Documentation, Coding and Billing Guidance Document, version 6

Public Health Nursing and Professional Development Unit (PHNPDU)

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This document replaces all prior versions of Coding & Billing Part II

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Introduction

This document was developed to provide local health departments (LHD) with guidance and resources specific to public health coding and billing of services rendered. This information was developed using current program Agreement Addenda, Medicaid bulletins and Clinical Coverage Policies, and Current Procedural Terminology (CPT) and International Classification of Diseases or Diagnosis (ICD-10) code books. Although we have made every attempt to provide comprehensive and correct information, it is still advisable to contact your program consultants if this information is unclear or if you have specific questions.

General Information

Documentation

1. Documentation within the health record must clearly support the procedures, services, and supplies coded.

2. Accuracy, completeness, and timely documentation are essential, and agencies should have a policy that outlines these details. Please refer to the Documentation Guidance from Local Technical Assistance and Training (LTAT) Branch Head (http://publichealth.nc.gov/lhd/) for additional information and guidelines.

3. If there is insufficient documentation to support claims that have already been paid, the reimbursement will be considered overpayment and a refund will be requested.

Medicaid payment process through NC Tracks: June, 2015

Electronic adjustments are the preferred method to report an overpayment or underpayment to NC Medicaid. There are two separate actions that may be filed:

- A provider should use "void" when he/she needs to cancel or submit a refund for a previously paid claim. The entire claim will be recouped under the void process.
- A provider should "replace" a claim if he/she is updating claim information or changing incorrectly billed information. This term is interchangeable with adjusting a claim.

The entire claim will be recouped and reprocessed under the replacement

4. CMS guidelines require that the **chief complaint/reason for a visit is** documented in the record. In most cases it will be a complaint of a symptom but could be "annual Family Planning (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. In some cases, the Physician or Advanced Practice Practitioner may change the "chief complaint" if, during the exam, a significant problem is identified that must be addressed during the visit.

5. **New versus Established client:** A new client is defined as one who has not received any professional services from a physician/qualified health care professional in your health department, within the last three years, for a billable visit that includes some level of evaluation and management (E/M) 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. Remember that a client may be new to a program but established to the health department if they have received any professional services from a physician/qualified health care professional. In this case, you would use the forms for a "new" patient for that program even though the client is billed as "established" to the health department.

Since billing is based on the rendering provider NPI number, should you receive a denial based on "New vs Established", the provider needs to recode the visit and then you can rebill. For example- if you receive a denial on a "New" patient, and the denial says they are an "Est" patient, it may be that the patient was seen at another practice that the provider works/worked at and had services rendered within the past 3 years.

Due to National Correct Coding Initiative (NCCI) edits the practice of billing a 99211, and then later billing a *new* visit code, has been eliminated. Many LHDs have been billing a 99211 (usually an RN only visit) the first time they see a patient and then, up to 3 years later, bills 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 NCCI

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 PHNPDU Nursing Consultant if you have questions.

Attention: All Providers- January 2017 Medicaid Bulletin (pg 14)
Shared/split E/M Visits
A shared/split Evaluation and Management **(**E/M) visit is defined as a medically necessary encounter with a patient where the physician and a qualified Non Physician Practitioner (NPP) each personally perform a **substantive portion** of a face-to-face E/M visit with the same patient on the same date of service. A "substantive portion" of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.
Note: [NPP includes the terms "mid-level provider", "Nurse Practitioner (NP)", "Physician Assistant (PA)" and Certified Nurse Midwife (CNM) *(also acceptable is APP-Advance Practice Practitioner)*.
Every party must document the work they performed. The documentation must show a face-to-face encounter with the physician, in which case the service is billed under the physician's National Provider Identifier (NPI). If there is no face-to-face encounter with the physician, the NPP must bill the service using the NPP's National Provider Identifier (NPI). A notation of "seen and agreed" or "agree with above" would not qualify the situation as a shared/split visit because these statements do not support a face-to-face contact with the physician. Only the NPP could bill for the services.
According to the Centers for Medicare & Medicaid Services (CMS), shared/split visits are applicable for services rendered in the following settings:

- Hospital inpatient or outpatient
- Emergency department
- Hospital observation
- Hospital discharge
- Office or clinic

Shared/split visits are not allowed:

- In a skilled nursing facility or nursing facility setting
- For consultation services
- For critical care services (99291-99292)
- For procedures

- In a patient's home or domiciliary site

Shared/split visits are not considered "incident to" services.

