

Part II: Coding and Billing Guidance Document Public Health Nursing & Professional Development June 2014

General Information:

- Local Health Departments now **bill** for services using the NPI of the provider who sees the client or for the provider/medical director who signs the standing orders for the nurse to provide the service. This means that services provided by nurses (including Enhanced Role Nurses) should be **billed** using the NPI of the physician who wrote the standing order to provide the examination. Further, nurses providing services for which they would bill a 99211 should **bill** that visit under the Medical Director's NPI unless there is a specific order from another physician for that particular client to support the visit. PAs may now directly enroll with Medicaid so should bill under their own NPI..
- All services on the Encounter Form should continue to use the individual staff member's identification number assigned by the agency's billing system, whether reported or billed.
- Standing Orders must be in place for a nurse to provide medical services such as ultrasounds or any other procedure/lab tests not previously ordered for the client by a physician or mid-level provider. (To link to the NC Board of Nursing's document on Standing Order, at: <http://www.ncbon.com/myfiles/downloads/position-statements-decision-trees/standing-orders.pdf> You will also find helpful information at: www.ncpublichealthnursing.org)
- If you are using Enhanced Role Nurses and billing 3rd party payors, other than Medicaid, make sure that you check and are in compliance with the guidelines consistent with the insurer's supervision and "incident to" definitions. Enhanced Role Nurses must have completed the approved training and be Rostered. For information on these courses and rostering requirements contact the appropriate Branch in DPH.
- A sliding fee scale can be attached to any program type, except STDs and TB. Some DPH programs require that if their monies are used to provide a service, the fee for that service must slide to zero (e.g. MH, FP and CH). Not every program provided by local health departments must include a sliding fee schedule (SFS); however, sliding fees can be applied to any program as long as all clients are treated alike. A SFS in Primary Care does not have to slide to zero; the exception is when staff are paid by Title V funds, the SFS must slide to zero. Specifics by Program are under that Program header below.
- "General Rule" for **Program Type**: What brought the client to the Health Department is the primary reason for that visit. Clients may present with more than one problem. It is up to the provider to determine which problem is actually driving the visit in order to code it to the correct program; there may be specific situations where services provided on that encounter need to be billed under a different program (contact your PHN&PD Unit Nursing Consultant.)
- A number of factors influence whether a local health department may apply a "flat fee" to a service provided in the agency: the description of the service; whether the service is provided to individuals with Medicaid coverage, private insurance and/or self-pays; whether third party payors

cover the service and how it must be billed; the Program in which the service is provided; relevant statutes and Administrative Code; and the requirements of specific types of funds.

- The first “rule” to consider is that “your charge is your charge”; i.e., you may not vary your charge by payor source but you may accept a variety of reimbursements as full payment for that service (e.g. you might have a charge of \$100 for a service, but accept as full payment: \$92 from Medicaid; \$85 from a particular industry in your community with whom you have negotiated a discounted rate; and \$0, \$20, \$40, \$60, \$80 or \$100 from self-pays, depending on where they fall on the sliding fee scale.)
- Second, for all women’s and children’s health services, 15A NCAC 21B .0109 (a)(2) and (3) apply: “If a local provider imposes any charges on clients for maternal and child health services, such charges:..(2) will not be imposed on low-income individuals or their families; (3) will be adjusted to reflect the income, resources, and family size of the individual receiving the services.” This means that, in all cases for WCH Programs, the sliding fee scale must be applied and it must slide to zero (\$0.00).
- Third, Medicaid policy clearly states that “in no case shall charges for services provided to Medicaid clients exceed charges for that service to the general public.” The only exception to this is for STD and TB services where, by statute, services cannot be billed to the client.
- Charges for the same **procedure/test** would be the same fee regardless of the Program type. For example, an 81025 pregnancy test would have the same fee in FP, MH and Other Services (OS) because it is a standard service with no variation in the degree of complexity. There are a few exceptions to this rule such as contracted rates and programmatic regulations specific to each program.
- Situations may exist where Public Health must bill **visits** to Medicaid one way and private insurance (3rd party payors) a different way. Examples include: STD & TB (PH bills a T1002 to Medicaid while billing a 99211 to private insurance since private insurers do not recognize the T codes).
- Local health departments cannot vary their charge **by payor** (“Your charge is your charge”); i.e., you cannot charge one rate to Medicaid and another to BCBS or self-paying clients (before application of the Sliding Fee Scale). However, you can provide the same CPT code for an office visit in different Program types with different rates; this is true in HIS. For example, this can be done by adding a modifier e.g., a preventive medicine code such as 99385 or 99395 can be set up with 3 different rates as follows: 99385 or 99395 with no modifier is an Adult Health annual exam (AH or OS Program type with approval): a 99385FP or 99395FP is an annual exam for a Family Planning client and must include all the components required by that Program, and a 99385EP or 99395EP is a Health Check exam for an 18 -21 year old and includes all the required Health Check components. In addition, the same code (such as a 99203) could also be set up with different rates by Program type if the costs of providing a problem-focused exam differed by program type.
- All services provided should be coded, reported and/or billed by marking them on the encounter form. (If you are not sure if a service is billable or reportable check with the program supervisor.) This includes the use of CPT, HCPCS and/or LU codes. If a procedure or test that is commonly provided as part of a service is not provided please note "not done" so that billing staff will not think that it was just forgotten and bill it anyway. The provider of the service is responsible for marking the encounter form with everything they provided to the client. Correct CPT and ICD-9 codes must be used; make sure that all digits required are used with the ICD-9 codes.

