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Dear Medical Director:

The American Academy of Pediatrics (AAP), representing over 66,000 pediatricians, pediatric medical sub-specialists and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents and young adults, is advocating for coverage and payment for new CPT codes and modifiers that are effective January 1, 2017. The AAP urges all payers to pay for health risk assessments as a separately reported service as well as live audio and video visits between the patient and the pediatrician as the same level as payment for in person office visits.

Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the “version of the medical data code sets specified in the implementation specifications must be the version that is valid at the time the health care is furnished,” covered entities must incorporate the new codes into their claims processing systems by January 1, 2017. We want to inform you of these new codes and ascertain how your claims systems and payment edits will pay on claims reporting the following:

Health Risk Assessment: There will be new codes on Jan. 1 for reporting administration and scoring of a patient-centered health risk assessment and a caregiver-focused health risk assessment. Following is additional information on the new health risk assessment CPT codes:

●**96160** *Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.*

Code 96160 replaces code 99420 (administration and interpretation of health risk assessment instrument, e.g., health hazard appraisal) for administration of a patient-focused health risk assessment.

●**96161** *Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.*

Code 96161 is new for 2017 and used to report use of a standardized instrument to screen for health risks in the caregiver for the *benefit* of the patient. It is intended that code 96161 will be reported to the patient’s health plan as it is a service for the benefit of the patient.

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In 2017 RBRVS, CMS published both codes as status 'A' (Active), with the RUC-recommended RVUs as follows:

CPT	Status	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total Non-Facility RVUs	Total Facility RVUs	Global
96160	A	0.00	0.13	NA	0.00	0.13	NA	ZZZ
96161	A	0.00	0.13	NA	0.00	0.13	NA	ZZZ

CMS also designated both codes as 'add on' codes (i.e., ZZZ global period), meaning that the resources expended in providing these services is not presently accounted for in the base code (i.e., E/M code) and, therefore, should be reported separately.

A common scenario in pediatrics is the administration and scoring of a caregiver-focused health risk assessment, such as a recommended routine maternal depression screen conducted for the benefit of the infant and, as of 1/1/2017 would be reported with CPT code 96161. CMS is on record of encouraging state Medicaid agencies to allow such screenings to be claimed as a service for the child as part of the EPSDT benefit. As per the attached CMS Informational Bulletin dated May 11, 2016, state Medicaid agencies have discretion to determine reimbursement approaches available to the pediatric provider for furnishing the maternal depression screening. "In keeping with the expert recommendations, several state Medicaid agencies have recognized the importance of the maternal depression screening and are allowing providers to perform and bill for this screening as part of the EPSDT well-child visit." The AAP calls upon private carriers to pay separately for CPT codes 96160 and 96161.

Moderate Sedation: There are a number of changes to the moderate sedation codes, their guidelines and relative values. These revisions accommodate a change in the practice of medicine and provide instruction regarding report of moderate sedation services to reflect clarification regarding how time is reported for these services. The changes include: 1) the deletion of the existing moderate sedation codes that identify one hour or thirty-minute sedation periods (99143, 99144, 99145, 99148, 99149, and 99150); 2) the addition of six new codes to identify thirty or fifteen-minute increments for sedation (99151, 99152, 99153, 99155, 99156, 99157); 3) revision of the accompanying guidelines (including time requirements) and parentheticals associated with the moderate sedation codes and 4) published relative values for moderate sedation.

The Academy urges all payers to provide appropriate payment for reported moderate sedation codes that reflect the total relative value of the service as shown in the table below.

