-child exam reimbursement for the screening (4)

Yellow: State Medicaid program pays an additional fee for it and the usual well-child exam reimbursement for standardized developmental screening, but does not require this screening as part of well-child exams (11)

Green: State Medicaid program does not require standardized developmental screening as part of well-child exams and does not pay an additional fee for it and the usual well-child exam reimbursement for the screening. (Alaska and D.C.)

White: Data did not respond. (11)

[1] The Colorado Medicaid program requires the use of a standardized screening tool, but the screening is not required to be completed at a well child check. It can be completed at other times of the year (e.g. sick child visit). It is paid to be a separate code.
[2] The Kansas Medicaid program reimburses for screening, but it is during an EPSDT well child exam.

State Policies (cont)

- AZ –requires PCPs to use PEDS (effective 1/1/2006)
- MA requires routine social-emotional screening
- NC-requires PCPS to use a validated, standardized tool such as PEDs and ASQ. Providers referred to dbpeds.org for a complete list. Specific ages required.

AAP Policy Statements: Key Points

2001 statement:

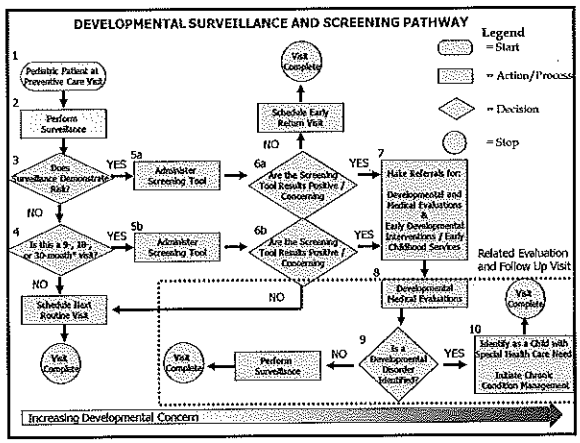
Developmental surveillance is an important method of detecting delays. Moreover, the **use of standardized developmental screening tools at periodic intervals will increase accuracy.** Successful early identification of developmental disabilities requires the pediatrician to be skilled in the use of screening techniques, **actively seek parental concerns about development, and create links with available resources in the community.**

AAP Policy Statements: Key Points

2006 statement

- Developmental surveillance should be a component of every preventive care visit. **Standardized developmental screening tools should be used** when such surveillance identifies concerns about a child's development & for children who appear to be at low risk of a developmental disorder at the 9-, 18-, and 30-month* visits.
- Establish **working relationships with state and local programs**, services, and resources.
- Use a **quality-improvement model to integrate surveillance and screening into office procedures** and to monitor their effectiveness and outcomes

**Note: Note that the Bright Futures periodicity schedule, and therefore the 30-month visit, have been included in the ACA. A key focus of the 30 month visit is development. A pediatrician who expects that his or her patients will have difficulty attending a 30-month visit should conduct screening during the 24-month visit.*



School Readiness Screening?

We recommend that developmental surveillance, as described later, be incorporated at every well-child visit. Any concerns raised during surveillance should be promptly addressed. In addition, standardized developmental screening tests should be administered regularly at the 9-, 18-, and 30-month* visits. Pediatric health care professionals may also find it useful to conduct school-readiness screening before the child's attendance at preschool or kindergarten. These recommendations represent our consensus; further research to evaluate the effectiveness of the proposed approach and available screening tools is encouraged. Separate recommendations aimed at the screening of children for behavioral and emotional disorders are also under consideration by the AAP and are not included in this document.

Measurement

ABCD States:

- During pilots many used chart audits, many measured rates of 96110
- Most now using 96110 (claims data)

CMS Core Quality Measure

- Current CHIPRA Measure (#8 of 24)
- NQF # 1448
- Developmental Screening in the First Three Years of Life
- Measure Steward: Oregon Health and Science University, Child and Adolescent Health Measurement Initiative (CAHMI) (http://www.cahmi.org)
- Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday
- Administrative or hybrid
- All states will be required to report for both Medicaid and CHIP in the CARTS reporting system annually

Measure 8 Denominator

- Denominator 1: The children in the eligible population who turned 1 during the measurement year.
- Denominator 2: The children in the eligible population who turned 2 during the measurement year.
- Denominator 3: The children in the eligible population who turned 3 during the measurement year.
- Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Measure 8 Numerator

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. The measure is based on three, age-specific indicators.

- Numerator 1: Children in Denominator 1 who had a claim with CPT code 96110 by their first birthday
- Numerator 2: Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays
- Numerator 3: Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays
- Numerator 4: Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Measure 8 Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 used to identify the numerator for the administrative method has been shown to have questionable validity. The measure steward recommends that states conduct a validity assessment of the claims data, as compared to medical chart review, before using the administrative method to calculate this measure.

Measure 8 Reporting Caveats

- Important Note about Appropriate Use of Claims Data: This measure is anchored to standardized tools that meet four criteria specified below in the paragraph beginning with "Tools must meet the following criteria." States who have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.
- Claims NOT Included in This Measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

Reporting Issues

- Rates based on paid claims – denied or pending claims not included
- EHR's often do not include 96110 as part of standard well-child electronic billing

eMeasure for DSF Considerations

Numerator:

- 1 96110 claims for appropriate age ranges

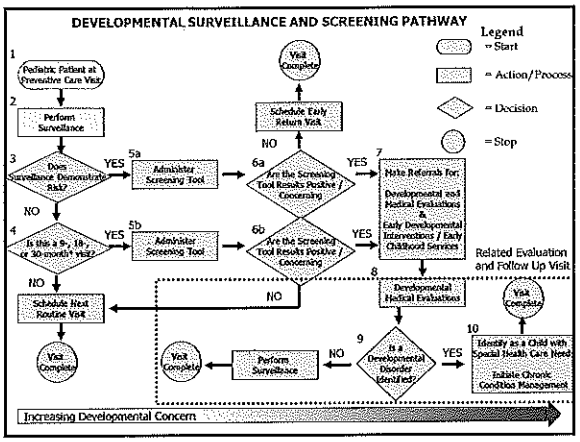
Denominator?:

- Plan (Medicaid) perspective: all enrollees for measurement period
- Practice perspective:
  - All age appropriate patients in EHR system for measurement period
  - All age appropriate EPSDT visits during measurement period

PMCoE DSF

Follow-up

February 6, 2013



Pathways for Follow-up

Borderline Screen – timely follow-up before next routine visit (e.g. ASQ-3 recommendation)

Positive screens

- Internal follow-up (interim visit, f/u with integrated LCSW)
- Referral: Part C, parent support, Head Start,…
- Referral: D&B Pediatrician, Psychologist, Geneticist, specific therapies

Current Measure Gaps

- 96110 rate indicates only that screening was done
- No measure for rates of positive screens
- No measure of discussion with family/anticipatory guidance
- No measure of follow-up planned
- No measure of appropriate referral(s)
- Administrative data not available for some types of referrals (Part C, family support, Head Start)
- No measure for feedback to PCC ("closing the loop")-referral tracking

Barriers to Address

- Limitations of EHR's in regard to pediatric content
- Most EHR's do not have screening documentation (scoring, discussion, disposition) as part of well-visit templates
- Inclusion of DSF in referral tracking system
- No current e measure
- Limitations for feedback – FERPA

eMeasure for DSF Considerations

Denominator?:

- Plan (Medicaid) perspective: all enrollees for measurement period
- Practice perspective:
  - All age appropriate patients in EHR system for measurement period
  - All age appropriate EPSDT visits during measurement period

eMeasure for DSF Consideration

Numerators:

- *1 96110 claims for appropriate ages (screening measure)*

Follow-up measures

- 2 positive screens (by domain?)
- 3 documentation of results discussed
- 4 referral, by type
- 5 documentation of feedback from referral source

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Developmental Screening & Follow-Up
Available Information on Impact and Gaps/Variations in Care

Impact of Topic

Prevalence:

- A study conducted by the CDC and HRSA found that 1 in 6 children in the U.S. between the ages of 3 and 17 had a developmental disability in 2006-2008. In addition, the prevalence of learning disabilities in the U.S. was 7.66 percent, the prevalence of ADHD was 6.69 percent, the prevalence of autism was 0.47 percent, and the prevalence of other developmental delays was 3.65 percent (CDC, 2011). A different study by Rosenberg et al. also found that a significantly greater proportion of children had delays at 24 months than at 9 months (2008).

- In addition, the prevalence of parent-reported developmental disabilities was shown to have increased 17.1 percent from 1997 to 2008 (CDC, 2011). ADHD and Autism had the largest increases in prevalence with Autism showing a nearly fourfold change from 1997 to 2008 (Boyle et al., 2011).

Morbidity:

- Between 12 and 18 percent of US children may have a developmental and behavioral problem but fewer than two percent of children with developmental delays, from birth to two years of age, will receive the necessary early intervention services (NCINQ, 2011). In addition, up to 70 percent of these delays may not be diagnosed until the children enter school which means by the time kindergarten begins, these children have already fallen behind their peers (Smart Start, 2011).

Costs:

- Developmental delays and disabilities incur additional costs of providing health care, educational support, and ongoing services. In addition, indirect costs such as lost potential income for affected individuals and educational, medical, and community resources are expended to support an individual who has a developmental delay (Sices, 2007).

- In 2003, using data from multiple surveys and reports, RTI International and the CDC estimated the direct and indirect economic costs associated with four developmental disabilities in the United States. Findings indicate that estimated lifetime costs in 2003 dollars are expected to total $51.2 billion for persons born in 2000 with mental retardation, $11.5 billion for persons with cerebral palsy, $2.1 billion for persons with hearing loss, and $2.5 billion for persons with vision impairment. Per-person cost estimates were also developed for the four developmental disabilities and average lifetime costs per person were estimated at $1,014,000 for persons with mental retardation, $921,000 for persons with cerebral palsy, $417,000 for persons with hearing

loss, and $566,000 for persons with vision impairment. Consequently, indirect costs accounted for between 63 and 81 percent of total costs associated with each disability (CDC, 2004).

- Assuming a combination of developmental screening tools and an equal distribution of children in the practice population at ages 1, 2, and 3, Dobrez et al. calculated steady-state costs per child in 2001 for developmental screening assuming greater visit frequency for the younger children and 100 percent compliance. In one model, the Ages and Stages screen, Family Psychosocial Screening, and cost of consultation were included, resulting in a cost of $167.20 per 0-3 year old child. In the second example, Family Psychosocial Screening, Early Language Milestone Scale, Bayley Infant Neurodevelopmental Screen, and the cost of consulting were included, resulting in a cost per-child of $234.96. Lastly, a per-child cost was calculated for the screens and services in the second example along with the CES-D (Mother), BABES, and another consultation which resulted in a total cost of $275.02 (Dobrez et al., 2001).

- A child who is identified as having a developmental delay by the time school starts and participated in early intervention programs is more likely to graduate high school, maintain a job, live independently, and avoid delinquency and violent costs. This represents a saved cost of between $30,000 and $100,000 per child (NCINQ, 2011).

Disparities:

- As mentioned in the aforementioned study by the CDC and HRSA, males had twice the prevalence of any developmental disorder than females and had a higher prevalence of ADHD, autism, learning disability, stuttering/stammering, and other developmental disorders. Similarly, Hispanic children had lower prevalence of ADHD and learning disabilities as compared to non-Hispanic white and non-Hispanic black children; however, non-Hispanic black children had higher prevalence of stuttering/stammering than non-Hispanic white children. Children insured by Medicaid had almost a two-fold higher prevalence of any developmental disorder compared to those with private insurance and children from families below the federal poverty level had a higher prevalence of developmental disabilities (CDC, 2011).

- In the cross-sectional study by Tang et al., the authors found that greater proportions of infants with low and high birth weights had high concerns for developmental delay as opposed to infants of average birth weight. In addition, a greater proportion of infants who had developmental concerns had problems in the neonatal period and had mothers whose primary language was not English, did not have a high school degree, and who had government health insurance (Tang et al., 2012).

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Gaps in Care

Disparities:

- After controlling for insurance status and poverty, Rosenberg et al. found that white children were more than twice as likely as black children to receive services to help with special needs (2008). In addition, Jimenez et al. found that among children referred to Early Intervention services, African American children were less likely to be evaluated than non-Hispanic white children (2012).

- Using data from the 2007 National Survey of Children's Health (NSCH), Bethell et al. found in multilevel regression that children were more likely to be screened by a parent-completed developmental tool if they were younger than 12 months as compared to children 36 to 71 months, if they were black, non-Hispanic as compared to white children, or were Hispanic children whose primary language was Spanish (Bethell et al., 2011).

- Bethell et al. also found that after controlling for child's age, gender, race/ethnicity, primary household income, type of health insurance, and developmental risk and special-needs status that the odds that a child aged 1 to 5 years had an Early Intervention plan or an Individual Family Service Plan were 2.41 times greater if the child was screened by a health care provider using a parent-completed development tool (Bethell et al., 2011).

- Recent U.S. Department of Education data show a relative decrease in the proportion of black children receiving EI services, from 18 percent in 1998 to 13 percent in 2007. This highlights a possible disparity in access to services (Feinberg et al., 2012). Similarly, Feinberg et al. found that while there was no significant racial differences in receipt of EI services at 9 months of age, by 24 months of age, black children were almost 5 times less likely to receive EI services than white children and this was most prominent among children who qualified for EI based on developmental delay rather than an established medical condition (Feinberg et al., 2012).

- Another study found that 23 percent of low-income children enrolled in Medicaid receive the recommended preventive and developmental services considered a basic threshold for quality of care. In addition, as of 2007, 28 states were engaged in lawsuits due to failure to properly deliver Early Intervention Periodic Screening, Diagnosis and Treatment (EPSDT) services (NCINQ, 2011).

