FAQs on Proposition 56
Developmental Screening Services

What is the Proposition 56 – Developmental Screening Services Program?

- Assembly Bill (AB) 74, Section 2, Item 4620-101-3305 appropriates Proposition 56 funding to support clinically appropriate developmental screenings for children with full-scope Medi-Cal coverage. Per DHCS APL 19-016, beginning January 1st, 2020 dates of service, contracted (network) providers are eligible to receive a directed payment of $59.90 for each qualifying developmental screening service.

  A qualifying developmental screening service is one that is provided by a network provider, in accordance with AAP/Bright Futures periodicity schedule and through use of a standardized tool that meets the developmental screening criteria set forth by DHCS (in APL 19-016).

What Provider types are eligible for this supplemental payment?

- Any professional "Network Provider" that is eligible to bill for the applicable directed payment. The definition of "Network Provider" can be found in DHCS APL's 19-001.

Which service settings are excluded from supplemental payment?

- There are no service locations that are excluded from this directed payment.

Who are the eligible Members?

- The Physician must have rendered qualified services to Medicaid Members who are **not**:
  - Full dual Members (eligible for both Medicare Part A & Part B coverage); or
  - Partial dual Members that are eligible for Medicare Part B coverage only.
  - over the age of 3; except when the service is provided on the member's third birthday.

What is the effective period for this incentive/supplemental payment?

- Services rendered on or after January 1st, 2020.

What are the eligible (qualified) procedure codes, directed payment amount, and provider responsibilities to earn this Prop 56 directed payment?

- The network provider must meet all of the following criteria to receive the directed payment.

  - The provider must utilize a screening tool that meets all of the CMS criteria, in accordance with the AAP/Bright Futures periodicity schedule. Please see DHCS APL 19-006 for more detailed information on the CMS criteria.

- The provider is required to use the standardized developmental screening tools during the 9- month, 18-month, and 30-month health visit. However, for the purposes of this directed payment, a developmental routine screening is eligible for payment if performed:
  - on or before the first (1st) birthday,
  - after first (1st) birthday and before the second (2nd) birthday,
  - or after the second (2nd) birthday and on or before the third (3rd) birthday,
  - screenings done when medically necessary, in addition to the routine screening based on age above, are also eligible for directed payment; so long as it is performed on or before the third (3rd) birthday.

- The provider must submit a claim or encounter with the qualifying CPT code below.

CPT Code:	Description:	Directed Payment:
96110, without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument	$59.90

- The provider must maintain all documentation in the Member's medical record of screening. This documentation must be available upon request from IEHP and/or DHCS.

How do we determine the payee for these payments?

- IEHP will pay the Prop 56 payment to the billing Provider and billing tax ID associated with the eligible claim or encounter.

How often will payments be disbursed?

- IEHP will pay Prop 56 payments on a monthly basis. For each payment cycle, we will pay Prop 56 payments for claims and encounter data adjudicated and/or received by the cutoff date for the corresponding service months. The most current payment schedule can be found at: www.iehp.org > For Providers > Plan Updates > Correspondence.

What is the Provider Dispute process related to Prop 56 payments?

- If a Provider has a dispute regarding Prop 56 payments, the Provider is to complete the applicable dispute form (claim or encounter) and email the completed dispute form to Prop56Inquiry@iehp.org. The Prop 56 Dispute Forms can be found on the Provider portal at: www.iehp.org > For Providers > Plan Updates > Proposition 56 & GEMT.

- Prop 56 payments is processed separately after the initial submission is adjudicated. Providers **will not find** Prop 56 payments payment in the initial claim payment.

What is the turnaround time for a resolution for Provider disputes?

- IEHP will provide written notification of the Provider dispute results (via mail) within 30 working days from date of receipt.

How long does a Provider have to file a dispute regarding Prop 56 payments?

- A Provider has 365 calendar days from the Prop 56 payment date to file a dispute regarding Prop 56 payments.

- DHCS allows 90 calendar days from the date of receipt a clean claim to issue Prop 56 payment. Disputes submitted prior to this 90-day window will lead to denial or rejection of the dispute.