- ICD-9 codes used on the billing form are to justify the CPT codes. The biller needs to be able to link the ICD-9 code to the respective CPT code which means the provider should mark the encounter form in such a way that the biller can easily identify the paired ICD-9 and CPT codes. Only one ICD-9 code is required to justify any CPT code. ICD-9 codes do not affect the amount that is paid for the CPT code; they are used only to justify the CPT code. Additional ICD-9 codes on the billing form are used only if needed to track diagnoses or for other data collection purposes.
- CMS guidelines require that the **chief complaint/reason for visit** be documented in the record. In most cases it will be a complaint of a symptom but could be “annual FP exam” or “Health Check exam”. (Remember that the client may present on the day of a visit with a different reason/chief complaint from the one identified when the appointment was made. Please refer back to earlier comments regarding program type.) In some cases the provider may change the “chief complaint” if, during the exam, a significant problem is identified that must be addressed during the visit. This may result in a change to the CPT code; for example, a child is brought in for a prevention visit and during that visit a significant problem is identified (e.g., symptomatic heart murmur) the visit would then be billed as an E&M visit but the prevention ICD-9 codes would be included with the claim.
- Providers may not charge for an office visit unless they are face to face with the client. Writing an order in the medical record does not constitute a provider office visit. Remember that the highest level provider **SEEING** the client determines the level of service billed. If the RN/ERRN sees the patient and then asks the provider to come in and see the patient, the visit is billed at the code for the level of visit done by the provider and the LU code would be reported for the ERRN contact. If an ERRN consults with a provider during a visit with a client but the provider does not see the client, it is billed using the code appropriate to the ERRN visit.
- **New versus Established client:** A new client is defined as one who has not been seen by the same provider in your agency within the last three years for a billable visit that includes some level of evaluation and management service coded as a preventive service using 99381-99387 or 99391-99397, or as an evaluation & management service using 99201-99205 and 99211-99215. If the client’s only visit to the Health Department is WIC or immunizations without one of the above service codes, it does not affect the designation of the client as a new client; the client can still be NEW.
- Due to new edits/audits in Medicaid’s NC Tracks related to the national Correct Coding Initiative, the practice of billing a 99211 and then billing a NEW visit code will be eliminated. Many local health departments have been billing a 99211 (usually an RN only visit) the first time they see a patient and then 2 weeks to up to 3 years later bill a 99201 – 99205 or 99381-99387 (New Visit). Examples may include: billing the 99211 for pregnancy test counseling or head lice check by RN and then a new visit when the patient comes in for their first prenatal, Family Planning or Child Health visit. Now that the new edits have been implemented all of those “new” visits will deny because the LHD will have told the system (via billing a 99211) that the patient is “established”. Consult your PHN&PD Unit Nursing Consultant if you have questions.

Local Use Codes (LU Codes)

- Local use codes - LU codes may be used to report or bill services that are NOT billable by a CPT or HCPCS code. These codes are **NOT** recognized by any third party payor source. They were established to provide a means for local agencies to account for time spent by the staff providing these services, to report locally defined services rendered, and to be able to charge flat or sliding fees directly to clients since the service is not billable to a third party payor source. Local codes may not be used to differentiate fees for the same service billed to clients versus those billed to a

third party payor. Your fee for a service must be billed with the same code and same fee to everyone, **“Your charge is your charge”**.