2017 CMS National Physician Fee Schedule Relative Value for Moderate Sedation Codes

CPT code	Short Descriptn	Work RVUs	Non-Facility PE RVUs	Facility PE RVUs	Mal-Practice RVUs	Total Non-Facility RVUs	Total Facility RVUs	Global
99151	Mod sed same phys/qhp <5 yrs	0.50	1.63	0.12	0.05	2.18	0.67	XXX
99152	Mod sed same phys/qhp 5/>yrs	0.25	1.18	0.08	0.02	1.45	0.35	XXX
99153	Mod sed same phys/qhp ea	0.00	0.30	0.30	0.01	0.31	0.31	ZZZ
99155	Mod sed oth phys/qhp <5 yrs	1.90	0.56	0.56	0.17	2.63	2.63	XXX
99156	Mod sed oth phys/qhp 5/>yrs	1.65	0.35	0.35	0.15	2.15	2.15	XXX
99157	Mod sed other phys/qhp ea	1.25	0.27	0.27	0.11	1.63	1.63	ZZZ

Modifier 95: CPT 2017 introduces a new modifier used to indicate that services represented by specific CPT codes were provided via synchronous (real-time) communication using audio and video telecommunications. The telemedicine modifier 95 is appended only to specific CPT codes included in the new CPT Appendix P. Appendix P includes codes for services commonly performed by pediatricians, including

- ■ New and established patient office or other outpatient evaluation and management services (**99201–99205, 99212–99215**)
- ■ Subsequent hospital care (**99231–99233**)
- ■ Inpatient and outpatient consultations (**99241–99245, 99251–99255**)
- ■ Subsequent nursing facility care (**99307–99310**)
- ■ Prolonged services in the office or outpatient setting (**99354, 99355**)
- ■ Individual behavior change interventions (**99406–99409**)
- ■ Transitional care management services (**99495, 99496**)
- ■ Remote real-time interactive video-conferenced critical care codes (**0188T, 0189T**)

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The Academy encourages all payers to provide coverage benefits and pay appropriately for these new codes as separately reported services, apart from the evaluation and management service. In addition, carriers are urged to pay for services reported with Modifier 95 at the same level of payment as in person office visits. **We request your coverage and payment policy for the above listed CPT codes and modifier.**

We look forward to your response on your coverage and payment policy for these new CPT codes. If you have questions or need additional information, please contact Lou Terranova, Senior Health Policy Analyst at lterranova@aap.org or 847-434-7633.

Sincerely,

/S/

Benard P. Dreyer, MD, FAAP
President

BPD/lt

Attachment: CMSC Informational Bulletin (May 11, 2016) *Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children*

CMCS Informational Bulletin

DATE: May 11, 2016

FROM: Vikki Wachino, Director
Center for Medicaid and CHIP Services

SUBJECT: Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children

Introduction

This Informational Bulletin discusses the importance of early screening for maternal depression and clarifies the pivotal role Medicaid can play in identifying children with mothers who experience depression and its consequences, and connecting mothers and children to the help they need. State Medicaid agencies may cover maternal depression screening as part of a well-child visit. In addition, states must cover any medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Prevalence and Impact of Maternal Depression

Maternal depression is a serious and widespread condition that not only affects the mother, but may have a lasting, detrimental impact on the child's health. Maternal depression presents a significant early risk to proper child development, the mother-infant bond, and the family. Maternal depression screening and treatment is an important tool to protect the child from the potential adverse physical and developmental effects of maternal depression. According to the American Academy of Pediatrics (AAP), screening mothers for maternal depression is a best practice for primary care pediatricians caring for infants and their families¹ and can be integrated into the well-child care schedule, as well as included in the prenatal visit.

Maternal depression is characterized by a spectrum of severity: the common "maternity blues" or "baby blues" are usually gone after a few days or one to two weeks and are helped with reassurance and support for the mother. This is distinct from postpartum depression and postpartum psychosis (the most serious condition), which meet specific diagnostic criteria.² According to AAP, it has been estimated that 5 percent to 25 percent of all pregnant, postpartum and parenting women have some type of depression depending on the population surveyed. "Maternal depression" in this guidance encompasses the full spectrum of severity, not only the most severe diagnoses. Mothers who have low incomes are more likely to experience some form of depression than the general population of mothers. For low-income women, rates of depressive symptoms are reported to be between 40 percent and 60 percent.³ There are estimates that 11 percent of infants in families with incomes below the federal poverty level live with a mother who has severe depression and that more than half (55 percent) of all infants living in poverty are being raised by mothers with some form of depression.⁴

In light of recent evidence that children living with mothers with depression may be at risk for long-term physical and behavioral health consequences, the importance of screening and treating

maternal depression is clear. As Harvard University's Center on the Developing Child indicated in 2009, children raised by a clinically depressed mothers may perform lower on cognitive, emotional, and behavioral assessments than children of non-depressed caregivers, and are at risk for later mental health problems, social adjustment difficulties, and difficulties in school.⁵ The risk to the child may depend on the severity of the maternal depression, but timely screening and appropriate treatment can reduce maternal depression and its consequences.

