Child and Teen Checkups (C&TC)
Billing Lab and Webinar

Jeri Boomgaarden | Provider Trainer
Erin Sheehy | C&TC Operations Specialist
• Welcome and Introductions
• Top 10 Billing Errors
• Eligibility
• Screening Exceptions
• Online Resources
• C&TC Billing Survey Questions
• Questions
C&TC Top 10 Billing Errors
1. Child and Teen Checkup screening not complete (N78)
Refer to the C&TC Schedule of Age-Related Screening Standards (DHS-3379) for the latest information. We also refer to this as the Periodicity Schedule.

### Minnesota Child and Teen Checkups (C&TC) Schedule of Age-Related Screening Standards

<table>
<thead>
<tr>
<th>C&amp;TC Screening Components by Age</th>
<th>Infancy</th>
<th>Early Childhood</th>
<th>Middle Childhood</th>
<th>Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>C&amp;TC FACT Sheet for each component</td>
<td><img src="image_url" alt="Image" /></td>
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<tr>
<td>Anticipatory guidance &amp; health education</td>
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<tr>
<td>Measurements:</td>
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<tr>
<td>- Head circumference</td>
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<tr>
<td>- Height and weight</td>
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<tr>
<td>- Weight for length percentile*</td>
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<tr>
<td>- Body mass index (BMI) percentile</td>
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<td>- Blood pressure</td>
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<tr>
<td>Health history, including social determinants of health</td>
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<tr>
<td>Developmental, social-emotional, mental health:</td>
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<td><img src="image_url" alt="Image" /></td>
<td><img src="image_url" alt="Image" /></td>
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<td>- Developmental screening</td>
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<tr>
<td>- Social-emotional or mental health screening*</td>
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<td>- Autism spectrum disorder screening</td>
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<tr>
<td>Maternal depression screening</td>
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<tr>
<td>Tobacco, alcohol or drug use risk assessment</td>
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<tr>
<td>Physical exam: head to toe, including oral exam and sexual development</td>
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<td>Immunizations/review</td>
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</tr>
<tr>
<td>Newborn screening follow up: blood spot and critical congenital heart defect</td>
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<tr>
<td>Laboratory tests/risk assessment:</td>
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<td>- Blood lead test</td>
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</tr>
</tbody>
</table>
New requirements starting October 1, 2017

• Adding C&TC visits at age 30 months, and annual visits for children and teens from 6 to 20 years of age

• Requiring fluoride varnish application beginning at the eruption of first tooth, then every 3-6 months at the primary care clinic or dental office through age 5 years

• Requiring standardized depression or mental health screening annually from 12 to 17 years of age

• Requiring HIV testing for all youth at least one time between ages 15 and 18 years and risk assessment for HIV testing followed by appropriate action for youth ages 11-14 years and 19-20 year olds

• Adding near vision screening (plus lens) beginning at 5 years old to the standard visual acuity screening (which starts at 3 years old)

• Adding high frequency hearing loss screening at 11 years and older to the standard hearing screening (which starts at 3-4 years old)
2. Recipient enrolled in PPHP or MCO (N216)
Any PPHP or MCO will be listed on the eligibility screen.

- This subscriber has eligibility for **MA**: Medical Assistance.
  - Elig Type CK: Children ages 2 through 18
  - Eligibility Begin Date: 06/01/2016
  - Eligibility End Date: 06/01/2016
- This subscriber is eligible for the following service types: Medical Care, Chiropractic, Dental Care, Hospital, Hospital - Inpatient, Hospital - Outpatient, Emergency Services, Pharmacy, Professional (Physician) Visit - Office, Vision (Optometry), Mental Health, Urgent Care

Prepaid Health Plan
- This subscriber receives **MA12** - Prepaid Medical Assistance Program (PMAP) delivered through HealthPartners Care. The phone numbers are: **952-967-7098** (metro) or **866-885-8880** (toll free).