Screening rates:

- A study conducted by Radecki et al. found that while pediatricians' use of standardized screening tools increased significantly from 2002-2009, in 2009, only 47 percent of physicians questioned in the study self-reported always/almost always using at least one screening tool to identify children at risk for developmental delay. Further, in 2009, 60.5 percent of pediatricians

reported using clinical assessment without a formal tool to identify children at risk for developmental delay (Radecki et al., 2011).

- Drawing on data from the AAP's Enhancing Developmentally Oriented Primary Care (EDOPC) project from 2005-2007 where the EDOPC conducted 336 trainings at 164 sites in Illinois, Allen et al. found that at baseline, only 25 percent of sites were doing any sort of routine developmental screening at the first year visit and they were only doing so in 4 to 32 percent of patients. Similarly, at the 2-year visit at baseline, only 12 percent of sites were routinely performing any screening for developmental delay and they were only doing so in 27 to 45 percent of children (Allen et al., 2010).

- Only about 20 percent of physicians use developmental screening tests despite supporting evidence for standardized developmental screening tools. For example, one study found that pediatricians failed to identify and refer 60 to 80 percent of children with developmental delays in a timely manner and another study found that 68 percent of children with delays were not detected by pediatricians (NCINQ, 2011).

- A national survey reported that parents of children between the ages of 10 to 35 months were asked whether their child has ever received a "developmental assessment," defined as a formal or informal assessment or screening done by a health care provider with or without the use of a validated screening tool, and that more than 40 percent of parents responded that their child had never received a developmental assessment (Sices, 2007).

- A study focused on improving the delivery of EPSDT well-child care in a pediatric practice found that 51 percent of patients in the practice were not up-to-date for well-child check-up visits and many children had multiple missed opportunities for services at acute visits (Patterson et al., 2012).

<u>Follow-up care:</u>

- Rosenberg et al. found that only 10.1 percent of children who were classified as having delays at 24 months received Early Intervention services (2008). In addition, in 2009, almost 340,000 infants and toddlers received EI services (3 percent of U.S. children birth to three years of age). This percentage has almost doubled over the past ten years (Feinberg et al., 2012).

- Feinberg et al. used data from the Early Child Longitudinal Study which draws from a nationally representative sample of the nearly 4 million U.S. children born in 2001 and found that among children eligible to receive EI services at 9 months, only 9 percent received services. Similarly, of the children eligible to receive EI services at 24 months, 12 percent received services (Feinberg et al., 2012).

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Variations in Care

Developmental Screening:

- A cross-sectional study conducted by Sices et al. screened 60 parent-child pairs using both PEDS and ASQ and found discordant results in 1 out of 3 children with differences in ratings of language/communication skill varying the most between the two screens. This suggests that while PEDS and ASQ are geared toward identifying a similar group of children at risk of developmental delay, the two screens are actually identifying two different groups of children (Sices et al., 2009). This could be due to different formatting of the screeners or the tools may function differently in different populations.

- A national study by Bethell et al. found that 20 percent of children aged 10 to 76 months were reported by their parents to have been screened for development, social, or behavioral delays using standardized parent-completed tools. Publicly insured children had a statistically significantly higher frequency of parents reporting screening compared to privately insured children and among publicly insured children, African American children had the highest screening rates and Asian children had the lowest (Bethell et al., 2011).

Developmental Follow-up:

- In a cross-sectional study by Tang et al., high risk infants who were seen at neonatal follow-up for at least two visits before their third birthday were studied in regards to developmental follow-up and referrals. The authors found that between 34 to 37 percent of high risk infants who failed a developmental screen were not referred to either Early Intervention or other therapies. The authors hypothesized that this might be due to the fact the providers take a "wait-and-see" approach in referring developmentally delayed children older than 12 months. Further, a study cited in the report notes that the mean time between identification of a developmental delay and Early Intervention referral is greater than 5 months (Tang et al., 2012).

- Tang et al. found that privately insured children were not referred to state or private programs at the same rate as publically insured children as Early Intervention referrals were positively associated with public insurance (Tang et al., 2012).

- In a qualitative study focusing on barriers to evaluation for Early Intervention (EI) services, Jimenez et al. found that parents who reported that their child was not evaluated by EI were more likely to report that their pediatrician did not explain what EI was or how to obtain services. In addition, the study noted that parents often thought of themselves as experts on their child's development and felt that they should decide whether their child pursued EI services or felt that they should wait to see if developmental problems resolved themselves before seeking EI services. Further, time constraints, issues contacting EI, and not understanding the referral process all interfered with the child being evaluated (Jimenez et al,

2012). This indicates that despite the promotion of EI services by various policies, many children who are referred to EI are never evaluated.

- In a study conducted by the AAP, 61 percent of children who failed a developmental screen were not referred for further evaluation. In addition, in contrast to screening rates, referral rates did not increase between July 2006 and March 2007, in fact they were noticeably lower in the later months of the project. Subgroup analysis found that among practices using the PEDS, less than one in three children with a failing result was referred to any source (King et al., 2012). Further, 6 of the 17 participating practices successfully tracked their patient referrals and found that a large number of families never followed through with their recommended referrals and that many families did not understand the reason for their referral (King et al., 2012).

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Measure Topic I: Developmental Screening

1. Measure: Rates of screening using standardized screening tools for potential delays in social and emotional development (Source: CHIPRA Initial Core Measure, IL-HFS)

Measure Description (numerator/denominator statements):

Numerator Statement: Number of children screened for social and emotional development with a standardized, documented tool or set of tools as part of a well-child or other visit to their primary care provider (report three rates – one for each age category listed in the denominator).

Denominator Statement: Children aged 0-12 months, 12-24 months, or 24-36 months, who had a well-child or other primary care visit during the measurement year who were enrollees in Medicaid or CHIP.

Measure Use (improvement, public reporting, etc.): Improvement

Data Source (admin, hybrid, etc.): Hybrid

Data Requirements (administrative, manual, e-measure): Administrative and manual

Is this measure functioning as intended?:

If not, what are the barriers to effective use?: The fact that the measure is hybrid makes it difficult to report. In conversations with Julie and Gwen from the IL-HFS, they informed us that it was too cumbersome to perform medical record review and that they had received a waiver to adapt the measure so that they only needed to specify it using administrative claims. Similarly, the 2011 Annual CHIPRA report indicated that only 2 states reported this measure in FFY2010. States that did not report the measure indicated it was because the data were not available or there were "other" reasons that they were not using the measure. It may be due to the difficulty of collecting data for a hybrid measure that includes medical chart review. Further, the measure is specified using the CPT code 96110 which is defined as "Developmental screening, with interpretation and report, per standardized instrument form." As the code does not differentiate between validated and non-validated tools, the measure does not capture how many children are diagnosed using a validated tool or which tools are used most frequently.

What aspects of the measure are beneficial?: This measure captures children at all three ages recommended for developmental screening by Bright Futures and the AMA. In addition, the tool used during the screen must also be standardized and documented.

Who is not captured by the measure?: (1) Children in states that do not have the resources to conduct manual chart review. (2) Children whose physicians did not bill an administrative code when conducting

screening. (3) How many children are diagnosed using a validated tool and which tools are used most frequently for diagnosis.

2. Measure: Standardized developmental and behavioral screening: proportion of children whose health care provider administered a parent-completed standardized developmental and behavioral screening tool (Source: NQMC/CAHMI)

Measure Description (numerator/denominator statements):

Numerator Statement: Children whose parents responded "Yes" to the question "In the last 12 months, did your child's doctor or other health care provider have you fill out a questionnaire about specific concerns or observations you may have about your child's development, communication or social behaviors?" as well as to two age-specific questions regarding the child's speech development and interactions.

Denominator Statement: Children age 3 months to 48 months who received a well-child visit in the last 12 months and whose parents responded to all three "Standardized Developmental and Behavioral Screening" items on the Promoting Healthy Development Survey (PHDS).

Measure Use (improvement, public reporting, etc.): Improvement, Public Reporting

Data Source (admin, hybrid, etc.): Patient/Individual Survey

Data Requirements (administrative, manual, e-measure): Manual

Is this measure functioning as intended?:

If not, what are the barriers to effective use?: In order for a child to be included in this measure, the parent must be given the PHDS, must fill out a PHDS, and the parent must remember and respond correctly to the three reported questions. Children may be excluded entirely if their parent either does not receive the survey or does not complete the survey. In addition, response bias is introduced as the parent must remember back and report on the previous visit. If a parent responds incorrectly to one of the three questions, the child will be categorized incorrectly.

What aspects of the measure are beneficial?: The measure relies on the PHDS which includes age-specific questions that can be tailored to each individual child. This improves the likelihood of a child being categorized correctly as questions will be specific to the age of the child.

Who is not captured by the measure?: (1) Children whose parents do not receive a PHDS, (2) Children whose parents receive but do not fill out a PHDS, (3) Children whose parents receive a PHDS but respond incorrectly to the three questions (i.e. if they respond "No" to one of the three questions, the child will not be included in the numerator even if the child should be there).

3. Measure: Developmental screening by 2 years of age (Source: NCQA via NQF)

Measure Description (numerator/denominator statements):

Numerator Statement: Children who had documentation in the medical record of a developmental screening (screening for risk of developmental, behavioral, and social delays) between 12 and 24 months of age. Screening must be conducted using a standardized tool.

Denominator Statement: Children with a visit who turned two years of age between January 1 and December 31 of the measurement year.

Measure Use (improvement, public reporting, etc.): Improvement

Data Source (admin, hybrid, etc.): Hybrid but specified primarily as medical record due to inability of administrative codes to identify standardized tool consistently.

Data Requirements (administrative, manual, e-measure): Manual

Is this measure functioning as intended?:

If not, what are the barriers to effective use?: This measure was originally specified as a hybrid or administrative measure but due to the inability of administrative codes to identify the use of a standardized tool consistently, HEDIS 2012, indicates that it is currently specified as medical record only. In order for a child to be counted in the numerator, a note indicating the date on which a test was performed, the standardized tool used, and evidence of a screening result or score must be present in the medical record. However, documentation in medical records is not always ideal and children who do not have one of these three items present may be excluded. There may also be some human error in calculating the measure if medical record documentation is not consistent between physicians and/or practices. This measure also does not capture whether developmental screening occurred at a 9 month visit as recommended by Bright Futures.

What aspects of the measure are beneficial?: The screening tool must be a standardized tool which decreases the likelihood that children will be incorrectly and unpredictably included or excluded from the measure numerator.

Who is not captured by the measure?: (1) If specified as hybrid, children with incorrect administrative documentation, (2) children with incorrect medical record documentation, (3) children who had a developmental screen at 9 months of age but not between 12 and 24 months of age.

Measure Topic II: Developmental Follow Up

1. Measure: Follow-up for children at risk for delays: proportion of children who were determined to be at significant risk for development, behavioral, or social delays who received some level of follow-up care (Source: NQMC/CAHMI)

Measure Description (numerator/denominator statements):

Numerator Statement: Children whose parents responded positively to the items indicating the risk-appropriate follow-up care was provided. The items include the child's doctor or health provider noting a concern that should be watched carefully, testing child's learning development and behavior, referring child to another doctor or health provider, referring child for testing of learning, development, and behavior, or referring child for speech-language or hearing testing.

Denominator Statement: Children ages 3 months to 48 months who received a well-child visit in the last 12 months, who were identified as significant risk (high/moderate) for developmental, behavioral, and social delays (based on the Parents Evaluation of Developmental Status [Peds] items in the Promoting Healthy Development Survey [PHDS]), and whose parents answered at least half of the items asking about follow-up care received.

Measure Use (improvement, public reporting, etc.): Improvement

Data Source (admin, hybrid, etc.): Patient/Individual Survey

Data Requirements (administrative, manual, e-measure): Manual

Is this measure functioning as intended?:

If not, what are the barriers to effective use?: This measure requires that the parents receive and complete the PHDs (at least half of the items about follow-up care). Thus, if a parent does not receive the survey or does not fill out at least half of the requisite items, the child will be omitted from the measure completely. In addition, the parent must remember the previous well-child visit and what type of follow-up care was provided. If a parent responds incorrectly to one of the questions, a child may be included in the numerator who should not be or a child may be omitted from the numerator when appropriate follow-up care was provided. Similarly, if a parent is responding to the survey, they may not want to report

What aspects of the measure are beneficial?: The measure captures children between the ages of 3 and 48 months and includes many different aspects of follow-up allowing for variability between physician referrals. The measure also relies on the referring physician's notes which are easily accessible.