Billing

1. LHDs bill for services using the NPI of the Physician or Advanced Practice Practitioner who provided services to the client or for the Medical Director who signed the standing orders for the nurse to provide the service.

2. Services provided by nurses (including Enhanced Role Registered Nurses) should be **billed** using the NPI of the physician who wrote the standing order to provide the examination.

3. 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.

4. To be eligible to bill for procedures, products, and services related to this policy, Physician or Advanced Practice Practitioners shall:

   a. meet Medicaid or NCHC qualifications for participation;
   b. be currently Medicaid - enrolled; and
   c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

5. Place of Service:
6. Copays:

- LHDs should charge Medicaid copay for Adult Health /Primary Care and Adult Dental and Adult Immunizations only. Other health department programs are exempt from collecting any Medicaid copay.
- For other insurance copays, you would collect the copay on the insurance card IF
  you are in-network with the insurance carrier. Otherwise, you are not obligated to do so.
- For FP, you may collect the copay or their SFS amount due: whichever is lower (a Title X requirement). OPA- Title X Program Requirements April 2014, http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf section 8.4.6.

- ***LHDs should include specific negotiations in their insurance company contracts.*** NC Law prohibits LHDs from charging patients for STD screening services. This includes collecting insurance copays. We are also prohibited by Family Planning from charging a patient more than they would pay on the sliding fee scale. These items, and others like them, should be included in the contract between the Health Department and the insurance company to ensure no out-of-compliance issues with the insurance company

7. Encounter Forms:
   a. All services provided should be indicated on the Encounter Form/Superbill whether reportable or billable.
   b. Encounter forms should reflect the individual staff member's identification number assigned by the health department's billing system, whether reported or billed, for statistical purposes.
   c. The **Rendering Physician or Advanced Practice Practitioner's** (different then the Billing Physician or Advanced Practice Practitioner) NPI is the person who provided the service. If the person who provided the service was an RN or LPN then we use the NPI of the physician who wrote the standing order.
   d. The **Billing Physician or Advanced Practice Practitioner** (used when filing your claim) NPI is the health department's NPI. Health Departments also use the health department's taxonomy code. NCTracks requires each LHD to have a health department NPI.
   e. All Physician or Advanced Practice Practitioners, (except nurses who are not eligible to obtain an NPI), are required to use their own NPI. Every Physician or Advanced Practice Practitioner should get credentialed and obtain an NPI. Advanced Practice Practitioners do not work under standing orders. Only RN's and LPN's work under a physician's standing order.
   f. 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. The Physician or Advanced Practice Practitioner providing the service is responsible for marking the encounter form with everything they provided to the client. Correct CPT and ICD codes must be used; make sure that all digits required are used with the ICD codes. <u>Remember that the CPT code identifies what you did and the ICD code identifies why you did it.</u>
   g. ICD codes used on the billing form are to justify the CPT codes. The biller needs to be able to link the ICD code to the respective CPT code which means the Physician or Advanced Practice Practitioner should mark the

encounter form in such a way that the biller can easily identify the paired ICD and CPT codes. Only one ICD code may be required to justify any CPT code. However, there may be multiple ICD codes required to provide detailed justification of the service(s) provided. ICD codes do not affect the amount that is paid for the CPT code; they are used only to justify the CPT code.

h. Physician or Advanced Practice Practitioners 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 Physician or Advanced Practice Practitioner office visit. Remember the highest-level Physician or Advanced Practice Practitioner **providing services to** the client determines the level of service billed. If the RN/ERRN sees the patient and then asks the Physician or Advanced Practice Practitioner to come in and see the patient, the visit is billed at the code for the level of visit done by the Physician or Advanced Practice Practitioner and the LU code would be for the RN/ERRN contact. If an RN/ERRN consults with a Physician or Advanced Practice Practitioner during a visit with a client but the Physician or Advanced Practice Practitioner does not see the client, it is billed using the code appropriate to the RN/ERRN visit.