Other Eligibility Information
- No Special Transportation.
- This subscriber’s eligibility is not determined for Long term Care and waiver services.
- No Hospice.
- Living arrangement: 80.
- County of residence is 073.
- Refer to Health Care Programs and Services Overview of the MHCP Provider Manual for a list of covered services.

Waivers
None

Subscriber Responsibility Information
None

Restricted Recipient Program
None

Medicare
None
3. Pay Child and Teen Checkup screenings as a package (N70)
Remember – if one line on the claim denies the whole claim will deny. Child and Teen Checkups is billed as a package.
4. Treating provider category of service conflict (N95)

• The treating provider for this claim has not signed a **C&TC agreement** under [Enrollment Applications & Agreements](#), or the provider file is not active.

• The treating provider may not have the correct information on their file to provide the service

• Verify your treating provider’s file or call the Provider Call Center at 651-431-2700.
How to enroll as a C&TC provider?

Minnesota Health Care Programs providers: Policies and procedures

This page has information for providers who may want to enroll with Minnesota Health Care Programs (MHCP), as well as for providers who are already enrolled. Find information for specific provider types, covered services and submitting claims through the online claims system.

Learn more about:

- Enrolling as an MHCP provider

Providers and billers must enroll with Minnesota Health Care Programs (MHCP) to receive payment for providing services to MHCP members. Learn more about enrolling as a provider for the types of services you want to provide in the MHCP Provider Manual.

Providers must be aware of requirements for their provider type in addition to the information in Provider Basics, Provider Requirements and the general enrollment process.

Electronic funds transfer (EFT) or direct deposit

Providers must have a vendor number from Minnesota Management & Budget (MMB) to receive payments from MHCP. Payment for all services to MHCP members is through direct deposit or electronic funds transfer (EFT).

To establish a vendor number for MHCP payments:

1. Request a vendor number through the MMB supplier portal.
2. Fax a completed EFT Vendor Number Notification (DHS-3725-2016) with your assigned vendor number to MHCP.

To change banking information to an existing vendor number, use the MMB EFT Bank Change Request (PDF).
5. Duplicate – same provider (M86)
Check your claim status
Check to see what other claims were billed (this screen shows top of the page)
See all claims for the date you selected
(this screen shows the bottom of the page)

<table>
<thead>
<tr>
<th>Service Dates:</th>
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<tr>
<td>Payment</td>
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<td>Status Information Effective Date:</td>
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<table>
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<th>UN:</th>
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<td>PD Date: 06/01/2016</td>
<td>Paid Amt: $0.00</td>
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<tr>
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<td>03 Control #: 51615800400001471</td>
<td>Total Chg: $88.00</td>
<td>PD Date: 06/14/2016</td>
<td>Paid Amt: $46.20</td>
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</table>
6. NCCI procedure code conflict

An incorrect code pair was used on this claim, causing the denial edit under the National Correct Coding Initiative (NCCI or CCI).

• See Minnesota NCCI FAQs for more information on NCCI. For NCCI code pair edits, see Medicaid NCCI Coding.
Minnesota National Correct Coding Initiative

The Centers for Medicare & Medicaid Services (CMS) implemented the National Correct Coding Initiative (NCCI) or CCI to promote national correct coding methodologies and control improper coding that leads to inappropriate payments. NCCI consists of code pair edits and medically unlikely edits (MUEs).

- CCI procedure-to-procedure code pair edits define pairs of Healthcare Common Procedure Coding System (HCPCS) codes (Current Procedural Terminology (CPT) and HCPCS Level II) that should not be reported together except under certain circumstances. The edits are applied to services billed by the same provider for the same patient for the same date of service.
- MUEs are unit-of-service edits that define for each HCPCS code, the maximum likely, medically reasonable and necessary number of units of service that would be reported for the vast majority of appropriately reported claims. MUEs are applied to each line of service as rendered by a single provider or supplier to a single patient on the same date of service.

Where can I find CCI edits?

Medicaid CCI edits are available through CMS: Medicaid CCI Coding. The edits may be downloaded and are sorted by NCCI for hospital and practitioner and MUEs by hospital, practitioner, and supplier.