Who is not captured by the measure?: (1) Children whose parents do not receive the survey, (2) children whose parents do not respond to the survey, (3) children whose parents respond incorrectly to

one of the key questions and are placed either in the numerator or are excluded from the numerator incorrectly.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these **Recommendations for Preventive Pediatric Health Care** are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. **Additional visits may become necessary** if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of **continuity of care** in comprehensive health supervision and the need to avoid **fragmentation of care.**

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	PRENATAL[2]	NEWBORN[3]	3–5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 m	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[5]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision		★	★	★	★	★	★	★	★	★	★	★	★	●[6]	●	●	●	★	●	★	●	★	●	★	★	●	★	★	●	★	★	★
Hearing		●[7]	★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	★	★	★	★	★	★	★	★	★	★	★	★
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																																
Developmental Screening[8]								●			●		●																			
Autism Screening[9]											●	●																				
Developmental Surveillance[8]		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Alcohol and Drug Use Assessment																						★	★	★	★	★	★	★	★	★	★	★
PHYSICAL EXAMINATION[10]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[11]																																
Newborn Metabolic/Hemoglobin Screening[12]		◄	●	►																												
Immunization[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin[14]						★			●		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead Screening[15]							★	★	●or★[16]		★	●or★[16]		★	★	★	★															
Tuberculin Test[17]				★			★		★		★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia Screening[18]												★			★		★		★		★	★	★	★	★	★	★	★	◄	●	►
STI Screening[19]																						★	★	★	★	★	★	★	★	★	★	★
Cervical Dysplasia Screening[20]																						★	★	★	★	★	★	★	★	★	★	★
ORAL HEALTH[21]							★	★	●or★[21]		●or★[21]	●or★[21]	●or★[21]	●[22]			●[22]															
ANTICIPATORY GUIDANCE[23]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1456].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
4. Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, rescreen within 6 months per the AAP statement "Eye Examination in Infants, Children, and Young Adults by Pediatricians" (2007) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/4/902].
7. All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs " (2000) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/798]. Joint Committee on Infant Hearing. Year 2007 position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics.* 2007;120:898–921.
8. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics.* 2006;118:405–420 [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405].
9. Gupta VB, Hyman SL, Johnson CP, et al. Identifying children with autism early? *Pediatrics.* 2007;119:152–153 [URL: http://pediatrics.aappublications.org/cgi/content/full/119/1/152].
10. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
11. These may be modified, depending on entry point into schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedules per the Committee on Infectious Diseases, published annually in the January issue of *Pediatrics.* Every visit should be an opportunity to update and complete a child's immunizations.
14. See AAP *Pediatric Nutrition Handbook,* 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United States. *MMWR.* 1998;47(RR-3):1–36.
15. For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children: Prevention, Detection, and Management" (2005) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036]. Additionally, screening should be done in accordance with state law where applicable.
16. Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases.* Testing should be done on recognition of high-risk factors.
18. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) [URL: http://circ.ahajournals.org/cgi/content/full/106/25/3143] and "The Expert Committee Recommendations on the Assessment, Prevention, and Treatment of Child and Adolescent Overweight and Obesity." Supplement to *Pediatrics.* In press.
19. All sexually active patients should be screened for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.)

KEY

●= to be performed ★= risk assessment to be performed, with appropriate action to follow, if positive ◄—●—► = range during which a service may be provided, with the symbol indicating the preferred age

DRAFT Measure #1: Consistent Performance of Developmental Screening

Developmental Screening and Follow-up (DSF) Measure Set

Measure Description

Percentage of patients who have received consistent developmental screening and assessment by a pediatrician or other healthcare professional using a standardized developmental screening instrument that relies on parental input by age 3

Measure Components

Numerator Statement	Patients who have received ▪ A developmental screen before age 12 months, AND ▪ A developmental screen between ages 12 and 24 months, AND ▪ A developmental screen between the ages of 24 and 36 months, using a standardized developmental screening instrument that relies on parental input. <u>Definitions</u>: [1]Standardized developmental screening instruments that rely on parental input include the Parents' Evaluation of Developmental Status (PEDS) and the Ages and Stages Questionnaire (ASQ) tools
Denominator Statement	All patients who attended at least one well-visit appointment within each of the following timeframes: 0-12 months, 12-24 months, and 24-36 months.
Denominator Exceptions	This measure has no exceptions
Supporting Guideline & Other References	**The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:** More to be added after measure is finalized. Screening tests can identify children with developmental delay with reasonable accuracy. Research has shown that parental questioning is a valid means of screening for developmental delays, and that standardized instruments have sensitivity and specificity similar to that of screens that require direct elicitation of a child's skills. (Hamilton, 2006) PEDS questionnaire has a sensitivity of 74% to 79% and a specificity of 70% to 80% across ages 0 to 8 years in the detection of developmental delays and behavioral

	problems. It maintains its psychometric properties across various levels of parental education, socioeconomic status, and child-rearing experience. The sensitivity and specificity for all ages combined was 75% and 74% respectively. (Hamilton, 2006) The ASQ has a specificity ranging from 81% (16 months) to 92% (36 months) and 86% overall. There was a trend toward higher specificity when screening older children. Sensitivity was lower, averaging 72%. The instrument maintains its validity when screening high-risk children: when specifically used to evaluate infants born prematurely, the ASQ had 90% sensitivity, 77% specificity. (Hamilton, 2006)

Measure Importance

Relationship to desired outcome	Many children with developmental delays are not being identified as early as possible. Screening tests can identify children with developmental delay and such children may benefit from early intervention. Research shows that early intervention treatment services can significantly improve a child's development through services and therapies provided from birth through 3 years of age.
Opportunity for Improvement	There is a need for consistent developmental screening with use of evidence-based validated instruments in the diagnostic process. A national survey of pediatricians and family physicians found that 53% reported using no standardized instrument in their assessment of children for developmental delays.[1]
IOM Domains of Health Care Quality Addressed	• Effective • Timely • Equitable • Safe • Efficient
Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement
	•	Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan level
Care setting	•	Any inpatient or outpatient care
Data source	•	Administrative claims data, Electronic health record (EHR) data

[1] Sices L, Feudtner C, McLaughlin J, Drotar D, Williams M. How do primary care physicians identify young children with developmental delays? A National Survey. *Pediatrics* 2003;24:409-427

DRAFT Measure #2: Follow-up with Patient Family after Developmental Screening

Developmental Screening and Follow-up (DSF) Measure Set

Measure Description

Percentage of patients aged 6 months to 36 months whose family received a follow-up discussion of developmental screening results within [*specify timeframe*] of receiving the results

Measure Components

Numerator Statement	Patients whose family received a follow-up discussion of the developmental screening results by a clinician within [*specify timeframe*] of the receiving the results Definitions: Follow-up discussion:
Denominator Statement	All patients aged 6 months to 36 months who received a developmental screen using a validated screening tool
Denominator Exceptions	This measure has no exceptions
Supporting Guideline & Other References	**The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:** To be added.

Measure Importance

Relationship to desired outcome	Discussing both positive and negative results with family members and documenting them in the medical chart indicates that a physician has taken the time to interpret the screening tool results and relay these results and any follow-up information to a child's family.
Opportunity for Improvement	Patients whose families receive feedback from physicians on developmental screening results, whether positive or negative, have been shown to significantly benefit, particularly if there is any action the families can do to become more educated on development milestones.
IOM Domains of Health Care Quality Addressed	• Effective • Timely • Equitable • Safe • Efficient

Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement
	•	Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan Level
Care setting	•	Any inpatient or outpatient care
Data source	•	Electronic health record (EHR) data

DRAFT Measure #3: Follow-up Referral after Positive Developmental Screen

Developmental Screening and Follow-up (DSF) Measure Set

Measure Description

Percentage of patients aged 6 to 36 months who were referred for follow-up care within [*specify timeframe*] of receiving a positive developmental screening result

Measure Components

Numerator Statement	Patients who received a referral for follow-up care by the screening clinician within [*specify timeframe*]of receiving a positive developmental screening result Definitions: [1] A positive developmental screening result refers to a result from a validated developmental screening tool that indicates the patient tests positive for risk of a developmental delay [2]Referral for follow up care refers to any type of therapy, intervention, or education to mitigate developmental delays and can be within the medical home or outside of the medical home. Some referral types include: ▪ Children's Developmental Services Agency (CDSA), Part C ▪ Care Coordination 4 Children (CC4C) o *Note: This is specific to North Carolina. Is it comparable in other states?* ▪ Physical Therapy ▪ Occupational Therapy ▪ Medical Home Provider Internal ▪ Specialty Provider External ▪ Early Head Start ▪ Network Care Manager ▪ Parenting Support
Denominator Statement	All patients aged 6 months to 36 months who received a positive developmental screening result
Denominator Exceptions	This measure has no exceptions
Supporting Guideline & Other References	**The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:**

	To be added

Measure Importance

Relationship to desired outcome	A developmental delay can profoundly impact a child's ability to function in many settings. Therefore, it is important to ensure that children who have a positive result on a developmental screen are referred to follow-up services so that they can receive the care they need.
Opportunity for Improvement	This measure will capture children at risk of developmental delay and who were referred to a follow-up service which is currently not being measured.
IOM Domains of Health Care Quality Addressed	• Effective • Timely • Equitable • Safe • Efficient
Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement
	•	Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan Level
Care setting	•	Any inpatient or outpatient care
Data source	•	Electronic health record (EHR) data

DRAFT Measure #4: Developmental Follow-up Referral Tracking

Developmental Screening and Follow-up (DSF) Measure Set

Measure Description

Percentage of patients aged 6 to 36 months diagnosed with a developmental delay whose provider received feedback from the follow-up care physician within [*specify timeframe]* of receiving a referral for follow-up care

Measure Components

Numerator Statement	Patients whose provider received feedback from the follow-up care physician within [*specify timeframe*] of making the referral for follow-up care Definitions: [1]Feedback from follow-up care physician refers to correspondence between the two physicians by way of phone, fax, paper documentation transmitted through mail or other permissible means of transferring patient information [2]Referral for follow up care refers to any type of therapy, intervention, or education to mitigate developmental delays and can be within the medical home or outside of the medical home. Some referral types include: ▪ Children's Developmental Services Agency (CDSA), Part C ▪ Care Coordination 4 Children (CC4C) o *Note: This is specific to North Carolina. Is it comparable in other states?* ▪ Physical Therapy ▪ Occupational Therapy ▪ Medical Home Provider Internal ▪ Specialty Provider External ▪ Early Head Start ▪ Network Care Manager ▪ Parenting Support
Denominator Statement	All patients aged 6 months to 36 months who received a positive developmental screening result and a referral for follow-up care
Denominator Exceptions	**For Consideration** ▪ Patients who were referred for follow-up services but did not continue care in the medical home where diagnosed ▪ Patients who do not attend any visit for follow-up services
Supporting Guideline & Other References	**The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:**

	To be added

Measure Importance

Relationship to desired outcome	Given the importance of medical homes, it is important for pediatricians to know about the follow-up services their patients are receiving.
Opportunity for Improvement	This measure will capture feedback from referral sources and measure how frequently physicians receive feedback about their pediatric patients' developmental follow-up using electronic medical records data.
IOM Domains of Health Care Quality Addressed	• Effective • Timely • Equitable • Safe • Efficient
Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement
	•	Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan Level
Care setting	•	Any inpatient or outpatient care
Data source	•	Electronic health record (EHR) data

PMCoE Developmental Screening Primer
February 6, 2013

Reporting & Valuation of Code 96110

Developmental screening can only be separately reported when a standardized instrument form is utilized.

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

This code descriptor was revised in 2012 (effective January 1, 2012) as follows:

- The term "developmental testing; limited" was revised to "developmental screening"
- "Per standardized instrument report" was added to:
    1. Require use of standardized instruments in order to report the code
    2. Allow reporting of more than one developmental screening per single patient encounter

There have not been any additional revisions to code 96110 since 2012; therefore, these reporting guidelines continue for 2013.

The use of standardized developmental screening instruments (eg, PEDS, Ages and Stages, Vanderbilt ADHD rating scales, Pediatric Symptom Checklist (PSC-17) is reported using CPT code 96110, which is typically reported when performed in the context of preventive medicine evaluation and management (E/M) services (ie, well child care visits). However, code 96110 may also be reported when screening is performed with other E/M services such as acute illness or follow-up office visits (eg, 99213).

On the 2013 Medicare Fee Schedule Resource-Based Relative Value Scale (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]). 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 screening 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 developmental screen 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 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 developmental screening code, showing that developmental screening services were separate and necessary at the same visit.

The frequency of reporting 96110 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 developmental screening tools to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of developmental screens 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, this is not a "test" as such, and is not separately reportable.

96110 Vignettes

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		ICD-9-CM
99392-25*	Preventive medicine service; established patient, age 1-4 (appended with modifier 25)	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 developmental screening code.

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		ICD-9-CM
99392-25*	Preventive medicine service; check established patient, age 1-4 (appended with modifier 25)	V20.2 Routine infant or child health
96110	Developmental screening	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 developmental screening 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).

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	ICD-9-CM

99393-25*	Preventive medicine service; established patient, age 5-11 (appended with modifier 25)	V20.2 Routine infant or child health check
96110	Developmental screening	V20.2 Routine infant or child health check 315.4 Developmental coordination disorder 313.9 Unspecified emotional disturbance of childhood

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

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 a Vanderbilt ADHD rating scale completed two weeks ago by his classroom teacher: "Bobby's teacher says she keeps a stack of blank forms so she can give her students' doctors her impressions. She downloaded it off the internet. You give this 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		ICD-9-CM
99393-25*	Preventive medicine service; established patient, age 5-11 (appended with modifier 25)	V20.2 Routine infant or child health check
99213	Office or other outpatient service,	314.01 Attention deficit/hyperactivity disorder, established patient, combined type 15 minutes "typical time"
96110	Developmental screening	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 developmental screening code.

Developmental Screening Documentation

Each administered developmental screening standardized 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 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 standardized instrument forms:

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.

Examples of Developmental Screening Standardized Instrument Forms

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)

A Note on 2013 Revisions to CPT Psychiatry Codes

Until 2013, pediatricians reported code 90862 (pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy) when refilling controlled substance presecriptions typically utilized in the treatment of conditions such as ADHD. However, there were revisions to the psychiatry CPT codes for 2013 that affect this reporting guideline.

Starting in 2013, a complex revision of the CPT codes for psychiatry services (please see Attachment 1) includes establishment of new code 90863 for pharmacologic management with concurrent deletion of code 90862.

90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services

With this change, physicians or other qualified health care professionals who may report E/M service codes will no longer separately report pharmacologic management. Instead, E/M codes 99201–99255, 99281–99285, 99304–99337, or 99341–99350 should be reported with the pharmacologic management taken into consideration when determining the level of service provided. When appropriate, psychotherapy add-on codes 90833, 90836, or 90838 may be reported in addition to an E/M code for separate time spent providing psychotherapy services at the same encounter. Code 90863 is to be used by providers who cannot report E/M services and only as an add-on code with 90832, 90834, and 90837 (psychotherapy without an E/M service).

A Note on Consultations vs Referrals

A consultation is a rendering of advice or professional opinion, followed by a report of findings to the requesting physician (ie, primary care pediatrician). A consultation visit results in the patient returning to the primary care physician who initiated the care. Diagnostic testing can be provided and billed in a consultation.