- **LU codes are designated and controlled by Dr. Joy Reed’s office. Additions to the LU codes list may be requested through her office at joy.reed@dhhs.nc.gov** . The current list is available on the HIS Library Website:
<https://wss01.dhhs.state.nc.us/sites/dhhs/DPH/HIS%20Library/default.aspx>
- Do **NOT** use any modifiers with the LU codes. This includes the Medicaid only EP and FP modifiers.
- Using LU codes to bill a sports or camp physical: In order to use an LU code there must be a significant difference (the service definition **MUST** be significantly different from the CMS preventive medicine codes) between the exam done and billed to Medicaid and other third party payors with a 99383 – 385 or 99393 – 395 and the one billed to clients using an LU code. The decision on how to bill cannot be based on the form to be filled out (e.g., when an adolescent comes in with a form to be completed to participate in sports does not mean you can use LU208.) If the child/adolescent has already had a comprehensive exam and the agency is just filling out the form based on what is in the clinical record from that visit, LU021 could be an appropriate code to use. The definitions for the preventive medicine codes are based on age but all say either **Initial or Periodic preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor interventions, and the ordering of laboratory/diagnostic procedures** (CPT Plus, 2013.)
- **IMPORTANT:** If any exam of this type is billed to Medicaid or other third party using a CPT or HCPCS code, the ALL exams of this type must be billed using that same code and the local codes may not be used to differentiate fees for the same service billed to patients as opposed to third party payors.
- The guidance on what is to be included in the assessment for completing certain forms has changed over time to reflect “best practice” and usually calls for that comprehensive preventive health visit. For example:
 - ✚ Kindergarten Health Assessments now require the full examination
 - ✓ Head Start requirements:
 - ✓ Physical examination,
 - ✓ Updated immunizations,
 - ✓ Vision screening,
 - ✓ Hearing screening,
 - ✓ Dental screening,
 - ✓ Developmental screening.
 - ✚ AAP sports form: The goals of a pre-participation sports evaluation are:
 - ✓ Determine that the athlete is in general good health,
 - ✓ Assess the athlete's present fitness level,
 - ✓ Detect conditions that predispose the athlete to new injuries,
 - ✓ Evaluate any existing injuries of the athlete,
 - ✓ Assess the size and developmental maturation of the athlete,
 - ✓ Detect congenital anomalies that increase the athlete's risk of injury,
 - ✓ Detect poor pre-participation conditioning that may put the athlete at increased risk.

OS:

- OS program type and codes used within the program must be requested using the appropriate form and approved by Dr. Joy Reed. This program is generally used for services that are billed at flat rate. Services that you want to offer at a flat rate and that are not associated with another program can be charged to OS program with approval of Dr. Joy Reed. **Note: If these services are billed to Medicaid or third party payors, the same flat rate must be billed to them all.** This cannot be used to circumvent sliding to zero for services to children.

PC:

- PC (Primary Care) program type must be requested using the appropriate form and approved by Dr. Joy Reed. Services in this program do not circumvent sliding to zero for services to children.

Child Health:

It is very important to check the Health Check Billing Guide published Annually by DMA as Special Bulletin usually between April and July (Last published July 2013).

- Child Health Periodic and Interperiodic visits are all coded to Health Check (HC) program type in HIS **regardless of payor source, but be sure to use the EP modifier when the payor source is Medicaid.** This includes all components for the periodic and interperiodic visit types using the EP modifier including: immunization administration, vision, hearing, developmental and health risk assessments and/or behavioral risk assessment codes. **NOTE: See the Health Check Billing Guide for a list of all components required in order to bill periodic or inter-periodic services. Please be sure to enter all reportable services done when a Health Check visit occurs.**
- Child Health (CH) program type in HIS includes E&M problem/sick visit codes and other related services provided at those visits. The sliding fee schedule must be applied to any services coded to CH or HC.
- Child Health Primary Care visits (E&M services) are coded to program type CH (Child Health). In order to put these services in another program type i.e., OS or PC, the EP modifier would not be used and the agency must be able to prove that no Child Health monies (HMHC/Title V) are being used to support salary of staff (e.g. nurses, interpreters, providers, etc.) providing those services.
- LU Coded services can be coded to CH but without the EP modifier. For example LU206 which is the code that would be used for a limited day care physical. The physical provided **MUST** have a service definition that is significantly different from the CMS preventive medicine codes and therefore would not include all of the components for a full periodic or inter-periodic Health Check Visit.
- Urinalysis is a billable service if medically indicated; it is not part of the Periodic or Inter-periodic visit and not recommended unless there are symptoms or identified risks.
- In order to bill for a urinalysis or any other laboratory service (as a stand alone service, as part of a sick/problem visit or along with a preventive service) it must be supported with an appropriate ICD9/10 code to explain why the service is being provided/requested and the appropriate CPT code must also be included. This is the same as lab services provided in any other program type.
- Developmental Screening (ASQ or PEDS) 96110 is required for ages 6, 12, 18 or 24 months and 3, 4 and 5 years. It is part of the required service for these Health Check visits and must be reported with visit.

- Autism screening (MCHAT) 99420 has been required for 18 and 24 months old since July 1, 2010 and should be billed in addition to the HC (periodic or interperiodic) visit. CPT Code 99420 is also the code used for HEADSSS, ASQ-SE, PSC and PSCY which is used on children >11years old on Bright Futures forms. Two (2) units per visit can be billed for the HEADSSS and PSC-Y. **Do Not** bill if you are not performing the screen.
- **Note the Requirement for HMHC/Title V funds:** The agency must be able to demonstrate that no funds are used to support salary of staff providing services other than child health. (These funds may only be used to support staff providing child health services.)
- **Consult your Child Health Nurse Consultant with specific questions related to service provision.**

Immunization:

It is very important to check the Health Check Billing Guide published Annually by DMA as Special Bulletin usually between April and July (Last published July 2013).