- How are CCI code pair edits arranged?
- What are CCI associated modifiers?
- How do I know if a modifier would apply to code pair edits?
- When can I use modifier 50?
- How are claims adjudicated with MUEs?
- How do I report medically reasonable and necessary units of service in excess of the MUE issue?
The National Correct Coding Initiative in Medicaid

The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. For information about, and edits for, the Medicare NCCI program, please visit http://www.cms.gov/Medicare/Coding/NationalCorrectCoding/Eds/index.html. The Medicaid NCCI program has significant differences from the Medicare NCCI program.

The Affordable Care Act of 2010 required CMS to notify states by September 1, 2010, of the NCCI methodologies that were compatible with Medicaid. State Medicaid Director Letter #10-017 (PDF 133.63 KB) notifies states that all five Medicare NCCI methodologies were compatible with Medicaid. The Affordable Care Act required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims by October 1, 2010.

Types of NCCI Edits

The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI Procedure-to-Procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

2. Medically Unnecessary Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.
7. Procedure code modifier conflict
Refer to the Child and Teen Checkups Manual

• A modifier is missing or invalid for the submitted procedure code(s)

• Review claim or remittance advice (RA) for details

• Review the appropriate MHCP Provider Manual section for modifier requirements:

  • Child and Teen Checkups

  • Immunizations and Vaccines
8. Claim is over filing limit (81)
Timely billing

- Submit claims correctly, including Medicare crossover and TPL claims, so MHCP receives them no later than 12 months from the date of service.

- Submit replacement claims so MHCP receives them within six months of the date of incorrect payment, or within 12 months from the date of service, whichever is greater.

- Submit Medicare crossover claims that do not automatically cross over so MHCP receives them within six months of the Medicare determination or adjudication date, or within 12 months of the date of service, whichever is greater.

- Resubmit claims MHCP denied erroneously (due to system error or incorrect information from county) within 12 months of the date of service or up to six months from date of county correction, whichever is greater.

- Submit claims over one year old with appropriate, dated documentation. See Electronic Claim Attachments for instructions. MHCP will review documentation, but does not guarantee payment.
9. Recipient ineligible for service (N30)
Here is how to check eligibility

Always check eligibility at the beginning of each month. You can check eligibility two ways...

1. Call our automated phone system: 651-431-2700 or 800-366-5411
   You will be asked to select option 1 for Providers, then select 1 again for the automated phone eligibility.

2. Go to MN–ITS home page (on a screen 28 we will show you what to do once you log in to MN–ITS)
10. Procedure age conflict (N129)
Make sure you are billing for the correct age

<table>
<thead>
<tr>
<th>Code</th>
<th>Ages</th>
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<tbody>
<tr>
<td>99381</td>
<td>New Patient (under one year)</td>
</tr>
<tr>
<td>99382</td>
<td>New Patient (ages 1-4 years)</td>
</tr>
<tr>
<td>99383</td>
<td>New Patient (ages 5-11 years)</td>
</tr>
<tr>
<td>99384</td>
<td>New Patient (ages 12-17 years)</td>
</tr>
<tr>
<td>99385</td>
<td>New Patient (ages 18-39 years)</td>
</tr>
<tr>
<td>99391</td>
<td>Established Patient under one year</td>
</tr>
<tr>
<td>99392</td>
<td>Established Patient (ages 1-4 years)</td>
</tr>
<tr>
<td>99394</td>
<td>Established Patient (ages 12-17 years)</td>
</tr>
<tr>
<td>99395</td>
<td>Established Patient (ages 18-39 years)</td>
</tr>
</tbody>
</table>
How to check eligibility in MN–ITS
Log in to MN-ITS