The following chart summarizes the difference between a consult and a referral:

	CONSULT	REFERRAL
Request	"Please see patient for a consult." "Consulting services requested." Must be in writing	"Patient has been referred by..."
Problem	Suspected or known diagnosis Consulting physician unsure of condition or assumption of management	Identified problem
Treatment	Undetermined or possibly known	Known
Requesting Physician	Decides which physician will administer care Uncertain at time of consult	Oversees and manages care
Report	Written report to requesting physician	Written report to requesting physician is not necessary
CPT Codes	Office or other outpatient consultation codes (99241-99245)	New or established patient office or other outpatient visit codes (99201-99215)

HCPCS Level II Modifier: Potential Solution for Tracking Follow-Up on Positive Screens?

Healthcare Common Procedure Coding System (HCPCS) Level II is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT coding nomenclature, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies. They are established by CMS's Alpha-Numeric Editorial Panel (consisting of CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association).

Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes were established for submitting claims for these items. The development and use of Level II of the HCPCS began in the 1980s. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

Both the CPT nomenclature and the HCPCS Level II nomenclature are included as the standard procedural code set under HIPAA. This means that covered entities must recognize HCPCS Level II codes under HIPAA.

Also similar to the CPT nomenclature, the HCPCS Level II nomenclature includes modifiers. Modifiers are used to supplement information or adjust the code description to provide additional details concerning a procedure or service provided by a physician.

A possible solution to tracking the follow-up on positive developmental screens might be to utilize a current HCPCS Level II modifier or, alternatively, develop a new HCPCS Level II modifier specifically for this purpose.

Current HCPCS Level II Modifiers That Might Be Utilized:
HA Child/adolescent program
HE Mental health program
HI Integrated mental health and mental retardation/developmental disabilities program
HK Specialized mental health programs for high-risk populations
HT Multi-disciplinary team
SE State and/or federally funded programs/services
SM Second surgical opinion
TL Early intervention/individualized family service plan (IFSP)
TS Follow-up service
U1-UD Medicaid Level of Care, 1 through 13, as defined by each State

Please see Attachment 2 for a complete listing of all HCPCS Level II modifiers.

Process To Develop A New HCPCS Level II Modifier:
Please see Attachments 3 & 4 for the HCPCS application and decision tree.

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Subspecialty Corner: *CPT 2013* Psychiatry Codes (Online Exclusive)

November 2012

Those who provide and assign codes for psychiatry services may need to make a few adjustments related to *Current Procedural Terminology (CPT®) 2013.* The codes for psychiatry services have undergone big changes—a new code structure, some new terminology, and updated guidelines. Following is an overview of the major changes and reporting guidelines.

The guidelines preceding the codes for reporting psychiatry services begin by defining the scope of these services. The general description provided in the new guidelines includes the following:

- Psychiatry services include diagnostic services, psychotherapy, and other services to an individual, a family, or a group.
- Services are provided in all settings of care, and psychiatry service codes are reported without regard to setting.
- Services may be provided by a physician or other qualified health care professional.
- Some psychiatry services may be reported with evaluation and management (E/M) services (**99201–99255, 99281–99285, 99304–99337,** or **99341–99350**) or other services when performed.
- E/M services (**99201–99285, 99304–99337,** or **99341–99350**) may be reported for treatment of psychiatric conditions, rather than using psychiatry service codes, when appropriate.

Two important characteristics of certain psychiatry services are further defined.

1. *Interactive complexity*—specific communication factors that complicate the delivery of a psychiatric procedure. Psychiatric procedures may be reported "with interactive complexity" when at least one of the following is present

a) The need to manage maladaptive communication such as high anxiety, high reactivity, repeated questions, or disagreement among participants that complicates delivery of care

b) Caregiver emotions or behaviors that interfere with the caregiver's understanding and ability to assist in the implementation of the treatment plan

c) Evidence or disclosure of a sentinel event and mandated report to third party (eg, abuse or neglect with report to state agency) with initiation of discussion of the sentinel event or report with patient and other visit participants

d) Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who

– Is not fluent in the same language as the physician or other qualified health care professional

– Has not developed, or has lost, the expressive language communication skills to explain his or her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he or she were to use typical language for communication

2. *Patient in crisis*—a patient in high distress presenting with typically life-threatening or complex problems requiring immediate attention. Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status examination, and a disposition. Treatment includes psychotherapy, mobilization of resources to

defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychologic trauma.

Other guidelines and instructions are specific to the use of certain codes. A review of the deleted, new, and revised codes may help with understanding of these. As a reminder, the symbols used are as follows a bullet symbol (●) indicates a new code; a plus symbol (✚) indicates an add-on code, used only in conjunction with other specified codes; and a triangle symbol (▲) indicates a revised code.

Deleted codes include those currently reported for psychiatric diagnostic interview examinations (**90801-90802**) and individual psychotherapy (**90804–90829**).

Interactive Complexity

New add-on code **90785** is reported in conjunction with new codes for psychiatric diagnostic evaluations, psychotherapy with or without an associated E/M service by the same physician, and group psychotherap when at least one of the criteria for reporting interactive complexity is met. This code is not reported in addition to codes for psychotherapy for crisis or with an E/M service not provided in conjunction with a psychotherapy service. Interactive complexity is not a factor for E/M code selection (**99201–99255, 99281–99285, 99304–99337, 99341–99350**), except as it directly affects key components of history physical examination, and medical decision-making.

✚● **90785** Interactive complexity (List separately in addition to the code for primary procedure)

Psychiatric Diagnostic Evaluation

Codes **90791** and **90792** are used to report psychiatric diagnostic evaluations including assessments an reassessments once per day. These services may take place with family members or other informants under certain circumstances but are still reported as services provided to the patient. They do not include psychotherapeutic services. Psychotherapy codes including services for crisis may not be reported on the same day. Also do not report **90791** or **90792** in conjunction with E/M services (**99201–99337, 99341–99350, 99366–99368,** and **99401–99444**). Report code **90785** for interactive complexity, when applicable.

● **90791** Psychiatric diagnostic evaluation

● **90792** Psychiatric diagnostic evaluation with medical services

Psychotherapy Services

Codes for psychotherapy services are time-based with separate codes for those provided with or without an E/M service by the same provider on the same date to the same patient. Use face-to-face time with the patient or family member when selecting the level of psychotherapy service. The patient must be present for all or some of the service. For family psychotherapy without the patient present, use code **90846**. Codes for reporting psychotherapy services without an associated E/M service are

● **90832** Psychotherapy, 30 minutes with patient and/or family member

● **90834** Psychotherapy, 45 minutes with patient and/or family member

● **90837** Psychotherapy, 60 minutes with patient and/or family member

Codes **90833, 90836,** and **90838** are psychotherapy add-on codes reported in conjunction with the cod for an associated E/M service (**99201–99255, 99304–99337,** or **99341–99350**). The E/M service must be significant and separately identifiable from the associated psychotherapy service. Time is not a

factor in choosing the level of E/M service when psychotherapy is provided on the same date, and prolonged E/M services may not be reported in conjunction with psychotherapy codes **90833, 90836,** and **90838**. Choose the level of E/M service based on the 3 key components of history, physical examination, and medical decision-making, and then choose the level of psychotherapy service provided based only on the amount of time devoted directly to those psychotherapy services.

90833 Psychotherapy, 30 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)

90836 Psychotherapy, 45 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)

90838 Psychotherapy, 60 minutes with patient and/or family member when performed with an Evaluation and Management service (List separately in addition to the code for primary procedure)

When pharmacologic management is provided in addition to psychotherapy services by a physician or other qualified health care professional who can report E/M services, report the appropriate E/M service code (**99201–99255, 99281–99285, 99304–99337, 99341–99350**) and the appropriate psychotherapy service (**90833, 90836, 90838**). Time spent in pharmacologic management is not counted toward time spent in psychotherapy. Code **90862** has been deleted for 2013 and a new code, **90863**, may be reported in conjunction with codes **90832, 90834,** and **90837** when pharmacologic management is reported in addition to psychotherapy by health care professionals who cannot report E/M services.

90863 Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)

Interactive complexity code **90785** may be reported in conjunction with codes **90832–90838** when applicable. Interactive complexity should be reflected in the documentation of the psychotherapy service and does not directly affect the level of service for any associated E/M service. In reporting psychotherap services, choose the code closest to the actual time (ie, 16–37 minutes for **90832** and **90833**, 38–52 minutes for **90834** and **90836**, and 53 or more minutes for **90837** and **90838**). Do not report psychotherapy of less than 16 minutes' duration

Psychotherapy for Crisis

Psychotherapy for crisis includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychologic trauma. Interactive complexity (**90785**), psychiatric diagnostic evaluation (**90791–90792**), and other psychiatry services are not separately reported.

90839 Psychotherapy for crisis, first 60 minutes

90840 each additional 30 minutes (List separately in addition to code for primary service)

Codes **90839** and **90840** are based on the physician or other qualified health care professional's total face-to-face time with the patient or family providing psychotherapy for crisis, even if the time spent on that date is not continuous. Time reported as psychotherapy for crisis state must be only that in which th physician or other qualified health care professional is fully devoted to the patient and therefore cannot provide services to any other patient during the same period. The patient must be present for all or some of the service.

Code **90839** is used to report the first 30 to 74 minutes of psychotherapy for crisis on a given date. It

Publisher Updates:

- PQRS
- Qp Quantity Physician Appendix A
- Qh Quantity Hospital Appendix B
- ♀ Female only
- ♂ Male only
- A Age
- ♿ DMEPOS
- A2-Z3 ASC Payment Indicator
- A-Y ASC Status Indicator

Coding Clinic

Do not report HCPCS modifiers with PQRI CPT Category II codes, rather use Category II modifiers (i.e., 1P, 2P, 3P, or 8P) or the claim may be returned or denied.

LEVEL II NATIONAL MODIFIERS

✻ **A1**	Dressing for one wound
✻ **A2**	Dressing for two wounds
✻ **A3**	Dressing for three wounds
✻ **A4**	Dressing for four wounds
✻ **A5**	Dressing for five wounds
✻ **A6**	Dressing for six wounds
✻ **A7**	Dressing for seven wounds
✻ **A8**	Dressing for eight wounds
✻ **A9**	Dressing for nine or more wounds
✪ **AA**	Anesthesia services performed personally by anesthesiologist *IOM: 100-04, 12, 90.4*
✪ **AD**	Medical supervision by a physician: more than four concurrent anesthesia procedures *IOM: 100-04, 12, 90.4*
✻ **AE**	Registered dietician
✻ **AF**	Specialty physician
✻ **AG**	Primary physician
✪ **AH**	Clinical psychologist *IOM: 100-04, 12, 170*
✻ **AI**	Principal physician of record
✪ **AJ**	Clinical social worker *IOM: 100-04, 12, 170* *IOM: 100-04, 12, 150*
✻ **AK**	Nonparticipating physician
✪ **AM**	Physician, team member service Not assigned for Medicare
✻ **AP**	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
✻ **AQ**	Physician providing a service in an unlisted health professional shortage area (HPSA)
✻ **AR**	Physician provider services in a physician scarcity area
✻ **AS**	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
✻ **AT**	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)
✻ **AU**	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
✻ **AV**	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
✻ **AW**	Item furnished in conjunction with a surgical dressing
✻ **AX**	Item furnished in conjunction with dialysis services
✻ **AY**	Item or service furnished to an ESRD patient that is not for the treatment of ESRD
◆ **AZ**	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
✻ **BA**	Item furnished in conjunction with parenteral enteral nutrition (PEN) services
✻ **BL**	Special acquisition of blood and blood products
✻ **BO**	Orally administered nutrition, not by feeding tube
✻ **BP**	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
✻ **BR**	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
✻ **BU**	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
✻ **CA**	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission

✻ **CB** Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable

✻ **CC** Procedure code change (Use CC when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)

❂ **CD** AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable

❂ **CE** AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity

❂ **CF** AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable

✻ **CG** Policy criteria applied

▶ ❂ **CH** 0 percent impaired, limited or restricted

▶ ❂ **CI** At least 1 percent but less than 20 percent impaired, limited or restricted

▶ ❂ **CJ** At least 20 percent but less than 40 percent impaired, limited or restricted

▶ ❂ **CK** At least 40 percent but less than 60 percent impaired, limited or restricted

▶ ❂ **CL** At least 60 percent but less than 80 percent impaired, limited or restricted

▶ ❂ **CM** At least 80 percent but less than 100 percent impaired, limited or restricted

▶ ❂ **CN** 100 percent impaired, limited or restricted

✻ **CR** Catastrophe/Disaster related

→ ✻ **CS** Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities

~~DA~~ ~~Oral health assessment by a licensed health professional other than a dentist~~ ✖

✻ **E1** Upper left, eyelid

✻ **E2** Lower left, eyelid

✻ **E3** Upper right, eyelid

Coding Clinic: 2011, Q3, P6

✻ **E4** Lower right, eyelid

❂ **EA** Erythropoetic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy

CMS requires claims for non-ESRD ESAs (J0881 and J0885) to include one of three modifiers: -EA, -EB, -EC.

❂ **EB** Erythropoetic stimulating agent (ESA) administered to treat anemia due to anti-cancer radiotherapy

CMS requires claims for non-ESRD ESAs (J0881 and J0885) to include one of three modifiers: -EA, -EB, -EC.

❂ **EC** Erythropoetic stimulating agent (ESA) administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy

CMS requires claims for non-ESRD ESAs (J0881 and J0885) to include one of three modifiers: -EA, -EB, -EC.