- Services to clients seen only for immunizations services should be coded to Immunization Program.
- Services to clients receiving immunizations as part of another program's requirements should have immunizations coded to the program which brought the client in for services e.g., CH, FP, ST, MH or AH. Remember that immunizations coded to CH, FP and MH programs are subject to sliding fee scale. If the immunization is recommended, it could be provided under the Immunization Program and the fee does not have to slide.
- VFC vaccines given along with a program visit should be reported to that program.
- Medicaid beneficiaries who are VFC age (0 through 18) are automatically eligible for VFC vaccine, even those who are dually covered by Medicaid and another insurance plan. However, CDC recommends that providers ask the family their preference; if they want their insurance billed, privately purchased vaccine must be used.
- An administration fee can be billed for Immunizations provided by VFC but you must follow the eligibility guidelines sent out by the Immunization program, including the rule that no one under 200% of the Federal Poverty Level may be charged. The vaccine code may need to be reported in order to get paid for the administration fee. **NOTE: Clients may not be charged a fee higher than the Medicaid reimbursement rate for the administration fee and the fee must be waived if the client expresses an inability to pay the administration fee.**
- Health Choice beneficiaries are considered *insured*; therefore, they are not eligible for VFC vaccines, with one exception. Health Choice beneficiaries who are American Indian or Alaska native are entitled to VFC vaccines—Health Choice will only reimburse an administration fee for these beneficiaries. Refer to individual Health Choice articles in the general Medicaid Bulletin and the *Basic Medicaid and NC Health Choice Billing Guide, Section 12*, for details regarding the NCHC eligibility groups and the billing and claims processing of Health Choice claims.
- All immunizations should have an administration and vaccine code either billed or reported.

- The EP modifier must always be appended to the immunization administration CPT procedure code when billing for Medicaid recipients from birth through 20 years of age; the TJ modifier must be appended if it is a Health Choice client.
- Immunization administration fee can be billed with a preventive visit or any E&M (problem-focused) visit code. The 25 modifier should be used with the visit code to show that it is a significant separately identifiable E/M service.
- Providers must use purchased vaccines for Health Check beneficiaries ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines. When purchased vaccine is administered to this age group, Medicaid will reimburse providers for the vaccine product and the administration fee. Note that some NCIP vaccines may be administered to clients ages 19 and older, in which case Medicaid will cover the administration fee. **In that case, the CPT vaccine code for the NCIP vaccine must be reported with \$0.00.** Vaccine procedure codes must always be included on the claim.
- An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check assessment or an office or sick visit.
- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) with the **EP** modifier.
- Additional injectable immunization administrations are billed with CPT code 90472 with the **EP** modifier. The appropriate number of units must be billed for each additional immunization administration CPT procedure code, with the total charge for all units reflected on the detail.
- Administration of **one** vaccine that is an **intranasal/oral** immunization is billed with the administration CPT code 90473 with the EP modifier. **Note: CPT code 90473 can only be billed if the intranasal/oral vaccine is the only immunization provided on that date of service. CPT code 90473 cannot be billed with another immunization administration code on that date of service. See guidance in next bullet for further clarification. A second intranasal/oral immunization cannot be billed at this time.**
- Administration of an intranasal or oral vaccine provided **in addition to** one or more injectable vaccines is billed with CPT code 90474 with the EP modifier.
- Purchased vaccines may be coded to Immunization program so that you can recoup your cost. Vaccine inventory and purchasing policies should describe the process as to what program type to code the services. Local health departments must inform the client about any charges before the service.
- National Drug Codes (NDCs) should NOT be reported to Medicaid for vaccines.
- **Consult your Immunization Consultant with specific questions related to service provision.**

EPI: Communicable Disease:

- EPI Program type is used for General Communicable Disease activities including Hepatitis A, Hepatitis B, food-borne outbreaks as well as other reportable disease investigations and follow ups other than STD or TB. Clinical visits can be reported by the appropriate CPT code and there are LU codes that can be used to report activities that don't fit into a CPT code.
- EPI services cannot be charged to the client but if a clinical service is provided that is a billable service Medicaid and other third party payors may be charged with permission from the client.

STD:

- Mid-Level Providers and Physicians may provide services to clients seeking an STD evaluation, but every provider should receive an orientation to STD Program and agree to provide services according to DPH STD Program guidelines.
- Currently Rostered STD Enhanced Role Nurses (STD ERRN) may also provide services to clients seeking STD evaluation and can bill Medicaid for these services if the STD ERRN conducts the interview, performs the physical examination, orders the appropriate testing and provides appropriate treatment and counseling. The STD ERRN uses the T1002 for Medicaid covered clients, or may bill private insurance if allowed by the client's plan using 99211 with the client's permission.
- If the provider orders a test that is medically indicated but is not offered by the SLPH, then the client or the client's insurance (with the client's permission) may be billed for the lab.
- If the LHD has a contract in place with a reference lab (private lab) for the tests, then the client or client's insurance (with the **client's** permission) may be billed the contract rate/fee.
If there is no contract in place for the tests, then the reference lab may bill the client or clients insurance (with **clients'** permission). If the client does not have insurance or refuses to have their insurance billed, then the LHD does not have to perform the tests. This type of optional testing is at the client's expense.
Refer to the Lab Section of this document for guidance on billing venipuncture and handling fees.
- T-codes are billed in units. One unit = RN services up to 15 minutes. The T1002 is billable when all of the service components are provided, even if the treatment component is completed on a different day while waiting for the results of a lab test. A maximum of 4 units per day may be billed per client. The time spent for each visit must be documented in the medical record. Time is defined as total time spent; for instance, 30 minutes time spent = 2 units. The documentation recording the STD service components provided should support the number of units billed.
- If during the course of a Child Health, Family Planning, Maternity or other program visit the clinician needs to rule out STDs to meet standards of care, the client cannot be charged for the STD testing and treatment services. The client should be evaluated using the same standard of care and medical record documentation as if they were being evaluated in the STD clinic. Even in these clinics **within the Health Department**, the 340B STD drugs may be given to the client for treatment; however, all follow-up on the STD must be done in that program. Third party payors (Medicaid and private insurance) can be charged for these services. *NOTE that in this case and all subsequent examples, billing private insurance will result in an EOB to the home address; therefore, the client should be informed of that and have the opportunity to say they do not want insurance to be billed.*
- At the current time, most STD services cannot be charged to the client but can be charged to Medicaid and to other third party payors with the client's permission. If you bill insurance, you must use 99211 for nurse or higher E&M codes for mid level providers or physicians. Remember that if the client presents as being concerned about having a reportable STD or presents in an STD Clinic, nothing related or required for STD evaluation is billable to the patient. Exceptions to this rule apply only for tests and procedures not offered by the NC SLPH or required by the DPH STD Program.

- Non STD Enhanced Role Nurses providing STD services should use the non billable STD visit code LU242 for reporting services provided to the client since they can not bill for the services provided. *(By Agreement Addenda it is preferred that STD Enhanced Role Nurses provide services to STD clients, but a registered nurse having demonstrated competency can administer treatment per standing order, obtain client history and provide client centered counseling.)*
- Mid-level providers and physicians bill Medicaid and third party payors (with permission) using the appropriate E&M codes for the level of service provided.
- When a client receives STD services billed with an E&M code and is also seen by another health department provider on the same date of service for a separately identifiable medical condition, the health department may bill both visits using modifier 25 provided the diagnosis on the claim form indicates the separately identifiable medical condition. The modifier 25 is appended to the second visit's E&M code. If a T1002 code is used to bill Medicaid, the 25 modifier is not needed. For Example: If a client comes in for a STD visit and gets treated and the services are billed using an E&M code and then later in the day returns for acute care visit for diabetes or Family Planning method problem (i.e., headaches or blurred vision, that would be billed using E&M codes), then both visits can be billed using Modifier 25 on the second visit as these are two very different diagnoses and reasons for a visit. However if you bill the first visit of the day using a T code, you cannot bill the second visit as an E&M code regardless as to whether the visits are based on two different diagnoses as the T code will be denied. Consult with your PHN&PD Unit Nursing Consultant for additional guidance if this occurs.
- If a client comes in to have a syphilis serology done *for purposes of employment ONLY* we have a ruling that says that client may be charged. **NOTE: that the local health department can only charge for drawing the blood IF it sends the blood to an outside lab for testing. The State Lab is not an appropriate lab to send tests done solely for employment. Please refer to the STD Contract Addenda which give additional circumstances for billing clients.**
- All local health departments must offer HIV and STD services at no cost to the client regardless of county of residence. **Exceptions include:**
 - ◆ asymptomatic clients who request screening for non-reportable STDs (e.g., herpes serology, Hepatitis C)
 - ◆ clients who receive follow-up treatment of warts after the diagnosis is established, and
 - ◆ clients who request testing not offered by the state. These clients may be billed for testing and screening according to local billing policy. Essentially, clients who present and ask for STD testing not offered by the state can be billed if the test is provided. Past legal guidance has stated that "screening and diagnostic testing still falls within the rubric of services provided at no charge to the client " but that "once a STD that is not specified in the rule [15A NCAC 19A.0204(a)], such as venereal warts, has been diagnosed; treatment and follow-up services may be charged to the client." See HIV/STD Agreement Addenda for more information.

TB:

- The T1002 visit for TB clients is billed in units based on time recorded in client record by a Public Health (PH) Nurse under the supervision of a PH Nurse that has had the Introduction to TB course. The T1002 visits are for the monthly evaluation of clients on TB medication and not for DOT visits. (DOT is not a billable service but DOT visits should be captured using the appropriate LU code). Time spent with eligible nurse seeing the client must be documented in the medical record. A good practice is to document time = units. Example: 30 minutes = 2 units. Remember: 1 unit = 15 minutes. Procedure code T1002 cannot be billed on the same day that a preventive medicine service is provided.