- MN-ITS mailbox changes: The work to update the MN-ITS mailbox functions and remove old data from MN-ITS mailbox folders over the weekend of January 20, 2017, was successful. We are in the process of restoring items in the following folders to display data received within at least the last 30 days (any other files that were previously sent to you will no longer be available): 035_X12, 633_PDF, 633C, 633E, 634, 620, 6208, SAL, PAL, PALP, PDI, CMIL. We do not know how long this process will take, but are hoping to have all items restored by Friday, January 27. Call the MNOPC Provider Call Center at 851-451-2700 or 612-365-5411 if you have any questions or need certain items restored in your mailbox. Please allow 40 hours for processing the replacement requests.
- New address for SFTP service: You may need to change your SFTP connection before February 1, 2017. DHS is changing to a new address for our SFTP service. If you are currently using this service, you are connecting to one of the following addresses:
  - secureftp.dhs.state.mn.us port 2222 - if you are using this address, you do not need to make any changes to your SFTP client connection. You should not experience any interruption in service.
  - 136.234.206.150 port 2222 - if you are using this address, we recommend that you change this to secureftp.dhs.state.mn.us port 2222 by February 1, 2017. If your client software does not support connecting through a host name entry, change the NAT address you are using to 136.234.188.15 port 2222. You may use either of these addresses through January 31, 2017.
- Secure FTP client users only: All FTP directories and sub-directories will retain data from the last 15 days only. Directories will be purged daily of data older than 15 days. Providers may also delete files from any FTP directory, including subdirectory files. If you think you may need data older than 15 days, you will need to save it to your own server. This affects only providers who submit and receive batch files through secure FTP clients. This does not affect files received through the MN-ITS mailbox.
- Providers who have not successfully completed 5010 testing for MN-ITS Claim Status (276/277) must first do so in order to use the Claim Status transaction due to the CORE changes. Review the 5010 X12 Batch Transaction Guidelines.

Related Pages:
- Troubleshooting Guide
- MNOPC Payment & Claim Cut-off Calendars
- MNOPC Fee Schedule
- Provider Training
- Provider Updates
- Provider Website
- Sign Up for Email Alerts

Related Links:
- Washington Publishing Company
- NDC Search
Click on Eligibility Request
Refer to Eligibility Help
Make sure you are entering all info needed

Eligibility Help

A recipient’s eligibility through MCHIP may terminate or change during any month. You should verify recipient eligibility monthly, before you provide services.

You must complete a combination of two or more subscriber fields on MN-ITS Interactive to verify eligibility. The chart below lists some possible search scenarios. You may enter as much as you know about the subscriber. When submitting first name, last name and birthdate, enter additional known search criteria that identifies that subscriber to ensure the correct match is found.

<table>
<thead>
<tr>
<th>Combination</th>
<th>Subscriber ID</th>
<th>Birth Date</th>
<th>SSN</th>
<th>Last Name</th>
<th>First Name</th>
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<tbody>
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There are two methods of checking eligibility through MN-ITS. You can verify eligibility for one recipient at a time using the Single Eligibility Inquiry tab, or you can complete multiple eligibility verifications using the Multiple Eligibility Inquiry tab.

Eligibility User Guide
Enter ID number and Date of Birth

NP ID / UMID: A342517700
Taxonomy Code Qualifier:
Taxonomy Code:
Date of Service: 09/13/2017 - 09/13/2017
Subscriber ID: 01234567
Birth Date: 01/01/2001
Social Security Number:
Last Name:
First Name:
Service Type Codes: 30 - Health Benefit Plan Coverage
Enter Optional Information
All eligibility information is listed

Minnesota Department of Human Services: Minnesota Health Care Programs

SUBSCRIBER INFORMATION

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<tr>
<th>Date of Service</th>
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Address 123 Street Rd

PROVIDER INFORMATION

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</table>

Major Programs

- This subscriber has eligibility for MA: Medical Assistance.
  - Elig Type CB: Infants to age 2
  - Eligibility Begin Date: 09/01/2016
  - Eligibility End Date: -/-/-/-
- This subscriber is eligible for the following service types: Medical Care, Chiropractic, Dental Care, Hospital, Hospital - Inpatient, Hospital - Outpatient, Emergency Services, Pharmacy, Professional (Physician) Visit - Office, Vision (Optometry), Mental Health, Urgent Care

Prepaid Health Plan

- This subscriber receives MA12 - Prepaid Medical Assistance Program (PMAP) delivered through UCare Minnesota. The phone numbers are: 612-676-3300 (metro) or 888-531-1493 (toll free).