❂ **ED** Hematocrit level has exceeded 39% (or hemoglobin level has exceeded 13.0 g/dl) for 3 or more consecutive billing cycles immediately prior to and including the current cycle

❂ **EE** Hematocrit level has not exceeded 39% (or hemoglobin level has not exceeded 13.0 g/dl) for 3 or more consecutive billing cycles immediately prior to and including the current cycle

❂ **EJ** Subsequent claims for a defined course of therapy, e.g., EPO, sodium hyaluronate, infliximab

❂ **EM** Emergency reserve supply (for ESRD benefit only)

✻ **EP** Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program

✻ **ET** Emergency services

✻ **EY** No physician or other licensed health care provider order for this item or service

Items billed before a signed and dated order has been received by the supplier must be submitted with an -EY modifier added to each related HCPCS code.

✻ **F1** Left hand, second digit

✻ **F2** Left hand, third digit

✻ **F3** Left hand, fourth digit

✻ **F4** Left hand, fifth digit

✻ **F5** Right hand, thumb

✻ **F6** Right hand, second digit

✻ **F7** Right hand, third digit

▶ New → Revised ✔ Reinstated ~~deleted~~ Deleted
❂ Special coverage instructions ◆ Not covered or valid by Medicare ✻ Carrier discretion

✻ **F8** Right hand, fourth digit

✻ **F9** Right hand, fifth digit

✻ **FA** Left hand, thumb

◆ **FB** Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)

⊙ **FC** Partial credit received for replaced device

✻ **FP** Service provided as part of family planning program

✻ **G1** Most recent URR reading of less than 60

✻ **G2** Most recent URR reading of 60 to 64.9

✻ **G3** Most recent URR reading of 65 to 69.9

✻ **G4** Most recent URR reading of 70 to 74.9

✻ **G5** Most recent URR reading of 75 or greater

✻ **G6** ESRD patient for whom less than six dialysis sessions have been provided in a month

⊙ **G7** Pregnancy resulted from rape or incest or pregnancy certified by physician as life threatening

IOM: 100-02, 15, 20.1; 100-03, 3, 170.3

✻ **G8** Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure

✻ **G9** Monitored anesthesia care for patient who has history of severe cardiopulmonary condition

✻ **GA** Waiver of liability statement issued as required by payer policy, individual case

An item/service is expected to be denied as not reasonable and necessary and an ABN is on file. Modifier -GA can be used on either a specific or a miscellaneous HCPCS code. Modifiers -GA and -GY should never be reported together on the same line for the same HCPCS code.

✻ **GB** Claim being resubmitted for payment because it is no longer covered under a global payment demonstration

⊙ **GC** This service has been performed in part by a resident under the direction of a teaching physician.

IOM: 100-04, 12, 90.4, 100

✻ **GD** Units of service exceeds medically unlikely edit value and represents reasonable and necessary services

⊙ **GE** This service has been performed by a resident without the presence of a teaching physician under the primary care exception

✻ **GF** Non-physician (e.g., nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified registered nurse (CRN), clinical nurse specialist (CNS), physician assistant (PA)) services in a critical access hospital

✻ **GG** Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

✻ **GH** Diagnostic mammogram converted from screening mammogram on same day

✻ **GJ** "Opt out" physician or practitioner emergency or urgent service

✻ **GK** Reasonable and necessary item/service associated with a GA or GZ modifier

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it. When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the LCD, the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers (-GK or -GL). (https://www.cms.gov/manuals/downloads/clm104c01.pdf)

✻ **GL** Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no Advance Beneficiary Notice (ABN)

✻ **GM** Multiple patients on one ambulance trip

✻ **GN** Services delivered under an outpatient speech language pathology plan of care

✻ **GO** Services delivered under an outpatient occupational therapy plan of care

✻ **GP** Services delivered under an outpatient physical therapy plan of care

✻ **GQ** Via asynchronous telecommunications system

✻ **GR** This service was performed in whole or in part by a resident in a department of Veterans Affairs medical center or clinic, supervised in accordance with VA policy

→ ⊙ **GS** Dosage of EPO or erythropoietin-stimulating agent has been reduced and maintained in response to hematocrit or hemoglobin level

❂ **GT** Via interactive audio and video telecommunication systems

✻ **GU** Waiver of liability statement issued as required by payer policy, routine notice

❂ **GV** Attending physician not employed or paid under arrangement by the patient's hospice provider

❂ **GW** Service not related to the hospice patient's terminal condition

✻ **GX** Notice of liability issued, voluntary under payer policy

-GX modifier must be submitted with non-covered charges only. This modifier differentiates from the required uses in conjunction with ABN. (https://www.cms.gov/manuals/downloads/clm104c01.pdf)

◆ **GY** Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit

Examples of "statutorily excluded" include: Infusion drug not administered using a durable infusion pump, a wheelchair that is for use for mobility outside the home or hearing aids. -GA and -GY should never be coded together on the same line for the same HCPCS code. (https://www.cms.gov/manuals/downloads/clm104c01.pdf)

◆ **GZ** Item or service expected to be denied as not reasonable or necessary

Used when an ABN is not on file and can be used on either a specific or a miscellaneous HCPCS code. It would never be correct to place any combination of -GY, -GZ or -GA modifiers on the same claim line and will result in rejected or denied claim for invalid coding. (https://www.cms.gov/manuals/downloads/clm104c01.pdf)

◆ **H9** Court-ordered

◆ **HA** Child/adolescent program

◆ **HB** Adult program, nongeriatric

◆ **HC** Adult program, geriatric

◆ **HD** Pregnant/parenting women's program

◆ **HE** Mental health program

◆ **HF** Substance abuse program

◆ **HG** Opioid addiction treatment program

◆ **HH** Integrated mental health/substance abuse program

◆ **HI** Integrated mental health and mental retardation/developmental disabilities program

◆ **HJ** Employee assistance program

◆ **HK** Specialized mental health programs for high-risk populations

◆ **HL** Intern

◆ **HM** Less than bachelor degree level

◆ **HN** Bachelors degree level

◆ **HO** Masters degree level

◆ **HP** Doctoral level

◆ **HQ** Group setting

◆ **HR** Family/couple with client present

◆ **HS** Family/couple without client present

◆ **HT** Multi-disciplinary team

◆ **HU** Funded by child welfare agency

◆ **HV** Funded by state addictions agency

◆ **HW** Funded by state mental health agency

◆ **HX** Funded by county/local agency

◆ **HY** Funded by juvenile justice agency

◆ **HZ** Funded by criminal justice agency

✻ **J1** Competitive acquisition program no-pay submission for a prescription number

✻ **J2** Competitive acquisition program, restocking of emergency drugs after emergency administration

✻ **J3** Competitive acquisition program (CAP), drug not available through CAP as written, reimbursed under average sales price methodology

✻ **J4** DMEPOS item subject to DMEPOS competitive bidding program that is furnished by a hospital upon discharge

✻ **JA** Administered intravenously

This modifier is informational only (not a payment modifier) and may be submitted with all injection codes. According to Medicare, reporting this modifier is voluntary. (CMS Pub. 100-04, chapter 8, section 60.2.3.1 and Pub. 100-04, chapter 17, section 80.11)

✻ **JB** Administered subcutaneously

✻ **JC** Skin substitute used as a graft

✻ **JD** Skin substitute not used as a graft

✻ **JW** Drug amount discarded/not administered to any patient

Use -JW to identify unused drugs or biologicals from single use vial/package that are appropriately discarded. Bill on separate line for payment of discarded drug/biological.

Coding Clinic: 2010, Q3, P10

* **K0** Lower extremity prosthesis functional Level 0 - does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
* **K1** Lower extremity prosthesis functional Level 1 - has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
* **K2** Lower extremity prosthesis functional Level 2 - has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
* **K3** Lower extremity prosthesis functional Level 3 - has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
* **K4** Lower extremity prosthesis functional Level 4 - has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.
* **KA** Add on option/accessory for wheelchair
* **KB** Beneficiary requested upgrade for ABN, more than 4 modifiers identified on claim
* **KC** Replacement of special power wheelchair interface
* **KD** Drug or biological infused through DME
* **KE** Bid under round one of the DMEPOS competitive bidding program for use with non-competitive bid base equipment
* **KF** Item designated by FDA as Class III device
* **KG** DMEPOS item subject to DMEPOS competitive bidding program number 1
* **KH** DMEPOS item, initial claim, purchase or first month rental
* **KI** DMEPOS item, second or third month rental
* **KJ** DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen
* **KK** DMEPOS item subject to DMEPOS competitive bidding program number 2
* **KL** DMEPOS item delivered via mail
* **KM** Replacement of facial prosthesis including new impression/moulage
* **KN** Replacement of facial prosthesis using previous master model
* **KO** Single drug unit dose formulation
* **KP** First drug of a multiple drug unit dose formulation
* **KQ** Second or subsequent drug of a multiple drug unit dose formulation
* **KR** Rental item, billing for partial month
* ⊘ **KS** Glucose monitor supply for diabetic beneficiary not treated with insulin
* **KT** Beneficiary resides in a competitive bidding area and travels outside that competitive bidding area and receives a competitive bid item
* **KU** DMEPOS item subject to DMEPOS competitive bidding program number 3
* **KV** DMEPOS item subject to DMEPOS competitive bidding program that is furnished as part of a professional service
* **KW** DMEPOS item subject to DMEPOS competitive bidding program number 4
* **KX** Requirements specified in the medical policy have been met
* **KY** DMEPOS item subject to DMEPOS competitive bidding program number 5
* **KZ** New coverage not implemented by managed care
* **LC** Left circumflex coronary artery
* **LD** Left anterior descending coronary artery
* **LL** Lease/rental (use the LL modifier when DME equipment rental is to be applied against the purchase price)
* ▶ **LM** Left main coronary artery
* **LR** Laboratory round trip
* ⊘ **LS** FDA-monitored intraocular lens implant
* **LT** Left side (used to identify procedures performed on the left side of the body)
* **M2** Medicare secondary payer (MSP)
* **MS** Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty

✻ **NB** Nebulizer system, any type, FDA-cleared for use with specific drug

✻ **NR** New when rented (use the NR modifier when DME which was new at the time of rental is subsequently purchased)

✻ **NU** New equipment

✻ **P1** A normal healthy patient

✻ **P2** A patient with mild systemic disease

✻ **P3** A patient with severe systemic disease

✻ **P4** A patient with severe systemic disease that is a constant threat to life

✻ **P5** A moribund patient who is not expected to survive without the operation

✻ **P6** A declared brain-dead patient whose organs are being removed for donor purposes

◆ **PA** Surgical or other invasive procedure on wrong body part

◆ **PB** Surgical or other invasive procedure on wrong patient

◆ **PC** Wrong surgery or other invasive procedure on patient

✻ **PD** Diagnostic or related non diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days

✻ **PI** Positron emission tomography (PET) or PET/computed tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing

✻ **PL** Progressive addition lenses

✻ **PS** Positron emission tomography (PET) or PET/computed tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy

✻ **PT** Colorectal cancer screening test; converted to diagnostic text or other procedure

Assign this modifier with the appropriate CPT procedure code for colonoscopy, flexible sigmoidoscopy, or barium enema when the service is initiated as a colorectal cancer screening service but then becomes a diagnostic service. (MLN Matters article MM7012 (PDF, 75 KB)

Coding Clinic: 2011, Q1, P10

✪ **Q0** Investigational clinical service provided in a clinical research study that is in an approved clinical research study

✪ **Q1** Routine clinical service provided in a clinical research study that is in an approved clinical research study

✻ **Q2** HCFA/ORD demonstration project procedure/service

✻ **Q3** Live kidney donor surgery and related services

✻ **Q4** Service for ordering/referring physician qualifies as a service exemption

✪ **Q5** Service furnished by a substitute physician under a reciprocal billing arrangement

IOM: 100-04, 1, 30.2.10

✪ **Q6** Service furnished by a locum tenens physician

IOM: 100-04, 1, 30.2.11

✻ **Q7** One Class A finding

✻ **Q8** Two Class B findings

✻ **Q9** One Class B and two Class C findings

✻ **QC** Single channel monitoring

✻ **QD** Recording and storage in solid state memory by a digital recorder

✻ **QE** Prescribed amount of oxygen is less than 1 liter per minute (LPM)

✻ **QF** Prescribed amount of oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed

✻ **QG** Prescribed amount of oxygen is greater than 4 liters per minute (LPM)

✻ **QH** Oxygen conserving device is being used with an oxygen delivery system

✪ **QJ** Services/items provided to a prisoner or patient in state or local custody, however, the state or local government, as applicable, meets the requirements in 42 CFR 411.4 (B)

✪ **QK** Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

IOM: 100-04, 12, 50K, 90

✻ **QL** Patient pronounced dead after ambulance called

✻ **QM** Ambulance service provided under arrangement by a provider of services

✻ **QN** Ambulance service furnished directly by a provider of services

⌾ **QP** Documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060.