- A maximum of 4 units per day may be billed per client. The time spent for each visit must be documented in the medical record. Time is defined as total time spent; for instance, 45 minutes time spent = 3 units. The documentation recording the TB service components provided should support the number of units billed.
- Clients that are contacts to TB or are symptomatic cannot be charged for a TB skin test. Clients who need a TB skin test for reasons of employment or for school may be charged if the agency uses purchased supply. (Reading the TST is included as part of the total charge.)
- By law, required services for treatment of TB or contacts to TB are free or billable to third party payors only.
- TST's can be provided as a flat fee service as long as the client does not qualify as "free" per TB program guidelines because the TB program doesn't have a required sliding fee scale.
- If the only service that a client comes in for is a skin test due to employment, school, etc., it should go under the TB program type. However, if the client comes in for another service like MH, CH, or FP and it is determined as a part of the history that they are at high risk for TB and need a skin test, then that TST should go under the program that the client is being seen under. The basic rule is that the TST was then related to the program that brought the client in which is determined by the purpose of the visit.
- To be able to separate purchased vs. state supplied TST use the LU114 code for state supplied TST (report only) and the CPT code 86580 for purchased TST which can have a charge attached.
- If the client has private insurance only and a RN is the provider, you can use the 99211 E&M code. Other providers eligible to bill private insurance would use the appropriate E&M code for the level of service provided.
- When a client receives TB services (must be for a billable TB service) billed with an E&M code and is also seen by another health department provider on the same date of service for a separately identifiable medical condition, the health department may bill the appropriate E&M code, provided the diagnosis on the claim form indicates the separately identifiable medical condition and modifier 25 is appended to the E & M code for the second visit.

Women's Health - Maternity:

- **OB Billing:**

As of 3/1/2012 self-pay clients seeking prenatal care from a local health department should be **billed using the appropriate E&M codes** and if applicable, the appropriate sliding fee. If the client receives "presumptive Medicaid coverage" for any period during the pregnancy, those visits and services that are covered by Medicaid cannot be billed to the client.

The Division of Medical Assistance (DMA) posted a revised OB Policy (1E – 5, Obstetrics: <http://www.ncdhhs.gov/dma/mp/1E5.pdf>) on their website for review in May 2012. The final revised version has not been posted. The most recent OB Policy is dated September 1, 2011.

The OB billing processes changed effective **October 1, 2011**, for all providers, including health departments, under the heading of "Implementation of Additional Correct Coding Edits: New Visits and OB Care. **Health Departments that do not provide full scope OB care must bill for ante-partum services using the following:**

- **Antepartum Package Services codes:**
59425 - antepartum care only, 4-6 visits
59426 - antepartum care only, 7 or more visits.
- **Individual Antepartum Services**
Individual antepartum services (use of Evaluation and Management codes) are covered if
 - a. a pregnancy is high risk and requires more than the normal amount of services for a routine pregnancy; or
 - b. antepartum care is initiated less than three months prior to delivery; or
 - c. the recipient is seen by a provider between one (1) and three (3) office visits as specified in the DMA Obstetrics Clinical Coverage Policy 1E-5, revised September 2011 on page 27.
- Local Health Departments cannot bill the prenatal package for visits until the client delivers, transfers care to another provider or moves to outside the county of residence. For guidance on how to report each prenatal visit without billing, please contact your Regional Women's Health Consultant.
- Pregnancy Medical Home (PMH) services are defined as managed care services to provide obstetric care to pregnant Medicaid beneficiaries with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care. Note that the SPA to allow LHDs to be designated as Pregnancy Medical Homes for purposes of billing the enhanced codes/rates has been signed (as of 6/6/14 local health departments are being paid for S0280 and S0281.)
Please see Pregnancy Medical Home at: <http://www.ncdhhs.gov/dma/mp/1E6.pdf>
- Since it is not unusual for a maternity client to be seen by more than one provider during the course of her pregnancy, each agency has to decide under which provider's NPI to bill the global billing package and write that decision into policy. A few examples would be billing the global code under:
 - ◆ The initial provider seen by the client
 - ◆ The last provider seen by the client
 - ◆ The provider providing the PP visit
 - ◆ The Medical Director

Consult your Women's Health Nurse Consultant with specific questions related to service provision.

Family Planning:

- Sliding fees apply to all FP services according to Family Planning Program guidelines.
- When clients with Medicaid coverage are billed for FP services make sure the Annual Exam Date (AED) is documented so the local health department and state laboratory can receive reimbursement for services provided. For new patients, use the date of the initial examination as the AED.
- Family Planning Waiver/Program Medicaid: DMA requires that the AED be placed in the "initial treatment date" area on the claim form for the initial annual exam and accompanying laboratory procedures, except pregnancy tests. Providers who placed the AED in the incorrect location on claim forms for Family Planning Waiver services received denials for provided services.
- Clarification from Title X has greatly expanded the services that should be included under the FP Program. The revised guidance clearly indicates that services to promote the reproductive and

general health of the clients are an expected part of FP services. Example One: Client has a Pap test done in Family Planning; the follow-up, re-test, etc. must be done in the FP program.