Other Eligibility Information

- No Special Transportation.
- No Hospice.
- Living arrangement: 80.
- County of residence is 027.
- Refer to Health Care Programs and Services Overview of the MHCP Provider Manual for a list of covered services.

Waivers

None

Subscriber Responsibility Information

None

Restricted Recipient Program

None

Medicare

None
You can also do multiple eligibility search
Eligibility Validation Message

Minnesota Department of Human Services: Minnesota Health Care Programs

Request processed: 07/24/2017 09:38

SUBSCRIBER INFORMATION

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<th>Birthdate</th>
<th>Age</th>
<th>Gender</th>
</tr>
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<td></td>
<td>member name</td>
<td>06272007</td>
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Address


PROVIDER INFORMATION

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<th>Taxonomy Code</th>
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<td>XX</td>
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<td>[ ]</td>
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Request Validation Messages

- Invalid/Missing Subscriber/Insured ID, Please Correct and Resubmit.

If correct information was entered, call the Provider Call Center for help.
Eligibility Validation Message continued

Minnesota Department of Human Services: Minnesota Health Care Programs
Request processed: 07/26/2017 14:59

SUBSCRIBER INFORMATION

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<th>Age</th>
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PROVIDER INFORMATION

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<th>Submitter Transaction ID</th>
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<th>Taxonomy Code Qualifier</th>
<th>Taxonomy Code</th>
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<td>xx</td>
<td>MINNESOTA DEPARTMENT OF HUMAN SERV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Request Validation Messages

- Invalid/Missing Subscriber/Insured Name. Please Correct and Resubmit.
- Patient Birth Date Does Not Match That for the Patient on the Database. Please Correct and Resubmit.

If correct information was entered, this means there was not a match in our system.
Who do I call if I still have questions or a problem with a claim?

Call the Provider Call Center at 651-431-2700 or 800-366-5411

- Select option 1
- If you have an NPI number, select 1 again
- Select option 5 for “physician” (option 5 does not state C&TC)
Screening exceptions background

• MHCP Provider Manual recognizes that for some situations it is not possible or appropriate to require C&TC providers to complete certain components of the C&TC screening as outlined in the Schedule of Age-Related Screening Standards.

• According to the Administrative Uniformity Committee (AUC) recommendations, use the screening exceptions guidelines for situations when you cannot perform screening component(s) or an initial screening is not appropriate.
When submitting a claim with screening exception(s), follow these requirements:

• Follow all billing policy requirements for submitting a C&TC screening claim

• Report one of the HIPAA compliant referral codes (ST, NU, AV and S2)

• Use the claim reporting and medical documentation for the exception reasons, as appropriate
Exceptions to the screening requirement are:

- Child has a diagnosis of a hearing or visual impairment
- Child has new glasses (identified visual impairment)
  - Completing a vision screening may not be indicated at this time
  - Refer child or parent for ongoing monitoring or treatment
- Child has been diagnosed as having an autism spectrum disorder or developmental delay
  - Completing a developmental screening may not be indicated
  - Refer child or parent for on-going treatment or services for the condition, or both
Exceptions to the screening requirement are:

- Blood lead test, hearing screening or vision exam was performed at a different agency, clinic, school or other location
Parent refusal

Exceptions to the screening requirement are:

• Rescheduling for a later date is not feasible
  Against personal or religious belief of the parent or family

• Rescheduling for later date is feasible (parent is willing)
  Parent indicates they do not want the component completed because of time constraints or mood of the child
Unsuccessful attempt (child uncooperative)

Exceptions to the screening requirement are:

• Rescheduling for a later date is not feasible

• A valid attempt was made to complete the service
Exception to the screening requirement are:

• A developmental screening instrument was sent to parents but not returned for review at the time of the C&TC screening
MHCP Online Resources
DHS website
DHS website continued
MHCP information
MHCP information – continued
MHCP provider types webpage

MHCP provider types

The Minnesota Health Care Programs (MHCP) fee-for-service delivery systems include a wide array of providers. This page provides quick links for providers listing the information, including how to enroll with MHCP and what services are covered. If specific information is not listed for a provider type, see the provided webpage.