According to the AAP, "If the maternal depression persists untreated and there is not intervention for the mother and the dyadic relationship, the developmental issues for the infant also persist and are likely to be less responsive to intervention over time."⁶ Recent research shows promising results for intensive interventions that focus specifically on mother-child interactions, suggesting that treatments designed to improve child well-being must attend both to relieving the mothers' depression and focus on interactions with the child as central dimensions of the interventions.⁷

Medicaid's Role in Maternal Depression Screening and Treatment

Screening

Maternal depression screening is endorsed by several independent expert medical panels that impact services provided to Medicaid eligible children and adults. For example:

The AAP-endorsed Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents™ is used by many states to implement their EPSDT well-child visits. Bright Futures includes recommendations for well-child visits at one week and one and two months of age, including a recommendation for "Parental (maternal) well-being," which includes a postpartum checkup, with depression and substance abuse screening. Any suggestion of depression should trigger screening questions and providers furnishing these services as part of a well-child visit are guided to refer the mother to her obstetrician or other health care professional and appropriate community-based mental health services. In terms of Medicaid coverage, covering Bright Futures recommended services as part of the preventive benefit strengthens access to these services.

In addition, the United States Preventive Services Task Force (USPSTF) recently published recommendations for screening for depression in the general adult population, including pregnant and postpartum women.⁸ The recommendation was given a B grade, based on the quality and strength of the evidence about potential benefits and harm for screening for this purpose. For state Medicaid agencies, section 4106 of the Affordable Care Act (ACA) established a one percentage point increase in the Medicaid federal medical assistance percentage (FMAP) applied to expenditures for preventive services to states that cover all USPSTF grade A and B preventive services and the Advisory Committee on Immunization Practices (ACIP) recommended vaccines.

The EPSDT benefit is Medicaid's comprehensive child health benefit. Under the EPSDT benefit, eligible individuals under age 21 must be provided periodic screening services (well child exams).⁹ One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development.

A maternal depression screening can be considered an integral part of a risk assessment for the child, in light of the evidence that maternal depression can place children at risk of adverse health consequences. There are several validated screening tools for depression which are simple to administer and can help identify maternal depression and potential risk to the child.¹⁰ Some of these screening tools are specific to postpartum women and some are more general.

Some states cover maternal depression screening as part of a Medicaid well-child visit. These states may instruct providers to claim for this activity either as a service for the child or for the mother, depending on the mother's Medicaid eligibility. The Centers for Medicare & Medicaid Services (CMS) wishes to clarify that, since the maternal depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit. State Medicaid agencies have discretion to determine reimbursement approaches available to the pediatric provider for furnishing the maternal depression screening.

In keeping with the expert recommendations, several state Medicaid agencies have recognized the importance of the maternal depression screening and are allowing providers to perform and bill for this screening as part of the EPSDT well-child visit:

- *Colorado:* The Colorado Department of Health Care Policy and Financing issued Provider Bulletins with guidance on maternal depression screening. Starting January 2014, postpartum depression screening is covered as an annual depression screening and Medicaid primary care providers are encouraged to screen new mothers at a well-child visit using the mother's Medicaid ID number. To facilitate screening in more settings, providers seeing an infant for a well-baby visit are alternatively allowed to bill for the service using the Medicaid ID of the infant.¹¹
- *Illinois:* The Illinois Department of Healthcare and Family Services (HFS) covers perinatal depression screening when an approved screening instrument is used. If the postpartum depression screening (for the woman) occurs during a well-child visit or episodic visit for an infant (under age one) covered by HFS' Medical Programs, the screening may be billed as a "risk assessment" under the infant's Medicaid identification number. Alternatively, if the woman is postpartum and covered by HFS' Medical Programs, the postpartum depression screening may be billed under the woman's identification number.¹²
- *North Dakota:* North Dakota Medicaid covers maternal depression screening as a separate service when performed in conjunction with a Health Tracks (EPSDT) screening or any other pediatric visit, and is considered a risk assessment for the child. Up to three maternal depression screenings are allowed for a child under the age of one. Providers are instructed to bill only when one of the standardized screening tools is used and to bill using the child's North Dakota Medicaid ID Number.¹³
- *Virginia:* Virginia covers the Behavioral Health Risks Screening Tool developed for pregnant and non-pregnant women of child-bearing age through the Maternal, Infant, and Early Childhood Home Visiting Program. The state provided information to practitioners on how to bill Medicaid for using the screening tool as well as what treatment services are available to women who screen positive. The Edinburgh Postnatal Depression Anxiety Subscale is used to address depressive symptoms and risk of co-occurring anxiety. Pregnant women are eligible for additional services, including case management

during pregnancy and up to the end of the month following their 60th day post-partum. Infants are eligible for case management services up to their second birthday.¹⁴

Diagnostic and Treatment Services

If a problem is identified as a result of an EPSDT screen, states have an obligation to arrange for medically necessary diagnostic and treatment services to address the child's needs.¹⁵ Diagnostic and treatment services directed solely at the mother would be coverable under the Medicaid program only if the mother is Medicaid eligible. Mothers who are not Medicaid eligible may receive some benefit from diagnostic and treatment services directed at treating the health and well-being of the child (such as family therapy services) to reduce or treat the effects of the mother's condition on the child. Consistent with current policy regarding services provided for the "direct benefit of the child," such diagnostic and treatment services must actively involve the child, be directly related to the needs of the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child. Such services also must be coverable under one or more section 1905(a) benefit categories such as rehabilitative services or other licensed practitioner services.

State Medicaid agencies should encourage the child's provider to refer mothers for other appropriate care, including diagnosis, therapy and/or medication. Mothers who are Medicaid eligible should be referred to their primary care providers or other appropriate providers. Mothers who are ineligible for Medicaid, or lose their eligibility 60 days postpartum, can be referred to community resources that offer appropriate mental health services, such as community mental health programs, federally qualified health centers or other programs that may exist in the community. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) offers a behavioral health treatment service locator at <https://findtreatment.samhsa.gov/>. Eligibility levels for parents in state Medicaid programs vary; in states that have taken up Medicaid's expansion of eligibility to low income adults, significantly greater number of low income mothers will be eligible and can receive comprehensive coverage than in states that have not.

The Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF), funds states, territories and tribal entities to create home visiting evidence-based programs that improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Medicaid coverage authorities offer states the flexibility to provide services in the home, which may improve care and service delivery for eligible pregnant women, parents, and young children. The majority of evidenced-based home visiting programs deliver services such as screening, case management, family support, counseling, and skills training for pregnant women and parents with young children and many of these services are also Medicaid-coverable. CMS issued an Information bulletin on March 2, 2016 describing the intersection between home visiting models and Medicaid¹⁶.

Promoting Maternal Depression Screening Under Medicaid

Generally, experience in states has shown that there is broad agreement that communication to providers about screening tools, Medicaid billing codes, referral options and other information is

central for successful uptake and continued use.¹⁷ States and managed care plans use a variety of approaches to promote maternal depression screening among providers, including:

- Posting information about maternal depression screening on provider websites and publishing information in provider newsletters.
- Delivering provider trainings to promote the use of maternal depression screening tools and proper billing codes.
- Conducting in-person visits to clinics to train providers on how to implement screenings, help practices modify clinic flow, and discuss referral strategies.
- Offering practitioners continuing medical education (CME) credits for participation.