8. National Correct Coding Initiative (NCCI)

Due to edits/audits related to the National Correct Coding Initiative, the practice of billing a 99211 and then billing a *new* visit code has been eliminated. Many local health departments have been billing a 99211 (usually an RN only visit) the first time they see a patient and then 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 PHNPDU Nursing Consultant if you have questions.

9. Billing Preventive and E/M visits to Medicaid on the same day- (add info for other programs if appropriate)

a. Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit in any program (see exception). The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology. You will need to consult with each

insurance carrier for their plan specific billing rules. *Exception: Please refer to Child Health Section, item F for changes from the 2016 Health Check Program Guide.*

b. If a client is seen by a Physician or Advanced Practice Practitioner for STD services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing.

c. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy. Effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.

STD ERRN- must bill T1002 for Medicaid clients and use 99211 to bill insurance clients. Some private insurance companies will also accept the T1002. Local Health Departments will need to check with each third-party payer to see how they would like the LHD to bill them for services.

d. The non- STD ERRN may bill insurance using 99211 ~~or T1002~~ for STD treatment only visits. Non-STD ERRNs may not bill ~~Medicaid~~ for STD treatment only visits

e. TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 **or T1002**.

10. Denials for Preventive Medicine Codes Billed with Immunization Administration Services: (NCTracks Newsletter March 17, 2016)

- Recent system updates resulted in NCCI edit denials (EOB 49270 - NCCI EDIT) of preventive medicine service codes submitted with EP modifier only and reported in conjunction with immunization administration service(s). These are accurate NCCI edit denials.
- CMS billing guidelines indicate Physician or Advanced Practice Practitioners may use modifier 25 with modifier EP or modifier TJ for preventive medicine service codes (99381 - 99397 and additional screening codes 99406-99409 and 96160) when reported in conjunction with immunization administrative services (90460-99474). Physician or Advanced Practice Practitioners may submit corrected replacement claims if appropriate. Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children. This issue has now been corrected by NCTracks and you should receive the correct reimbursement.

- Modifier 25 may be used with other non-preventive medicine E/M services when reported in conjunction with immunization administration when the E/M service is significant and separately identifiable. Exception: If a vaccine is billed with the same date of service as code 99211, NCCI edits do not permit the E/M code to be reimbursed. CMS has stated that an E/M code should not be billed in addition to the administration code(s) when the beneficiary presents for vaccine(s) only.

Standing Orders

1. Standing Orders must be in place for a nurse to provide or order medical services such as ultrasounds or any other procedure/lab tests not previously ordered for the client by a Physician or Advanced Practice Practitioner Physician or Advanced Practice Practitioner. (Link to the NC Board of Nursing's document on Standing Orders at:
   http://www.ncbon.com/myfiles/downloads/position-statements-decision-trees/standing-orders.pdf
   You will also find helpful information at: www.ncpublichealthnursing.org

2. The only level of E/M service that may be billed by an RN is 99211 since they are not allowed to be enrolled with Medicaid and do not have NPI numbers. All visits done by RNs are billed under the NPI of the medical director who signs health department policy/standing orders, writes an order, or writes a prescription.
3. The **Rendering Physician or Advanced Practice Practitioner's** (different than the Billing Physician or Advanced Practice Practitioner) NPI is the person who provided the service. If the person who provided the service was an RN or LPN then we use the NPI of the physician who wrote the standing order.
4. The **Billing Physician or Advanced Practice Practitioner** (used when filing your claim) NPI is the health department's NPI. Health Departments also use the health department's taxonomy code. NCTracks requires each LHD to have a health department NPI.
5. All Physician or Advanced Practice Practitioners, (except nurses who are not eligible to obtain an NPI), are required to use their own NPI. Every Physician or Advanced Practice Practitioner should get credentialed and obtain an NPI. Advanced Practice Practitioners do not work under Standing Orders. Only RN's and LPN's work under a physician's Standing Order.

Enhanced Role Registered Nurses (ERRN)

1. If you are using ERRNs and billing 3rd party payers, 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. ERRNs must have completed the approved training and be rostered in their specific program. For information on these courses and rostering requirements contact the appropriate Branch in NC DPH.