All providers: In addition to sections of the MHCP Provider Manual that pertain specifically to the kind of services you provide, see the Provider Basics section for general requirements and billing information.

- Refer to the Eligibility-related section for information about your program above.
- Refer to the MHCP Provider Manual for information about enrolling forms, on-going financial eligibility and checking status.

If you are an MHCP member looking for a provider, you can search our MHCP Provider Directory of fee-for-service providers. If you are enrolled in a health plan, contact your health plan to help find providers.

If you are a provider and have questions, call the MHCP Provider Call Center at 651-431-2700 or 866-365-5441.

A
- Acupuncture
- Apparel and drug abuse
- Ambulatory surgery centers (ASC)
- Arc rehabilitation and employment
- Audiology and hearing aid services

B
- Billing instructions and procedures

C
- Case managers
- Child and Teen Community (CATS) and Early Periodic Screening, Diagnosis and Treatment (EPSDT) programs
- Crisis/Intervention Services
- Chiropractic
- Community Emergency Medical Technician (XEMT)
- Community Health Aides
MHCP provider types webpage – continued

MHCP Provider Manual

- Child and Teen Checkups
- Immunizations and Vaccinations

Training

- MHCP available training for CATC providers
- CATC/MDH Screening Component Training: Provides the standards or component requirements, and training of skills needed to perform various component including basic hearing and vision screening.
- CATC/MDH online training programs: Designed to provide knowledge and information needed to provide Minnesota children eligible for Child and Teen Checkups with quality health care.
- University of Minnesota Flu and Viwatch Application Online Training

Additional resources

- Brochures, reports, screening and other documents

Children’s residential treatment (Rule 5)

Chiropractors

Community Emergency Medical Technician (CEMT)

Community health aides

Community health workers

Community paramedics

County and tribal human services
# MHCP Provider Manual – Home

This online MHCP Provider Manual is your primary information source for MHCP coverage policies, rates and billing procedures and is updated on an ongoing basis. On the menu to the left:

- Review the Provider Manual Table of Contents
- Find information for all providers under Provider Basics
- Find service/program-specific manual sections under the Provider Basics bulleted in alpha-order

As an enrolled provider, you are responsible to check frequently for updates, changes, and additions. Sign up to get email notices of revisions specific to the services you provide.

## Resources

- County Human Services Information (DHS-0009)
- MH-105

CPT codes, descriptions and other data only are copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply.

[Report/Rate this page]
MHCP provider news and updates

This page includes news and resources for providers enrolled to serve Minnesota Health Care Programs (MHCP) members. News articles are retained on the Minnesota Department of Human Services (DHS) website for one year. Current messages are listed below.

Systems announcements: Watch this space for information about MN-ITS availability, technical information, and other systems notifications.

MN-ITS Availability: We are continuing to experience some technical issues; however, the issue with batch submissions has been resolved. We are working to resolve the following remaining issues as soon as possible:

- Last Check (Option 2 of the Interactive Voice Response (IVR) phone system) If you call the IVR to learn the amount, date and check number of your most recent check, your call may be disconnected. You may log in to your MN-ITS account and use the Last Check application, located on the left navigational menu, to find this information, instead.
- Taxonomy codes in MN-ITS. Some MN-ITS transactions involving consolidated providers are experiencing issues, including Eligibility Request (270), Authorization Request (278), and Service Agreement Request (278).

Consolidated providers who need to check eligibility or the status of an authorization request or service agreement may call the Provider Call Center at 651-481-2700 or 800-988-5411. We will update this message when these issues are resolved.