⌾ **QS** Monitored anesthesia care service

IOM: 100-04, 12, 30.6, 501

✻ **QT** Recording and storage on tape by an analog tape recorder

✻ **QW** CLIA-waived test

✻ **QX** CRNA service: with medical direction by a physician

⌾ **QY** Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

IOM: 100-04, 12, 50K, 90

✻ **QZ** CRNA service: without medical direction by a physician

✻ **RA** Replacement of a DME, orthotic or prosthetic item

Contractors will deny claims for replacement parts when furnished in conjunction with the repair of a capped rental item and billed with modifier -RB, including claims for parts submitted using code E1399, that are billed during the capped rental period (i.e., the last day of the 13th month of continuous use or before). Repair includes all maintenance, servicing, and repair of capped rental DME because it is included in the allowed rental payment amounts. (Pub 100-20 One-Time Notification Centers for Medicare & Medicaid Services, Transmittal: 901, May 13, 2011)

✻ **RB** Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair

✻ **RC** Right coronary artery

✻ **RD** Drug provided to beneficiary, but not administered "incident-to"

✻ **RE** Furnished in full compliance with FDA-mandated risk evaluation and mitigation strategy (REMS)

✻ **RI** Ramus intermedius coronary artery

✻ **RR** Rental (use the 'RR' modifier when DME is to be rented)

✻ **RT** Right side (used to identify procedures performed on the right side of the body)

◆ **SA** Nurse practitioner rendering service in collaboration with a physician

◆ **SB** Nurse midwife

→ ✻ **SC** Medically necessary service or supply

◆ **SD** Services provided by registered nurse with specialized, highly technical home infusion training

◆ **SE** State and/or federally funded programs/ services

✻ **SF** Second opinion ordered by a professional review organization (PRO) per Section 9401, P.L. 99-272 (100% reimbursement - no Medicare deductible or coinsurance)

✻ **SG** Ambulatory surgical center (ASC) facility service

◆ **SH** Second concurrently administered infusion therapy

◆ **SJ** Third or more concurrently administered infusion therapy

◆ **SK** Member of high risk population (use only with codes for immunization)

◆ **SL** State supplied vaccine

◆ **SM** Second surgical opinion

◆ **SN** Third surgical opinion

◆ **SQ** Item ordered by home health

◆ **SS** Home infusion services provided in the infusion suite of the IV therapy provider

◆ **ST** Related to trauma or injury

◆ **SU** Procedure performed in physician's office (to denote use of facility and equipment)

◆ **SV** Pharmaceuticals delivered to patient's home but not utilized

✻ **SW** Services provided by a certified diabetic educator

◆ **SY** Persons who are in close contact with member of high-risk population (use only with codes for immunization)

✻ **T1** Left foot, second digit

✻ **T2** Left foot, third digit

✻ **T3** Left foot, fourth digit

✻ **T4** Left foot, fifth digit

✻ **T5** Right foot, great toe

✻ **T6** Right foot, second digit

✻ **T7** Right foot, third digit

✻ **T8** Right foot, fourth digit

✻ **T9** Right foot, fifth digit

✻ **TA** Left foot, great toe

✻	**TC**	Technical component; Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.
◆	**TD**	RN
◆	**TE**	LPN/LVN
◆	**TF**	Intermediate level of care
◆	**TG**	Complex/high tech level of care
◆	**TH**	Obstetrical treatment/services, prenatal or postpartum
◆	**TJ**	Program group, child and/or adolescent
◆	**TK**	Extra patient or passenger, non-ambulance
◆	**TL**	Early intervention/individualized family service plan (IFSP)
◆	**TM**	Individualized education program (IEP)
◆	**TN**	Rural/outside providers' customary service area
◆	**TP**	Medical transport, unloaded vehicle
◆	**TQ**	Basic life support transport by a volunteer ambulance provider
◆	**TR**	School-based individual education program (IEP) services provided outside the public school district responsible for the student
✻	**TS**	Follow-up service
◆	**TT**	Individualized service provided to more than one patient in same setting
◆	**TU**	Special payment rate, overtime
◆	**TV**	Special payment rates, holidays/ weekends
◆	**TW**	Back-up equipment
◆	**U1**	Medicaid Level of Care 1, as defined by each State
◆	**U2**	Medicaid Level of Care 2, as defined by each State
◆	**U3**	Medicaid Level of Care 3, as defined by each State
◆	**U4**	Medicaid Level of Care 4, as defined by each State
◆	**U5**	Medicaid Level of Care 5, as defined by each State
◆	**U6**	Medicaid Level of Care 6, as defined by each State
◆	**U7**	Medicaid Level of Care 7, as defined by each State
◆	**U8**	Medicaid Level of Care 8, as defined by each State
◆	**U9**	Medicaid Level of Care 9, as defined by each State
◆	**UA**	Medicaid Level of Care 10, as defined by each State
◆	**UB**	Medicaid Level of Care 11, as defined by each State
◆	**UC**	Medicaid Level of Care 12, as defined by each State
◆	**UD**	Medicaid Level of Care 13, as defined by each State
✻	**UE**	Used durable medical equipment
◆	**UF**	Services provided in the morning
◆	**UG**	Services provided in the afternoon
◆	**UH**	Services provided in the evening
◆	**UJ**	Services provided at night
◆	**UK**	Services provided on behalf of the client to someone other than the client (collateral relationship)
✻	**UN**	Two patients served
✻	**UP**	Three patients served
✻	**UQ**	Four patients served
✻	**UR**	Five patients served
✻	**US**	Six or more patients served
✻	**V5**	Vascular catheter (alone or with any other vascular access)
✻	**V6**	Arteriovenous graft (or other vascular access not including a vascular catheter)
✻	**V7**	Arteriovenous fistula only (in use with two needles)
	~~V8~~	~~Infection present~~ ✖
	~~V9~~	~~No infection present~~ ✖
✻	**VP**	Aphakic patient

▶ New → Revised ✔ Reinstated ~~deleted~~ Deleted

✪ Special coverage instructions ◆ Not covered or valid by Medicare ✻ Carrier discretion

HCPCS LEVEL II CODE MODIFICATION REQUEST PROCESS
RE: The 2014 HCPCS Update

The Healthcare Common Procedure Coding System (HCPCS) Level II contains alpha-numeric codes used to identify items (and sometimes, services) that are not included in the HCPCS Level I (American Medical Association's CPT) code set.

As a preliminary step in the process for recommending a modification to the HCPCS Level II coding system, it may be helpful for you to contact 3rd party payers for Medicare, Medicaid and private insurers to determine if, in their determination, existing HCPCS codes identify the item.

You may submit a recommendation to establish, revise or discontinue a code, using the attached, standard format. Please prepare a cover letter outlining your code request and a brief summary of why the code modification is needed. In addition to providing the information according to the format, please include descriptive material, which you think would be helpful in furthering our understanding of the medical benefits of the item for which a coding modification is being recommended. Submit the original request with supporting documentation and, to expedite distribution and review, please also include 35 complete copies of your recommendation information packet. At this time, we are not able to accommodate electronic requests, and all originals requests and copies must be submitted on paper.

In order to ensure timely review of your materials, it is necessary to limit your recommendations to no more than 40 pages. **PLEASE INCLUDE BOTH QUESTIONS AND ANSWERS ON YOUR APPLICATION** Applications exceeding 40 pages will not be accepted and must be trimmed to no more than 40 pages and resubmitted by the applicant by the application deadline. Applicants making a claim of significant therapeutic distinction to distinguish a product from an existing code category may find a need to exceed the 40-page limit in order to submit relevant substantiating clinical information. In these cases only, the applicant may provide one reference copy of each article in addition to 35 copies of the application. Each side of a page, including brochures, booklets and any other inclusions, counts as page in calculating the 40 page limit. The completed, signed and dated format, FDA (approval letter or explanation of exemption), supporting documentation, product brochures and/or booklets should be bundled securely to ensure that all the information submitted is distributed intact to all reviewers. Please note that FDA approval for drug coding applications may be submitted after the initial application but no later than March 31st. Please **do not use** bulky materials, such as 3-ring binders, to fasten recommendation materials, as this may result in difficulties distributing materials to reviewers. To ensure that applications are not overlooked, separate applications should be submitted in different packages.

We do not require or ask for samples. However, many applicants ask if they may send product samples, video tapes or compact discs as a supplement to their application. If it is practical and feasible for an applicant to submit a sample with their application, they may voluntarily do so, however, it becomes the property of CMS to keep or dispose of as the

agency sees fit. If the applicant chooses to send samples, video tapes, or compact discs, please send no more than 3.

When the recommendation is received, it is distributed to all reviewers. All timely and complete recommendations are placed on HCPCS Meeting Agendas and reviewed at regularly scheduled meetings by a panel whose membership includes representatives of Medicaid, Medicare, Private Insurers and the Veteran's Administration health care system.

All external recommendations, (e.g. requests not generated internally) will be placed on a Public Meeting Agenda together with the preliminary HCPCS coding decision. The HCPCS Public Meetings provide an open forum for interested parties to make oral presentations or to submit written comments in response to published preliminary coding decisions. A Federal Register notice will be published to announce dates, times and the location of the public meetings. We will also post on CMS' official HCPCS website at www.cms.gov/medhcpcsgeninfo the dates, times, agendas, preliminary coding recommendations, registration information and guidelines for participation in HCPCS Public Meetings. Although the Public Meetings are not decision-making meetings, they provide an opportunity for applicants and the general public to react to preliminary coding decisions and share additional information with decision makers, prior to final decisions.

All applicants will be notified, in writing, of the final decision on their application by mid-November 2013, and all modifications to the HCPCS codes set will be incorporated into the 2014 HCPCS Level II Annual update. The Update will be published on the official HCPCS worldwide website at www.cms.gov/medhcpcsgeninfo by mid November, 2013.

To be considered for inclusion in the year 2014 HCPCS update, completed recommendation packets must be received no later than close of business (COB) Thursday, January 3, 2013. The HCPCS coding review process is an ongoing, continuous process. Requests may be submitted at anytime throughout the year 2012, and up to January 3, 2013. Early submissions are strongly encouraged. Requests that are complete are reviewed and processed on a first come, first served basis. At CMS' discretion, incomplete recommendations may be returned or held until required information, as notified, is provided and the request is completed. Only complete code requests are entered into the review cycle. Applications for products/services that are not yet available on the U.S. market will be considered incomplete. **Recommendations received or completed on or after COB January 4, 2013 and those requiring additional review will be considered for inclusion in a later HCPCS update. Applications exceeding the 40-page limit are not acceptable with the single exception as noted on page 1 of these instructions and in question 7c of this application.**

For additional information regarding the HCPCS coding process or the application process, you may: 1) review documents on website at www.cms.gov/medhcpcsgeninfo ; 2) submit an inquiry to HCPCS@cms.hhs.gov; or 3) contact CMS HCPCS staff; Cynthia Hake at (410) 786-3404 or Jennifer Carver at (410) 786-6610.

Healthcare Common Procedure Coding System (HCPCS)

Alpha-Numeric Coding Recommendation Format for the 2014 Update

Instructions:

1. Please **sign and date** each recommendation. Be certain to provide the name, complete address and direct telephone number of the person to be contacted regarding this recommendation. We use this information to contact applicants regarding upcoming meetings, questions regarding applications, and to make notifications of the status of applications. Please be sure that your system can receive emails from cms.hhs.gov.

2. Please provide documentation of the item's current classification by the Food and Drug Administration (FDA). Include a copy of the cover page from the initial FDA application and **a copy of the FDA's determination, notification/approval letter.** If the drug/biological/product/service has been subject to an assessment by any other agency or recognized medical body, provide a copy of the results of that assessment. Note: Documentation of FDA approval of a drug or biological may be submitted after the coding application but no later than March 31st, provided all other requested information is complete and submitted by the deadline.

3. Please note: **All requested information must be supplied before your recommendation for modifications to the HCPCS coding system can be considered.** The following questions may be transferred to a word processor/computer to allow space to respond fully and completely. All questions must be answered. "N/A" is not an acceptable response. If the question does not appear to apply, provide a detailed explanation as to why it doesn't apply. Incomplete submittals will not be accepted.

4. Submit Coding Recommendations to:

Cynthia Hake, CMS HCPCS Workgroup Chair
Centers for Medicare and Medicaid Services
C5-08-27
7500 Security Blvd
Baltimore, Maryland 21244-1850

Alpha-Numeric HCPCS Coding Recommendation Format

INFORMATION SUPPORTING CODING MODIFICATION RECOMMENDATION

1. For the purpose of publication on our request list and public meeting agenda on the HCPCS website, please provide a brief summary of your request (not to exceed **300 words**). In this summary, please specify your request to modify the HCPCS code set: (e.g. number of new codes requested, recommended language; revise a code (provide old language and recommended language), discontinue a code). Include the name of the product, description, function, and the reason why existing codes do not adequately describe your product. For drugs, include the indications for use, action, dosage and route of administration, and how supplied. Text that exceeds the 300-word limit may be truncated and not appear on our published summary, therefore, it is important to provide a concise summary within the 300-word limit. CMS may edit your summary prior to publication.

2. Identify the Item (product or drug/biological) for which a Level II HCPCS Code is being requested.

A) Trade or Brand Name:
B) General Product Name or Generic Drug Name (active ingredient):
C) FDA classification:

3. Please check one HCPCS category from the following list, which most accurately describes the item identified in question #1:

__ A) Medical/Surgical Supplies
__ B) Dialysis Supplies and Equipment
__ C) Ostomy/Urological Supplies
__ D) Surgical Dressing
__ E) Prosthetic
__ F) Orthotic
__ G) Enteral/Parenteral Nutrition
__ H) Durable Medical Equipment
__ I) Blood/Blood Products
__ J) Drug/Biological
__ K) Radiopharmaceutical
__ L) Vision
__ M) Hearing
__ N) Other (please indicate/provide category)_____

4a.) Is the item durable, if so, explain how it can withstand repeated use?
Specify whether the entire item or only certain components of the item can withstand repeated use:

4b.) If the entire item can withstand repeated use, then please specify the length of the time that the item can withstand repeated use.
4c.) If only certain components of the device can withstand repeated use, then please identify the individual components and the length of the time that the individual components can withstand repeated use.
4d.) Please provide detailed information on the warranty of the device such as the parts included under the warranty, the length of the warranty and the parts excluded from the warranty. In addition, please specify if the device includes any disposable components and the expected life or the replacement frequency recommended for the disposable components.

5. Describe the item fully in general terminology. What is it? What does it do? How is it used? Describe the patient population for whom the product is clinically indicated. Descriptive booklets, brochures, package inserts, as well as copies of published peer-reviewed articles on the item may be included in the information packet submitted for review, but they do not replace the requirement to fully respond to this question and fully describe the item.
For drugs and biologicals, include: A) indications for use, B) action, C) dosage and route of administration, D) package insert and, E) how supplied.