Sliding Fee Scale

1. A sliding fee scale can be attached to any program type, except STD and TB. Wherever a sliding fee scale is used, it must be consistently applied to all clients.
2. Not every program provided by LHDs must include a sliding fee scale (SFS). When a health department provides Adult Health Primary Care, Other services, ~~Adult Dental services~~, it is their choice to apply a SFS (it is not required).
3. Health Department Dental Clinics are required to apply a SFS but it does not have to slide to zero.
4. 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. Maternal Health, Family Planning, and Child Health).

5. **Healthy Mothers Healthy Children (HMHC)/Title V (Well Child funding)**
   Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service (as per Peter Andersen, (Women's and Children's Health (WCH) Acting Section Chief).

Identifying Program Type

1. "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 ***Physician or Advanced Practice Practitioner*** to determine which problem is driving the visit and to code it to the correct program.

2. Other Services (OS) program type and codes used within the program must be requested using the appropriate form and be approved by the LTAT Branch Head.

This program is generally used for services that are billed at a flat rate. Services that you want to offer at a flat rate and that are not associated with another program can be billed under the OS program with approval of the LTAT Branch Head. **Note: If these services are billed to Medicaid or third-party payers, the same flat rate must be billed to them all.** This cannot be used to circumvent sliding to zero for services for program guidelines that require the use of a sliding fee scale. Other Services Request Form

3. Primary Care (PC)
   Children PC program type must be requested using the appropriate form and approved by the LTAT Branch Head, Phyllis Rocco. Services in this program must slide to zero for services to children.

   Adult PC program type must be requested using the appropriate form and approved by the LTAT Branch Head, Phyllis Rocco. Services in this program do not have to slide to zero; it is a health department decision.
   Primary Care Services Request Form

For additional guidance on use of OS and PC program types, please contact your PHNPDU Regional Nurse Consultant.

Establishing Fees

1. North Carolina law[1] allows a LHD to charge fees for services as long as:
   - Service fees are based on a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, or the appropriate governing entity;
   - The health department does not provide the service as an agent of the State (i.e. Vaccines for Children (VFC) immunizations); and
   - The fees are not against the law in any way;

   [1]North Carolina General Statute 130A-39(g)

2. How do we set fees?
   a. Health Department fees are set based on the cost to provide the service. If you need assistance with this process, contact your Administrative Consultant.
   b. Documentation of the methodology used for setting fees is a required piece of evidence for reaccreditation. Include any minutes from meetings held during the process.

3. A LHD cannot have a "free" service unless law mandates it, this includes pregnancy testing. Rather than having a "free" service, LHDs should slide those services to "0", keeping in mind they must comply with program rules which are governed by state and federal guidelines.
4. One rule to consider when setting fees is that "your charge is your charge"; i.e., you may not vary your charge by payer 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.) For exception regarding 340b drugs, please see guidance on page 33.
5. For all women's and children's health services, Administrative Code 15A NCAC 21B .0109 (a)(2) and (3) may apply: "If a local Physician or Advanced Practice Practitioner imposes any charges on clients for maternal and child health services, such charges: (1) will not be imposed on low-income individuals or their families; (2) will be adjusted to reflect the income, resources, and family size of the individual receiving the services." (3) This means that, in all cases for WCH Programs, the sliding fee scale must be applied and it must slide to zero ($0.00). Services may not be denied due to an unwillingness/inability to pay.
6. 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 Family Planning (FP), Maternal Health (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.
7. Situations may exist where LHDs must bill services to Medicaid one way and private insurance (3rd party payers) a different way. Example: STD & TB - LHD may bill a T1002 to Medicaid and some private insurers. Some private insurers only accept 99211. Verify with each insurance carrier which codes they accept.
8. Flat Fees- A number of factors influence whether a LHD may apply a "flat fee" to a service provided in the health department:
    - the description of the service;
    - whether the service is provided to individuals with Medicaid coverage, private insurance and/or self-pays;
    - whether third-party payers 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

9. There should not be 3 different fees/charges for billing 340b medications or devices. You should follow the guidance below:
    a. LHDs are required to bill Medicaid the acquisition cost of medication or devices purchased via the 340b drug program. Therefore, their fee/rate for Medicaid must be the purchase cost.
    b. LHDs may charge insurances and self-pay clients at a different fee/rate than what they charge Medicaid for the same medications or devices purchased via the 340b drug program.
    c. LHDs may choose to charge ~~all payors~~ Medicaid and insurance the acquisition cost of medications or devices purchased via the 340b drug program.
    d. However, LHDs (due to Title X funding) are required to slide the fee/rate of the medication or device on the SFS for all self-pay Family Planning clients.
10. As a reminder, Boards of Health, County Commissioners or other governing entities are required to approve the establishment of all fees and must approve any changes. Authority may not be conveyed to the Health Department or Health Director to approve any fees or fee changes.