Current news and updates:

- Meeting about new incontinence product program
- EOBI service agreement changes
- Provider Call Center changes
- Public comment period for amendments to disability value plan
- Prepaid aid volume purchase contract
- 2017 Legislative update
- Electronic stipend verification meetings
- Child and Teen Checkups (CATCH) schedule of age-related screening standards—October 1, 2017, changes
C&TC Billing Survey Questions
Child and Teen Checkups are based on the recommendations of the American Academy of Pediatrics (AAP) and the United States Preventative Services Task Force (USPSTF).

They are modified according to federal requirements of the EPSDT program, state legislation, and the unique needs and epidemiology of Minnesota's C&TC-eligible population.
# How are C&TC different from well child care?

<table>
<thead>
<tr>
<th>SAME!</th>
<th>DIFFERENT!</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Same goals: early identification and treatment</td>
<td>• Kids eligible for Medicaid are at higher risk</td>
</tr>
<tr>
<td>• Similar screening components and schedule</td>
<td>• Lead required at 12 months and 2 years</td>
</tr>
<tr>
<td></td>
<td>• Hemoglobin for menstruating females</td>
</tr>
<tr>
<td></td>
<td>• Addition of social-emotional screening</td>
</tr>
<tr>
<td></td>
<td>• Lipid profile testing as medically indicated, but not required</td>
</tr>
</tbody>
</table>
When should you use the S0302 code?

MHCP Provider Manual does not require the use of HCPCS code S0302 and considers this code as informational only.

- If a submitted charge is entered on the same line as the HCPCS code S0302, MHCP will deduct that amount from the total charges on the claim.

- If the HCPCS code S0302 is reported without a HIPAA compliant referral condition code on that claim, the claim will deny.
Do all C&TC claims need a HIPAA-compliant referral code?

Yes. DHS will recognize a claim as a C&TC screening only when a HIPAA-compliant referral condition code is entered on the claim.

• A referral for C&TC reporting purposes indicates that the child needs to be seen again for further assessment; diagnosis or treatment of a problem; or a concern that was identified during the C&TC screening.

• Local public health and tribal health C&TC staff provide follow up to children whose claims indicate that a referral health visit is indicated by the provider. This helps ensure the child receives recommended health services.
How do the HIPAA compliant referral codes work?

C&TC HIPAA compliant referral condition codes (referral codes) indicate if a referral was made as a result of the C&TC screening.

• C&TC claims must list the most appropriate HIPAA compliant referral condition code: NU, ST, S2 or AV.

• MHCP C&TC screening payment requires one of the four HIPAA compliant referral condition codes to be entered at the claim (header) level.

• Refer to the HIPAA Compliant C&TC Referral Codes Fact Sheet
Select the appropriate HIPAA compliant referral code from the table below:

<table>
<thead>
<tr>
<th>HIPAA Compliant Referral Condition Code</th>
<th>Use this referral condition code for billing when a C&amp;TC screening results in one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NU (no referral – not used)</td>
<td>• No referral(s) given (&quot;NU&quot;)&lt;br&gt;• If only a verbal dental referral was made for preventive dental health care</td>
</tr>
<tr>
<td>ST (new diagnosis or treatment service requested)</td>
<td>• One or more referrals were made (&quot;ST&quot;)&lt;br&gt;• Patient is referred to another provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals)&lt;br&gt;• or –&lt;br&gt;• Patient is scheduled for another appointment with the screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals)</td>
</tr>
<tr>
<td>AV – refused referral (referral recommended but it was refused)</td>
<td>One or more referrals were made and the patient refused one or more of the referrals (&quot;AV&quot;)</td>
</tr>
<tr>
<td>S2 (continue current services or treatment)</td>
<td>The patient is currently under treatment for a diagnostic or corrective health problem(s)</td>
</tr>
</tbody>
</table>
Fluoride varnish application (FVA) background

• FVA is required for infants upon eruption of the first tooth at each C&TC visit through age 5 years.

• FVA may also be provided for older children based on oral health risk factors.