States that elect to cover this service utilizing a managed care delivery system must ensure that the service is appropriately reflected in the managed care plans' contract, and can include performance standards to ensure that the service is widely performed. Activities designed to promote maternal depression screenings among Medicaid providers and to train them on how to incorporate maternal depression screening and treatment into the EPSDT well-child visit are generally eligible for Medicaid administrative matching funds.

Conclusion

Maternal depression can take a substantial toll on the health and well-being of both mothers and children, and can increase related health costs, impede the development of the child, and create negative social consequences. Maternal depression screening during the well-child visit is considered a pediatric best practice and is a simple way to identify mothers who may be suffering from depression and may lead to treatment for the child or referral for mothers to other appropriate treatment. In addition to covering this screening for Medicaid eligible mothers, states may cover maternal depression screening for non-Medicaid eligible mothers during the well-child visit. States may also cover treatment for the mother when both the child and the mother are present, treatment focuses on the effects of the mother's condition on the child, and services are for the direct benefit of the child.

States interested in learning more on this topic and to request technical assistance may contact Kirsten Jensen, Director, Division of Benefits and Coverage at Kirsten.jensen2@cms.hhs.gov.

Endnotes

¹ *Managing Maternal Depression Before and After Birth*, American Academy of Pediatrics, October 25, 2010 <http://pediatrics.aappublications.org/cgi/reprint/peds.2010-2348v1>

² Earls, Marian, MD. *Clinical Report – Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice*, American Academy of Pediatrics, 2010 <http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348>

³ Earls, 2010

⁴ Veriker, Tracey, Jennifer Macomber, and Olivia Golden, *Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve*, The Urban Institute. August 2010

⁵ *Maternal Depression Can Undermine the Development of Young Children*, Working Paper 8, Center on the Developing Child, Harvard University, December 2009. <http://www.developingchild.harvard.edu>.

⁶ Earls, 2010

⁷ Center on the Developing Child, Harvard University, December 2009

⁸ <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1#discussion1>

⁹ Section 1905(r) of the Social Security Act.

¹⁰ *Identifying and Treating Maternal Depression: Strategies and Considerations for Health Plans*, National Institute for Health Care Management Foundation, June 2010. See Table 4. http://www.nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf Tools like the Edinburgh Postpartum Depression Scale and Postpartum Depression Screening Scale have been developed specifically to measure postpartum depression. As part of their recommendation to screen adults for depression in primary care settings, the USPSTF concluded that asking two simple questions, such as those included in the Patient Health Questionnaire-2, may be as effective as more formal instruments.

¹¹ Colorado Department of Health care Policy and Financing, Provider Bulletins: *Postpartum Depression Screenings and Payment in the Pediatric Primary Care Office* (March 2014) and *Supplement* (August 2014).

¹² *Handbook for Providers of Healthy Kids Services: Policies and Procedures for Healthcare for Children*, Illinois Department of Healthcare and Family Services, January 2015. <http://hfs.illinois.gov/html/010915n.html>

¹³ North Dakota Department of Human Services, Medical Services Division, Medicaid Coding Guideline, effective July 1, 2011, revised June 11, 2013. <https://www.nd.gov/dhs>

¹⁴ *Reimbursement Efforts to Address Depression Among Pregnant and Postpartum Women*, Colorado Department of Public Health and the Environment, November 2013. https://www.colorado.gov/pacific/sites/default/files/PF_Reimbursement-Efforts-to-Address-Depression-Among-Pregnant-and-Postpartum-Women.pdf

¹⁵ EPSDT – *A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, Center for Medicaid and CHIP Services, CMS, June 2014 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf

¹⁶ *Coverage of Maternal, Infant, and Early Childhood Home Visiting Services*. Center for Medicaid and CHIP Services, CMS, March 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf>

¹⁷ *Reimbursement Efforts to Address Depression Among Pregnant and Postpartum Women*, Colorado Department of Public Health and the Environment, November 2013. https://www.colorado.gov/pacific/sites/default/files/PF_Reimbursement-Efforts-to-Address-Depression-Among-Pregnant-and-Postpartum-Women.pdf