ICD Coding Resources

- NC DPH/ For Local Health Departments
  http://publichealth.nc.gov/lhd/icd10/training.htm

- 5 Steps:
  ICD-10 Quick Start Guide, which is an awesome new FREE resource from our friends at CMS. This guide can help streamline your implementation plan no matter where you are in the ICD-10 transition process. (Ctrl + left mouse click to follow hyperlink.)
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10QuickStartGuide20150622.pdf

- For rural and small practices:
  http://www.roadto10.org

Program Specific Guidelines

Child Health (CH)

A. It is very important to check the Health Check Program Guide (HCPG) found on the following page: Health Check Program Guide published by the NC Division of Medical Assistance (DMA) as a Special Bulletin usually between April and July. The most current document was published in 2016.

- B. Child Health Periodic and Inter-periodic visits (well child/preventive health care) and sick visits (primary care) are all coded to Child Health (CH) program type in Health Information System (HIS) regardless of payor source. Problem-focused sick visits can now be provided on the same day as a well child/preventive care visit (see more guidance later in F). A 25 modifier must be used for the sick problem focused visit to indicate it is a separate billable service on the same date of service as the well child/preventive health care visit. Provider documentation must support billing of both services and providers must create separate notes for each service rendered in order to document medical necessity. As a reminder, the EP modifier must be used for most components of the Periodic and Inter-periodic well visits when the payor source is Medicaid. EP modifier is an abbreviation for EPSDT, (Early Periodic Screening, Diagnosis, & Treatment) which is administered by Medicaid to provide services to beneficiaries under age 21. It is allowable to append the EP modifier for all payor sources except Health Choice to be consistent and avoid confusion for staff even though it is not required for third party insurance. Health Choice requires the TJ modifier to be appended for most components of the Periodic and Inter-periodic well visits. Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children. This issue has now been corrected by NCTracks and you should receive the correct reimbursement.

The EP modifier must be included on most of the components for the periodic and inter-periodic visit types including:

- immunization administration, (but not vaccine product codes)
- vision,
- hearing,
- maternal postpartum depression screening
- developmental screenings

- autism screenings
- screening for emotional/behavioral problems
- screening for adolescent health risks
- Other screening-related services for adolescents (i.e., smoking and tobacco cessation counseling, alcohol and/or substance abuse structured screening and brief intervention services)

EP is a required modifier for all of these Health Check claim details but not to be used with laboratory services and vaccine products. **NOTE: See the HCPG for a list of all components required in order to bill periodic or inter-periodic services. Please be sure to enter all reportable services when a Health Check visit occurs.**

C. Child Health (CH) program type in HIS includes Periodic and Inter-periodic well child/preventive services as well as E/M problem/sick (primary care) visit codes and other related services provided at those visits. The sliding fee schedule must be applied to any services coded to CH Program Type. **Please be sure to enter all reportable services under program CH when a Child Health visit occurs. The HC Program Type was retired on April 1, 2016 due to the HC Program Type only recognizing ICD-9 Codes.**

D. Completion of Forms:

The CPT code 99080 may be able to be reimbursed when Physicians or Advanced Practice Practitioners complete a form for administrative purposes such as for a sports physical or a school health assessment. If a form is presented during the visit for completion, it should be considered a part of the visit and the patient would not be charged for completion of the form. In this case, the CPT code 99080 would be "reported" and the patient would not be charged. If the form is brought in at a later date for completion, agencies could charge for the service using the CPT code 99080. Since most insurance companies will not pay this code, agencies need to inform patients that this is a non-covered service, and they may be responsible for the charge. This code is not reimbursable by Medicaid.