Example Two: FP Annual Exam is done and client needs a thyroid screen that has nothing to do with FP or method the client is receiving; in this case, the client should be referred for the thyroid screen to another clinic or agency and the client would be responsible for the cost of that screen. When a FP client calls in to make an appointment for a problem (discharge, headaches, breakthrough bleeding, etc.) the client should be seen initially in the FP Clinic for a determination of whether this is related to or has an impact on the method of contraception being used. If the problem requires follow-up with another provider or a specialist, the referral can be made after that evaluation. If you have questions, please contact your Women's Health Nursing Consultant.

- **Note:** One **EXCEPTION** to this under Title X is for STD services (diagnosis and treatment) for clients enrolled in Family Planning. Even though Title X would include those services under the FP Program, there is a system issue with doing that at this time. HIS will automatically apply the sliding fee scale to services entered in the FP Program and by Administrative Code [10A NCAC 41A .0204(a)], clients may not be charged for those services and they should be listed as reportable. STD services can be billed to Medicaid and should not be placed on the sliding fee scale. Any agency wishing to include them in the FP Program should call the HIS Help Desk for instructions on how to manually prevent the sliding fee scale from being applied to these services. If the client has insurance, STD services can be billed with approval of the client to assure confidentiality is maintained and services should not be billed on a sliding fee scale.
- **Note:** The second exception is for FPW clients; for those clients STD services can only be billed to FPW if done during the annual examination.
- FP modifier should be appended to all preventive and problem visit service codes (CPT / HCPCS) in the Family Planning Program that have to do with the method or are required by the program. If the client has Medicaid or FPW the contraceptive method CPT code should have both a FP modifier and UD modifier. The UD modifier indicates that the contraceptive was purchased through the 340B Drug Pricing Program. **Agencies are encouraged to provide prescriptions for clients with Medicaid or insurance prescription coverage for oral contraceptives, Ortho Evra patch, NuvaRing and Plan B or other emergency contraception to be taken and filled at a private pharmacy of the client's choice. The pharmacy will use their own stock and bill DMA directly.**
- Family planning diagnosis (DX) codes V25.0 – V25.9 (except V25.3) must be the 1st Dx for all Medicaid clients when family planning services are provided; you may use V72.3 Gynecological exam for private insurance. If the client is receiving postpartum clinical follow-up in the FP clinic, code the contraceptive method diagnosis first and V24.2 second for the routine postpartum follow-up.
- For sliding fee scale clients use HCPCS code S4993 with the modifiers FP and UD to bill for oral contraceptives and include the number of packs. Refer to the joint memo from Dr. Holliday and Dr. Joy Reed, 6-18-08, which gives recommendations for determining a fee based on the agency's average cost for oral contraceptives.
- If a **billable** visit is not provided there are LU Codes that can be used to capture related services provided, LU235 Pill Replacement (REPORT ONLY) and/or LU236 Pill Pick-up (REPORT ONLY)
- Preventive visit - If the client is being seen for a Preventive visit during her menses and a pap smear is required, the complete exam with the exception of the pelvic exam should be performed. It is preferred that you do everything possible at the Preventive visit. You should charge for the Preventive visit and lab work done on that day. If the client returns for a pap smear and/or labs,

you can then charge for the labs that are done to complete the visit. No visit code or pelvic exam should be billed, since this is considered the completion of the Preventive visit you have already billed.

- Annual check up – The preventive exam should be age appropriate and services provided as medically necessary.
- Providers may bill an E/M visit code when administering Depo-Provera. However, the use of this visit code is subject to the 6-visit per year limit for FPW. There are two ways to bill for Depo-Provera:
 1. If you only administer Depo-Provera you should bill J1050 for Depo and the administration fee 96372 FP
 2. If you evaluate and document the client 's condition then you may bill the appropriate office visit code, based on documented components completed and J1050 for Depo-Provera.Do not charge both an administration fee and an office visit for Depo-Provera.
- J1050-INJECTION, MEDROXYPROGESTERONE has been changed to the 150mg dose and the 1MG has been deleted. LHDs should bill 1 unit which will be converted to 150mg when the claim is sent to NC Tracks. Also, don't forget to associate the code with the appropriate programs.
- When a client presents for a service which is usually performed by a nurse such as a “pill pick up” or a “Depo only” visit and is instead seen by a mid-level provider or a physician because the nurse is unavailable, that visit should still be coded as a CPT code 99211 since that is the usual level of service. Coding the visit to a higher level without provision of higher level services penalizes the client based only on having been seen by a higher level provider. When a client presents for that same type visit and sees a mid-level provider and it is noted in the history that the client is having severe headaches or other problems requiring the judgment of the mid-level or MD provider, then the visit should be billed at the appropriate higher level.
- Nurses providing follow up care to Family Planning clients for birth control methods (including Depo) should always bill or report these services under the prescribing provider. For example, Sue comes for her annual FP exam and the provider writes a new prescription for Depo for the next 12 months. Each time Sue returns during that 12 months, the Depo should be billed under the provider who prescribed it and not the provider/nurse who gives it. This should remain constant until a new prescription is written (whether it be for Depo or for a different method.)
- If a HC exam is provided in FP and a method is provided, LHDs will need to add the FP modifier in the first modifier field (to match the FP CPT and diagnosis codes) AND the EP modifier in the second modifier field (to match the HC CPT and diagnosis codes). Please contact your CH or PHN&PD Unit Nursing Consultants with questions related to this combined service.