• FVA is an MHCP covered service for up to four times per year in the primary care setting for children from birth to the age of 21 years.
Fluoride varnish application (FVA) overview

All locations that provide C&TC services may provider FVA. Staff must successfully complete an approved FVA training course. The following types of trained staff may perform FVA:

• Physicians
• Physician assistants
• Nurse practitioners
• Nurses
• Clinical staff under the direct supervision of a physician or other qualified health care professional
• Other licensed or certified health care professionals in a community setting if under the direct supervision of a treating physician (or other qualified health care professional) or dentist
How do you bill for FVA?

• FVA billing by primary providers

  Use CPT code 99188: Primary care providers (physicians or other qualified health care professionals) and trained clinical staff. This code replaces HCPS Code D1206. You may bill FVA at three- to six-month intervals.

• Head Start, WIC, and public health agencies

  • CPT code 99188: trained licensed or certified health care professionals in a community setting under the direct supervision of a treating physician or other qualified health care professional.

  • CDT code D1206: trained licensed or certified health care professionals in a community setting under the direct supervision of a treating dentist.

• Dental providers – must use CDT code D1206
Complete and submit a C&TC claim for a child in foster care just the same as for a child who is not in foster care.
Private pay insurance as primary and MA secondary

- Always bill the primary private insurance first
- Medical Assistance may pay for expenses not covered by insurance

Note: View the [MHCP MN-ITS User Manual](#)
Eligible providers

To be reimbursed for C&TC screening services, fee-for-service C&TC screening providers must be enrolled as either of the following:

• An MHCP C&TC provider (and must sign a C&TC agreement)

• A C&TC clinic or a facility supervised by a physician, that provides screening according to EPSDT (Minnesota Rules 9505.1693-9505.1748)

Eligible treating providers include the following:

• Nurse practitioners

• Physicians

• Physician assistants
Other clinic staff

Staff eligible to provide some components under supervision of a physician includes the following:

- Public health nurses
- Registered nurses
- Other staff through delegation by a licensed health professional within their scope of practice
Public health nurses not enrolled with MHCP who are approved by the Minnesota Department of Health (MDH) may provide services after completing the three-day C&TC screening component training.

Bill for these services under the public health agency or clinic NPI.
What is the accepted interval between checkups?

• The Schedule for Age-Related Screening Standards (Periodicity Schedule) is a minimum standard; provide and bill for more C&TC visits or screenings as medically necessary.

• Children in out-of-home placement or foster care should receive C&TC visits at double the frequency listed on the schedule. The schedule is available at [Schedule of Age-Related Screening Standards (Periodicity Schedule) (DHS-3379) (PDF)](Schedule of Age-Related Screening Standards (Periodicity Schedule) (DHS-3379) (PDF))
How to bill for screenings?

• You may bill for both a developmental and a social-emotional or mental health screening on the same date of service on the same claim.

• However, you may not bill for more than two developmental screenings and more than two social-emotional and mental health screenings on the same date of service.
Where do you find current codes or modifiers?

MHCP Billing Policy Overview section of the Provider Manual has information about coding schemes.

Follow the CPT Guidelines for codes and modifiers.
When should you use new CPT codes?

• CMS makes announcements about new CPT codes
• Update your system to include new codes
• Watch the Provider news and updates page for new codes and the effective date(s)
• Refer to revisions of the MCHP Provider Manual
Fee-for-service online resources

• The Child and Teen Checkups (C&TC) Program section has links to the MHCP Provider Manual, training and additional resources.
Contact the Minnesota Department of Health for more information.

• Clinical questions related to screening and referral

• Child and Teen Checkups (www.health.state.mn.us) website has fact sheets & resources for each screening component

• Email: health.childteencheckups@state.mn.us

• Phone: 651-201-3760
Contact DHS for the following:

• Policy, billing and coding questions
• DHS C&TC staff
  • Anne Kollmeyer, Policy and Project Manager
    Phone: 651-431-2633
  • Erin Sheehy, C&TC Operations Specialist
    Phone: 651-431-2916
• Email dhs.childteencheckups@state.mn.us
Thank you!