6. Describe how the item/product is primarily and customarily used to serve a medical purpose.

7A) Identify similar products and their manufacturers.
(If a drug - list other drugs by trade name marketed under the same active ingredient category/generic name.)
7B) Identify significant differences between this item and other products listed above. (Include differences in item cost; material; product design; how it is used; different mechanism of operation, differences in function/treatment provided to a patient; clinical indication; and clinical outcome.)
7C) Complete item 7C only if you are making a claim of significant therapeutic distinction). Claims of significant therapeutic distinction when compared to the use of other, similar items, must be described in detail. Articulate the clinical theory behind the claim, including differences in the product or its operation as it compares to currently coded products. Specify how the product results in a significantly improved medical outcome or significantly superior clinical outcome. (Please refer to the HCPCS decision tree for additional information.) Provide the best available information related to your claim. Include copies of all articles that result from your systematic analysis of the available literature. Information submitted should be as complete as possible. Unfavorable articles should be provided with any appropriate rebuttal or explanation. If the articles submitted cause you to exceed the overall 40-page limit, then submit one reference copy of each article and 35 copies of the application.

8. Answer each of the questions A), B), and C) below:
A) List any 3rd party payers that pay for this product
B) List any codes that are currently being billed to those payers for this product.

C) Explain why existing code categories are inadequate to describe the item.

9. A) Is this product prescribed by a health care professional?
B) If yes - who prescribes the product and in what setting(s) is the product prescribed?

10. A) Is the item useful in the absence of an illness or injury?
B) Explain:

11a.) Provide the date that the item/product was cleared for marketing by the FDA. If the product is exempt from FDA review and classification, please explain the basis for the exemption.

b.) Attach copy of the FDA approval letter including the 510(k) summary for those items that are approved using the 510(k) process. Also, if an item is cleared using the 510(k) process, identify the HCPCS codes, if applicable, that describe the predicate products listed in the 510(k) submission and explain why these codes do not adequately describe the item that is the subject of the HCPCS recommendation. In other words, if an item is listed as being substantially equivalent to another item(s) in an application for FDA marketing clearance, why is it not equivalent or comparable for coding purposes?

c.) For drugs and biologicals only: In order for an application for a code for a drug/biological can be considered timely and complete: FDA approval documentation may be submitted after the code application, but no later than March 31, 2013, provided all other application materials are complete and submitted by the deadline of January 3, 2013, and provided the application for marketing approval has been submitted to the FDA by September 30, 2012. Applicants awaiting FDA clearance for drugs or biologicals at the January 3rd submission deadline must submit with the application documentation evidencing submission for FDA approval, along with the date the application was submitted to the FDA.

12A) When was the item/product marketed in the United States?
Note For drugs and biologicals, the date of first sale is required.

12B) For all items that are not drugs and not biologics, the applicant must submit 3 months of marketing experience following the FDA approval date.
For the 3 months prior to submitting this coding recommendation, what is the total number of units sold in the U.S. and the total dollar amount in sales (Medicare, Medicaid and private insurance)? Do not estimate or provide projections - the information provided must represent actual volume of sales for the product for the period of time indicated. Note: For drugs and biologicals, information regarding the number of units sold is not required.

13. Identify the percent of use of the item across the following settings. For drugs/biologicals, provide the percentage of use for the setting in which this product is or would be administered.

Physician's Office: _____

Freestanding Ambulatory Care Clinics: _____
Patient's Home by patient: _____
Patient's Home by Health Care Provider: _____
Nursing Home/Skilled Nursing Facility: _____
Hospital Inpatient Facilities: _____
Hospital Outpatient Facility: _____
Other- (identify): _____
TOTAL VOLUME OF USE ACROSS ALL SETTINGS SHOULD EQUAL 100%

14. What is the Manufacturer's Suggested Retail Price (MSRP) or list price of the item? This question must be answered for all items, except drugs/biologicals.

HCPCS Coding Recommendation submitted by:
* Please provide a **complete** mailing address and **direct dial** phone number. We use this information to contact applicants regarding upcoming meetings, questions regarding applications, and to make notifications of the status of applications.

Name:
Name of Corporation/Organization:
Mailing Address (street):
City, State, Zip
Telephone Number and extension:
FAX Number:
E-Mail Address:

I attest that the information provided in this HCPCS coding recommendation is accurate and correct to the best of my knowledge.

_____ _____Date:_____
Signature of Applicant

Is applicant the manufacturer? Y/N If not, the manufacturer must sign the following attestation:

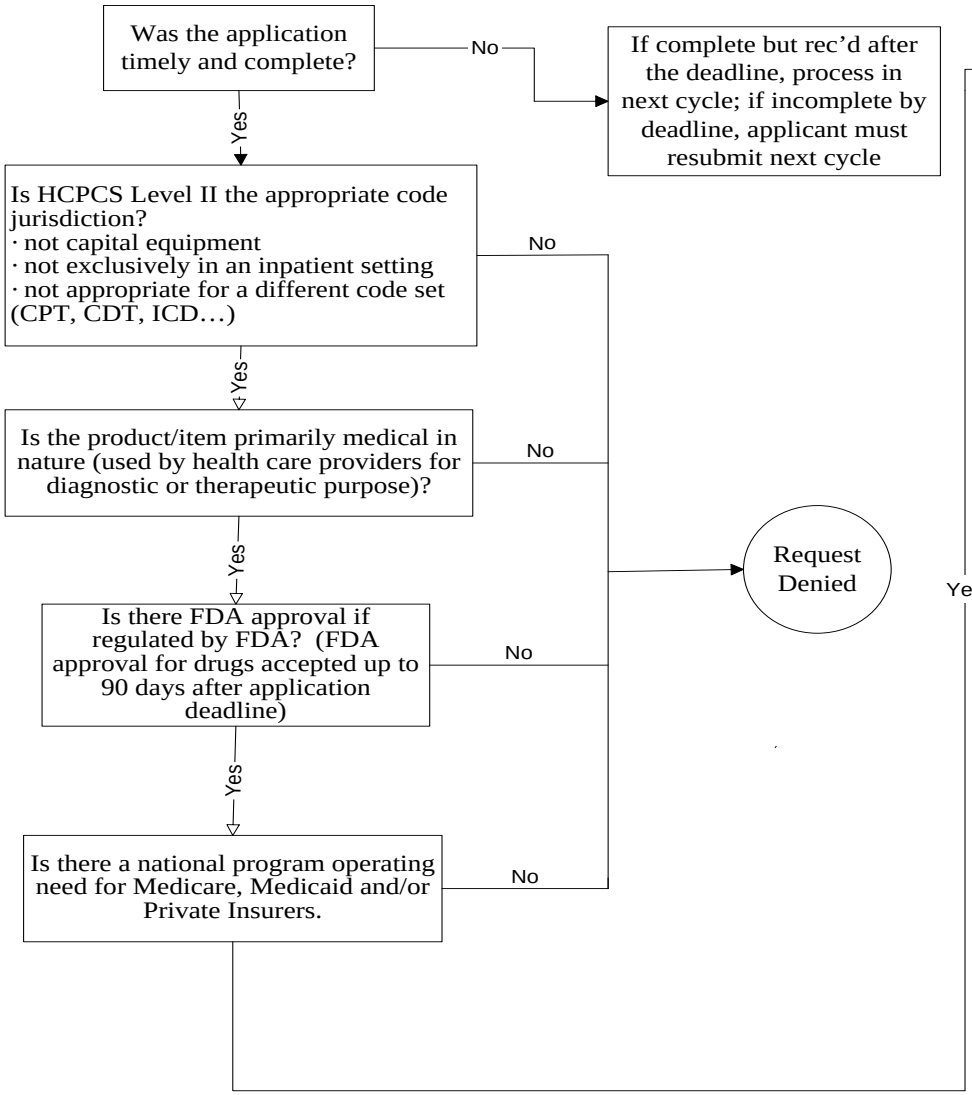
I attest that the information describing the product is accurate.

_____ _____Date:_____
Signature of Manufacturer

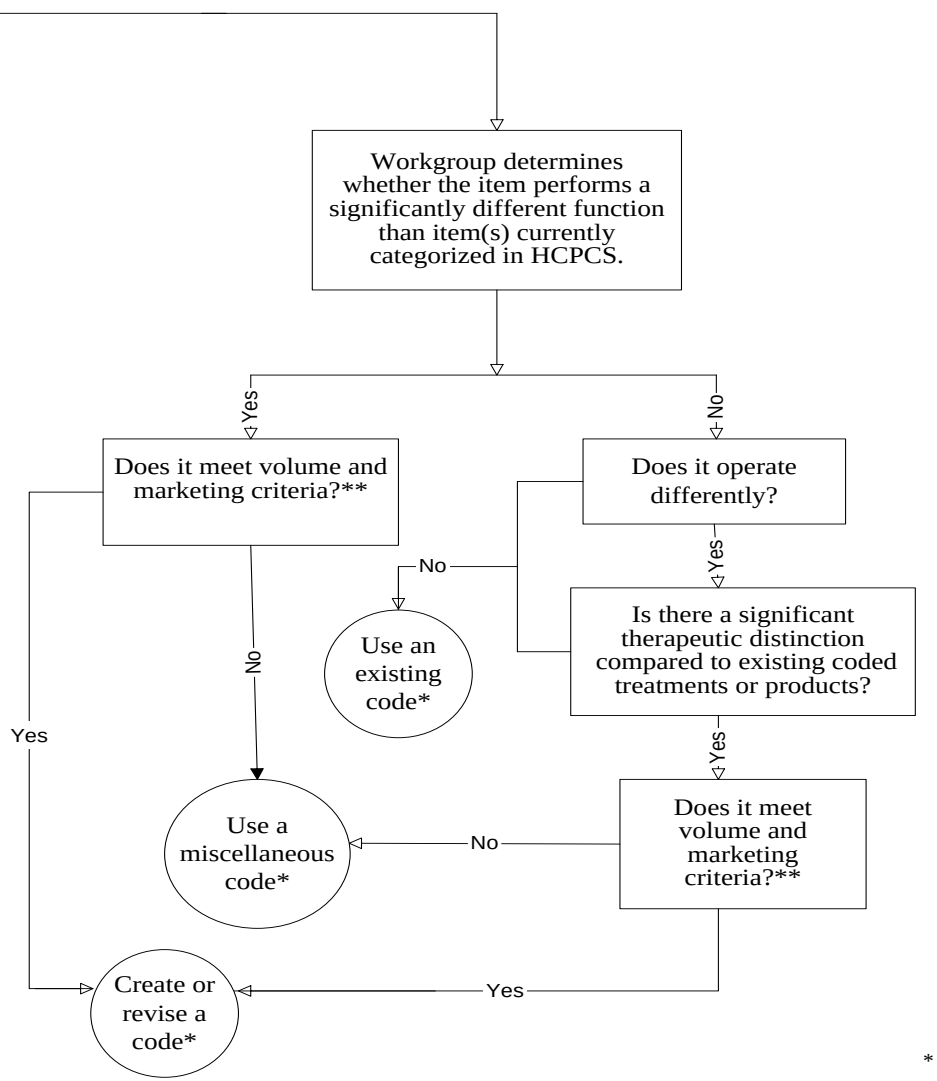
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1042**. The time required to complete this information collection is estimated to average 11 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HCPCS Decision Tree
For External Requests to Add or Revise Codes

TIER 1: Does the item that is the subject of the request belong in HCPCS Level II?



TIER 2: Which HCPCS Level II code should be used?



*

*Subject to national program operating need

**For drugs, volume and marketing criteria are waived, and "yes" is assumed for the purpose of following the decision tree

Definitions and Clarifications

Tier 1:

HCPCS 2 is the appropriate code jurisdiction: Item is not within the jurisdiction of CPT, CDT, ICD or DRG coding.

Primarily Medical in nature: Item is primarily and customarily used to serve a medical purpose and is not useful in the absence of a medical condition or injury.

FDA approved if regulated: See the online Medicare Benefit Policy Manual #100.2, Chapter 15 – Covered Medical and Other Health Service, Section 50.4.1 – Approved Use of Drug. Does not apply if regulated items are not yet approved. Note: FDA approval for drugs accepted up to 90 days after the application deadline.

National Programmatic Need: At least one insurance sector, public (Medicare or Medicaid) or private (commercial insurers) identified a program operating need to separately identify the item and that need is common across the sector, (i.e., nationally, as opposed to one or a handful of individual insurers or states). Does not apply if item identification is statutorily required.

Tier 2:

Existing or similar code: Describes a similar function to previously coded products

Volume and marketing criteria: There must be sufficient claims activity or volume (3% of affected population), as evidenced by 3 months of marketing activity for non-drug products, so that the adding of a new or modified code enhances the efficiency of the system and justifies the administrative burden of adding or modifying a code and establishing policy and system edits.
Note: Marketing data requirements waived for drugs only.

Performs a different function: Does something completely different to the patient. Examples: suction for a different purpose; static vs. dynamic; swing vs. stance.

Operates differently: Performs the same or similar function to other items, using a different mechanism. Examples: mechanical vs. electronic; automatic vs. manual regulating; extrinsic vs. intrinsic lubrication.

Significant Therapeutic Distinction: Improved medical benefit when compared with the use of other, similar items, e.g., significantly improved medical outcome or significantly superior clinical outcome. Requests for modifications to the HCPCS Level II code set based on such claims are reviewed on a case-by-case basis, taking into consideration clinical information provided by the applicant and other commentators that supports or refutes the claim(s) made by the applicant. In submitting a request, an applicant should provide the best available information supporting his or her claim. Greater weight will be given to more methodologically rigorous and scientifically reliable evidence. Note that process indicators (such as improved compliance, convenience and personal preference) are considered significant distinctions only to the extent that they result in demonstrably improved clinical outcomes.

should be used only once per date even if the time spent by the physician or other health care professional is not continuous on that date. Psychotherapy for crisis of less than 30 minutes' total duratio on a given date should be reported with **90832** or **90833** (when provided with E/M services). Code **90840** is used to report any additional blocks of time of up to 30 minutes each beyond the first 74 minutes.

Other Psychotherapeutic Procedures

Psychoanalysis (**90845**), family psychotherapy (**90846–90847**), multiple family group psychotherapy (**90849**), and group psychotherapy (**90853**) are unchanged in 2013. However, code **90857**, interactive group psychotherapy, has been deleted. Report interactive group psychotherapy for the specified patient with codes **90853** and **90785**.