Lab:

- **Venipuncture/Specimen Collection:**

Use CPT code 36415. Medicaid reimburses for venipuncture specimen collection fee only to the provider who obtained the specimen. The provider billing for this collection fee must be sending the lab work to an outside lab to be performed. One venipuncture fee is allowed for each recipient, regardless of the number of specimen(s) drawn.
- The amount you bill the **client** for a CPT code for lab work done **in your agency** should include everything it takes to provide that service: supplies, collection, processing, and interpretation of

results. Therefore you would not charge an additional fee for a venipuncture if done since that cost should be included in the total fee for the CPT code for the test.

- **Handling Fee:**

Use CPT code 99000 for handling, transfer and/or conveyance of specimen from the physician's office (Health Department) to another laboratory. Medicaid does not reimburse for handling and/or conveyance of specimen. You may bill this code but remember that if you bill, you must bill **everyone** for the handling fee but you will get denials from Medicaid. You should include in your fee/billing policy that you do not have to continue to bill services that you know are "not a covered service", this will limit unnecessary denials. Since it is not a covered service for Medicaid, it could and should (if you are billing to other insurers) be billed to the client.

- **Pap Test Fee:**

For non-Medicaid covered Pap tests that are sent to the State Lab for processing the Health Department may bill the CPT code 88175 with the 90 modifier and for CPT Code 87621 (with HPV co-test) with the 90 modifier; this is to recoup what the State Lab charges the Health Department for non-Medicaid processing. **Do Not** charge for Pap test processing to clients with Medicaid as health departments are not charged by the State Lab for them since the State Lab bills Medicaid directly for processing.

Medicaid Specific Modifiers:

Health Department specific: (these are modifiers **not** program types)

- **EP** modifiers are used for immunizations, preventive visits and other services under Health Check.
- **FP** modifiers are used in Family Planning program type with Family Planning related services.
- **TJ modifiers are used for immunizations, preventive visits and other services under Health Choice.**
- **UD modifiers are used to identify contraceptives purchased with 340b pricing.**

Modifiers that are used most often:

- **Modifier 25 - Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day of the Procedure or Other Service.** Modifier 25 needs to be used if a separately identifiable evaluation and management (E/M) service by the same provider or other qualified health care professional is done on the same day as a procedure or other service. The modifier 25 is attached to the E/M code, not the procedure code. See examples under program specific sections above.
- **Modifier 51 - Multiple Procedures.** Modifier 51 indicates several procedures were performed on the same day, by the same provider. Medicaid will not determine the major procedure for the provider. It is the provider's responsibility to correctly identify the primary and secondary procedures in order to be reimbursed appropriately. Code the primary procedure first and add 51 to the 2nd and other subsequent procedures.
- **Modifier 76 - Repeat Procedure by the Same Physician or other qualified health care professional on the Same Day.** Modifier 76 is appended to report that a diagnostic procedure or service was repeated by the same provider on the same date of service. Modifier 76 is used to indicate that a repeat diagnostic procedure was medically necessary and is not a duplicate billing of the original procedure done on the same date of service.
- **Modifier 90 – Reference (outside) Laboratory.** When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure should be identified by adding the modifier "90" to the usual procedure number.

- **Modifier 91 - Repeat Clinical Diagnostic Laboratory Tests.** It may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier "91". This modifier may not be used when tests are repeated to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. It may not be used when other codes describe a series of test results (e.g. Fasting and 2-hour Postprandial Glucose.)

Consultation Codes:

- The only consult codes currently allowed and on the LHD fee schedule are 99241-99245 and 99275. The consultation visit codes can be used when another "physician or appropriate source" refers a client to the LHD "to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem." For example: Under new procedures supported by AAP and CCNC, DSS requires an initial assessment (not necessarily a full PE) prior to assigning the child to foster care. The assessment is meant to identify any issues that require immediate medical attention such as uncontrolled asthma or significant behavioral health issues and to link with needed resources such as CC4C or behavioral health. The LHD may or may not become the medical home for the child. DSS is engaging LHDs across the state to provide these services to expedite transfer to foster care.

References:

- Current CPT, ICD-9 and HCPCS code books, which are updated annually, should be available to the appropriate staff.
- DMA website should be reviewed regularly for monthly General Medicaid and Special Bulletins as well as Clinical Policy Manuals and Billing Guidelines: <http://www.ncdhhs.gov/dma>
- Contact your program consultants or PHNPD Unit Nursing consultant for coding questions

PHNPD Unit Nurse Consultants:

Pamela Cochran: (910) 892-3580

Gay Welsh: (704) 986-3822

Rhonda Wright (828) 453-7841

Lynn Conner: (336) 207-3300

Susan Little: (919) 215-4471

Joy Reed, EdD, RN – Head, Public Health Nursing and Professional Development Unit (919) 707-5131