The parenthetic instructions for reporting therapeutic repetitive transcranial magnetic stimulation (TMS) treatment (**90867–90869**) have been revised to exclude separate reporting of needle electromyography (**95860–95870**) and central motor evoked potential study in the upper and lower limbs (**95939**). A new instruction also directs to code **0310T** for transcranial magnetic stimulation motor-function mapping for therapeutic planning other than for repetitive TMS.

Codes **90875** and **90876** have been revised to delete time ranges and insert single time designations as follows:

▲**90875** Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); ~~approximately 20-~~30 minutes

▲**90876** ~~approximately~~ 45~~-50~~ minutes

Learn More

While this article has provided an overview of changes to the psychiatry service codes in 2013, it is advisable for those who provide or assign codes for these services to review all code changes and begin making preparations for them effective January 1, 2013.

DRAFT Measure #1: Follow-up with Patient Family after Developmental Screening

Developmental Screening Follow-up (DSF) Measure Set

Measure Description

Percentage of patients aged 6 months to 36 months whose family received a follow-up discussion of developmental screening results on the same day of the screening visit

Measure Components

Numerator Statement	Patients whose family received a discussion of the developmental screen by a primary care clinician on the same day of the screening visit Definitions: [1] Follow-up discussion is defined as a communication from clinician to patient family in which the clinician reports the screening scores, explains the screening results, and outlines next steps (which may include referrals) and expectations.
Denominator Statement	All patients aged 6 months to 36 months who received a developmental screen using a standardized developmental screening tool that was administered either by the primary care clinician or if conducted elsewhere, appears in the patient's medical chart. Definitions: [2] A standardized developmental screening instrument is defined as an instrument that meets the following criteria: ▪ *Developmental domains*: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional ▪ *Reliability*: Reliability scores of approximately 0.70 or above. ▪ *Validity*: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s) ▪ *Sensitivity/Specificity:* Sensitivity and specificity scores of approximately 0.70 or above Some tools that meet these criteria include: ▪ Ages and Stages Questionnaire (ASQ), 2 months – 5 years ▪ Battelle Developmental Inventory Screening Tool (BDI-ST), birth – 95 months

	▪ Bayley Infant Neuro-developmental Screen (BINS), 3 months – 2 years ▪ Brigance Screens-II, birth – 90 months ▪ Child Development Inventory (CDI), 18 months–6 years ▪ Child Development Review-Parent Questionnaire (CDR-PQ), 18 months – 5 years ▪ Infant Development Inventory, birth – 18 months ▪ Parents' Evaluation of Developmental Status (PEDS), birth – 8 years Non-recommended tools are those that do not meet the above criteria. It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Denominator Exceptions	This measure has no exceptions
Evidence	**The following clinical recommendation statements are quoted verbatim from the referenced policy statement and represent the evidence base for the measure:** If the results are normal, the child health professional should inform the parents and continue with other aspects of the preventive visit. If there was concern prior to the screen or the screening result was concerning, additional surveillance or evaluations should be scheduled.[1] **In addition:** An implementation study of standardized developmental screening found that when providers were instructed to score and respond to survey results with the parent at the visit during which the screen was interpreted, providers' confidence in their ability to screen and identify developmental delays increased. Similarly, discussing screening results with parents not only allowed providers to better refer children to follow up services, it also provided an opportunity for parents to discuss general developmental concerns that might not have been identified with the screening tool.[2] Taking the time to discuss both positive and negative screening results with family members and documenting them in the medical chart indicates that the provider has interpreted and discussed the screening results and provided the family with time to ask clarifying questions or voice any additional concerns.

Measure Importance

Relationship to desired outcome	Discussing both positive and negative results with family members and documenting them in the medical chart indicates that a clinician has taken the time to interpret the screening tool results and relay these results and any follow-up information to a child's family.
Opportunity for Improvement	Patients whose families receive feedback from clinicians on developmental screening results, whether positive or negative, have been shown to significantly benefit, particularly if there is any action the families can do to become more educated on development milestones.
IOM Domains of Health Care Quality Addressed	• Effective • Timely • Equitable • Safe • Efficient
Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement
	•	Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan Level
Care setting	•	Any inpatient or outpatient care
Data source	•	Electronic health record (EHR) data
	•	Paper Medical Record

1. Council on Children with Disabilities Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics, 118(1),* 405-420.

2. Schonwald, A., Huntington, N., Chan, E., Risko, W. Bridgemohan, C. (2009). Routine developmental screening implemented in urban primary care settings: more evidence of feasibility and effectiveness. *Pediatrics, 123(2),*660-668.

DRAFT Measure #2: Follow-up Referral after Positive Developmental Screen

Developmental Screening Follow-up (DSF) Measure Set

Measure Description

Percentage of patients aged 6 to 36 months who were referred for follow-up care within 7 calendar days of receiving a positive developmental screening result

Measure Components

Numerator Statement	Patients who received a referral for follow-up care[1] by the screening clinician within 7 calendar days of receiving a positive developmental screening result[2] Definitions: [1]Referral for follow up care is defined as the formal event by which the clinician providers a referral to the patient family (and does not include any further steps in the process like securing the appointment, confirming the appointment attendance, etc.) and refers for further evaluation or to any type of therapy, intervention, or education to mitigate developmental delays. A referral can be within the medical home or outside of the medical home. A referral can also include a form of watchful waiting by which the clinician offers practice-based intervention(s) and schedules a follow-up visit within 3 months. Some referral types are listed below but the list is not exhaustive: Part C, Early Intervention Program ▪ Referral for Follow-up Testing ▪ Home Visiting for 0-5 ▪ Physical Therapist ▪ Occupational Therapist ▪ Speech/Language Pathologist ▪ Medical Home Clinician Internal ▪ Specialty Clinician External ▪ Early Head Start ▪ Network Care Manager ▪ Family-to-family Support ▪ Hearing and Vision Specialists ▪ Mental Health Specialist [2] A positive developmental screening result refers to a result from a validated developmental screening tool that indicates the patient tests positive for risk of a developmental delay
Denominator Statement	All patients aged 6 months to 36 months who received a positive developmental screening result or an indication from the family that there is a developmental

	concern
Denominator Exceptions	Patients who have already received or are receiving therapy, intervention, or education that would also be applicable for developmental delay follow-up care.
Evidence	**The following clinical recommendation statements are quoted verbatim from the referenced policy statement and represent the evidence base for the measure:** If screening results are concerning, the child should be scheduled for developmental and medical evaluations. They should be scheduled as quickly as possible and professionals should coordinate activities and share findings.[1] **In addition:** It has been reported that physicians fail to identify and refer 60 to 90% of children with developmental delays in a timely manner.[2] Similarly, among children classified as having delays at 9 months, only 9% received follow-up services and among children classified as having delays at 24 months, only 10-12% had received services.[3] Likewise, a study by Tang et al. found that 34-37% of high risk infants who failed a developmental screen were not referred to either Early Intervention or other therapies. A study cited in the report notes that the mean time between identification of a developmental delay and Early Intervention referral is greater than 5 months.[4] Furthermore, in a qualitative study focusing on barriers to evaluation for Early Intervention services, Jimenez et al. found that parents who reported that their child was not evaluated for developmental delay were more likely to report that their pediatrician did not explain what EI was or how to obtain services.[5] An implantation study of the American Academy of Pediatrics (AAP) recommendations for developmental screening and referrals found that not only were referral rates among children with failed screens low (27%-100%), but practices tended to deviate from the recommendation that children with failed screens be simultaneously scheduled for developmental/medical evaluations and referred for early-intervention services. Providers tended to stratify their referrals by perceived severity of symptoms, age of child, and type of delay and occasionally failed to refer a child despite a failed screen.[6] As a developmental delay can profoundly impact a child's ability to function in multiple settings, it is imperative that children who fail screens are referred to follow up services as soon as possible.

Measure Importance

Relationship to desired outcome	A developmental delay can profoundly impact a child's ability to function in many settings. Therefore, it is important to ensure that children who have a positive result on a developmental screen are referred to follow-up services so that they can receive the care they need.
Opportunity for Improvement	This measure will capture children at risk of developmental delay and who were referred to a follow-up service which is currently not being measured.

IOM Domains of Health Care Quality Addressed	• Effective • Timely • Equitable • Safe • Efficient
Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement
	•	Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan Level
Care setting	•	Any inpatient or outpatient care
Data source	•	Electronic health record (EHR) data
	•	Paper Medical Record

1. Council on Children with Disabilities Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics, 118(1)*, 405-420.
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DRAFT Measure #3: Follow-up Referral Tracking

Developmental Screening Follow-up (DSF) Measure Set

Measure Description

Percentage of patients aged 6 to 36 months whose primary care clinician received feedback from a referral to a follow-up care clinician within 6 months of the date that referral for follow-up care was made

Measure Components

Numerator Statement	Patients whose primary care clinician received feedback from a referral to a follow-up care clinician[1] within 6 months of the date that referral for follow-up care[2] was made Definitions: [1]Feedback from follow-up care clinician refers to correspondence between the two clinicians by way of phone, fax, paper documentation transmitted through mail, or other permissible means of transferring patient information regarding the result of the patient's visit for follow-up services [2]Referral for follow up care is defined as the formal event by which the clinician provides a referral to the patient family (which does not include any further steps in the process like securing the appointment, confirming appointment attendance, etc.) and refers for further evaluation or to any type of therapy, intervention, or education to mitigate developmental delays and can be within the medical home or outside of the medical home. Some referral types are listed as examples below but the list is not exhaustive: ▪ Part C Early Intervention Program ▪ Referral for Follow up Testing ▪ Home Visiting for 0-5 ▪ Physical Therapist ▪ Occupational Therapist ▪ Speech/Language Pathologist ▪ Medical Home Clinician Internal ▪ Specialty Clinician External ▪ Early Head Start ▪ Network Care Manager ▪ Family-to-family Support ▪ Hearing and Vision Specialists ▪ Mental Health Specialist Notes: 1. Proper referral by the physician should include a parent consent form

	authorizing the use or disclosure of health information between healthcare providers. This authorization should prevent any limitation of the follow-up care clinician in being able to effectively provide feedback on the patient.
Denominator Statement	All patients aged 6 months to 36 months who received a referral for developmental delay follow-up care or evaluation
Denominator Exceptions	Patients who were referred for follow-up services but did not continue care in the medical home where diagnosed
Evidence	**The following clinical recommendation statements are quoted verbatim from the referenced policy statement and represent the evidence base for the measure:** If a child is found to have a developmental delay (disease etiology does not need to be defined), the child should be identified by the medical home for appropriate chronic-condition management and regular monitoring and entered into the practice's children and youth with special health care needs registry. Children should also be referred to community-based family support services such as respite care, parent-to-parent programs, and advocacy organizations.[1] **In addition:** A study aiming to assess the degree to which a national sample of pediatric practices could implement the American Academy of Pediatrics (AAP) recommendations for developmental screening and referrals found that while difficult to implement, referral tracking was feasible with a few workflow modifications. In addition, practices that successfully tracked referral found that many families do not follow through with referrals, families often do not understand where they are being referred or the reason for referral, tracking of referrals leads to better communication with local referral resources, and tracking led some practices to conclude that more children are being identified and linked to services as feedback on eligibility status of the referred children informs practices about their screening success.[2] The definition of a medical home put forth by the AAP requires the maintenance of a central, accessible, and comprehensive record containing all pertinent information about the child. Furthermore, medical care may be provided in various locations but regardless of the venue in which care is provided, a designated physician must ensure that the services are in fact provided.[3] As a developmental delay can impact a child's ability to function in many settings, it is important that children who fail screens are referred promptly to follow up services and in order for a provider to comply with the AAP's medical home guidelines, referrals must be tracked.

Measure Importance

Relationship to desired outcome	Given the importance of medical homes, it is important for pediatricians to know about the follow-up services their patients are receiving.
Opportunity for Improvement	This measure will capture feedback from referral sources and measure how frequently clinicians receive feedback about their pediatric patients' developmental follow-up using electronic medical records data.
IOM Domains of	• Effective

Health Care Quality Addressed	• Timely • Equitable • Safe • Efficient
Harmonization with Existing Measures	The PMCoE measure development team attempts to harmonize measures with other existing measures to the extent feasible.

Measure Designation

Measure purpose	•	Quality improvement • Accountability
Type of measure	•	Process
Level of Measurement	•	Practice/Plan Level
Care setting	•	Any inpatient or outpatient care
Data source	•	Electronic health record (EHR) data • Paper Medical Record

1. Council on Children with Disabilities Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. (2006). Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics, 118(1)*, 405-420.
2. King, T.M., Tandon, S.D., Macias, M.M., Healy, J.A., Duncan, P.M., Swigonski, N.L., Skipper, S.M., Lipkon, P.H. (2010). Implementing developmental screening and referrals: lessons learned from a national project. *Pediatrics, 125(2)*, 350-360.
3. Medical Home Initiatives for Children with Special Needs Project Advisory Committee.2008 (reaffirmed). The medical home. *Pediatrics, 122(2).*

Attachment 13.3 References

1. Centers for Disease Control and Prevention. Developmental monitoring and screening for health professionals. 2014. Accessed on August 25, 2014. Retrieved from http://www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html

2. King, TM, Tandon SD, Macias MM, Healy JA, Duncan PM, Swigonski NL, Skipper SM, Lipkin, PH. Implementing developmental screening and referrals: lessons learned from a national project. *Pediatrics*. 2012;125(2):350-360.

3. Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics.* 2008 (reaffirmed);*122(2)*.

4. Tang BG, Feldman HM, Huffman LC, Kagawa KJ, Gould JB. Missed opportunities in the referral of high-risk infants to early intervention. *Pediatrics*. 2012;*129(6):*1027-1034.