E. Laboratory services:

Medicaid will not reimburse separately for routine laboratory tests (Hemoglobin/Hematocrit and TB skin test) when performed during a Health Check early periodic screening visit. Other laboratory tests, including, but not

limited to, blood lead screening, dyslipidemia screening, pregnancy testing, urinalysis, and sexually transmitted disease screening for sexually active youth, may be performed and billed when medically necessary. http://dma.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt- page 23. There must be documented symptoms or identified risks (based on history or physical exam) to bill for any additional labs (as part of a Periodic or Inter-periodic well child/preventive visit or as part of a sick/problem visit that may be provided on the same day as a preventive service). It must be supported with an appropriate ICD-10 code to explain why the service is being provided/requested, and the appropriate CPT code for the laboratory service must also be included.

F. Same Day Health Check Wellness Visits and Sick Child (E/M) Encounters:

When Medicaid beneficiaries under 21 years of age receiving a Periodic or Inter-periodic visit also *require* evaluation and management of a problem focused complaint, the Physician or Advanced Practice Practitioner may deliver all medically necessary care and submit a claim for both the preventive service (CPT 9938x / 9939x) and the appropriate level of E/M service (CPT 9920x/9921x). However, another option is to have the CHERRN document and bill for the well child/preventive visit if the CHERRN can complete the full well visit with all components and the Physician or APP complete a separate note for the sick visit and bill for that sick visit.

Beginning with services rendered after July 1, 2016, the Physician or Advanced Practice Practitioner need not submit additional documentation of medical necessity to the fiscal agent in order to reprocess a claim for the service rendered to treat the focused problem. All requirements in this section regarding documentation of the additional, focused service must be adhered to by the Physician or Advanced Practice Practitioner.

The E/M service must report only the additional time required above and beyond the completion of the Periodic or Inter-periodic well visit to address the focused complaint. The Physician or Advanced Practice Practitioner's electronic signature on the claim is the attestation of the medical necessity of both services if the Physician or AAP provides both services. However, if the CHERRN can complete the well child visit the Physician or APP needs to just sign for the sick visit completed on that same day.

Requirements for providing Preventive and Focused Problem (E/M) care same day:

• Provider documentation **must** support billing of both services. CHERRN and/or Physician or Advanced Practice Practitioners **must** create separate notes for each service rendered in order to document medical necessity.
• In deciding on appropriate E/M level of service rendered, only activity performed "above and beyond" that already performed during the ***Health Check*** wellness visit is to be used to calculate the additional level of E/M service. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.
• All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.
• The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph and additional review of systems paragraph that clearly describes the specific condition requiring evaluation and management.
• The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.

Modifier 25 must be appended to the appropriate E/M code. Modifier 25 indicates that the patient's condition required *a significant, separately identifiable E/M service* above and beyond the other service provided.

G. **Screenings**

Developmental screening:

- Developmental screening is a recommended component at ages 6, 12, 18 or 24 months of age and 3, 4, and 5 years of age using the ASQ-3,PEDS or other AAP recommended developmental screening tool which can be found at: Bright Futures Developmental Screening Tools
- Physician, CHEERN or Advanced Practice Practitioners should bill and report CPT code 96110 and EP modifier;
- CPT code 96110 can now be billed up to a maximum of two units per visit for children 5 years of age and younger; aadditional revenue is generated when completed and billed.

Screening for Autism Spectrum Disorders:

- Screening for autism spectrum disorders is required at 18 and 24 months of age using a validated screening tool,
- AAP recommended tools for screening for autism can be found at: Bright Futures Developmental Screening Tools

- M-CHAT and M-CHAT Revised with Follow-Up (M-CHAT R/F is preferred) are the most commonly used validated screening tools used to identify children who are at risk for autism spectrum disorders and can be used for children between 16 and 30 months of age (which allows for catch up of screening if the 18 or 24-month visit is missed)
- Physician, CHEERN or Advanced Practice Practitioners will bill CPT code 96110 and EP modifier; additional revenue is generated when completed and billed;

Screening for maternal postpartum depression:

- Examples of brief screening tools used on the caregiver of the infant (mother) include the Edinburgh Postnatal Depression Scale, Patient Health Questionnaire 2 - PHQ-2 (if positive should be followed by the PHQ-9) and PHQ-9
- **Use CPT 99420 through December 31, 2016 and the EP modifier with well child/preventive service visits**
- If an immunization administration is done (code is on the same claim as the 96160) use the EP and 25 modifiers with CPT 96160
- **On and after January 1, 2017 use CPT 96161 which is the administration of caregiver-focused health risk assessment instrument for benefit of the patient, with scoring and documentation per standardized instrument with the modifiers as described earlier**
- See the updated CCNC guidance document about maternal depression screening available at: https://www.communitycarenc.org/pediatric-essentials/

Screening for Emotional/Behavioral Health Risks:

- CPT code 96127 should be used to report the administration of a structured screen for emotional and behavioral health risks on the patient, including ADHD (i.e., Vanderbilt), depression (i.e., PHQ-2, PHQ-9, Patient Health Questionnaire Modified for Adolescents), suicidal risk, anxiety (i.e., SCARED), substance abuse (brief screen only), and eating disorders when their use is indicated by guidelines of clinical best practice and surveillance.
- A brief screen alone (CRAFFT) is to be reported and billed using CPT 96127 when no (or minimal counseling) is done

- This means that if the CRAFFT is administered and the score is less than 2, then minimal or no counseling is recommended by the developers of the tool. According to the tool instructions counseling for a negative score of 0 or 1 requires about 5 minutes of counseling.
- The ASQ:SE-2 can be used to screen for emotional/behavioral risks for infants and young children and must be billed using CPT code 96127.
- The Pediatric Symptom Checklist (PSC) or Pediatric Symptom Checklist for Youth (PSC-Y) can be used to screen for emotional/behavioral risks for school age children and adolescents. A Physician, CHEERN or Advanced Practice Practitioner can decide that using a PSC or Y-PSC would be beneficial to further assess positive risk factors that were identified in the HEEADSSS. CPT code 96127 must be used to bill for the PSC or PSC-Y.
- If the PHQ-2 or PHQ-9 is used to screen the patient for an emotional/behavioral health risk (not the caregiver) then the 96127 CPT code should be used.
- Physician or Advanced Practice Practitioners will bill CPT code 96127 and EP modifier to a maximum of two units per visit; if completed and billed this can generate additional revenue;
- Brief screens should be used only to identify risk for presence of an emotional/behavioral problem. The use of a brief screen to assess or change an already diagnosed mental health condition or illness is not supported or recommended by CPT, AAP or CMS.
- The AAP recommends the following table with examples of validated emotional/behavioral risk tools: https://www.aap.org/en-use/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

Immunizations:

All necessary immunizations *must* be administered by the provider delivering the *Health Check* periodic or inter-periodic Well Child visit. The immunization portion of the well child visit *may not be referred to another provider,* i.e. local health departments.

The most current *Recommended Immunization Schedules for Persons Aged 0 through 18: United States,* approved by the **Advisory Committee on Immunization**

Practices (ACIP), **American Academy of Pediatrics** (AAP), and the **American Academy of Family Physicians** (AAFP) may be found at: http://www.cdc.gov/vaccines/schedules/index.html

Excerpt of email correspondence from Tara Lucas to the Administrative Consultants 7/5/17: "Medicaid will reimburse providers for the PE when immunizations are not provided during a well child preventative visit. Our recommendations are listed below and are listed on our WCC audit tool and instructions. We are currently in the process of revising the audit tool and will have revised audit tools posted by the end of this month.

When completing the chart reviews, we include instructions on our audit tools that providers must document if immunizations were provided if needed or reason for not providing immunizations. A plan to administer vaccines as soon as possible must be noted in the record if immunizations were needed and not provided.

Children with medical and religious exemptions should have documentation in the chart"

Screening for Adolescent Health Risks

HEEADSSS Adolescent Health Risk Assessment:

- The HEEADSSS is part of the Bright Futures tools and must be used for adolescents starting at age 11 years and up to age 21 years of age
- The pre-visit questionnaire is not the HEEADSSS but should be reviewed to identify risks and determine clarifying questions to be asked as part of the HEEADSSS
- The HEEADSSS is a health risk assessment for a Medicaid beneficiary 11 years of age and older that should be reported and billed using CPT 99420 with the EP modifier through December 31, 2016. (If immunizations are administered during the same visit, the billing provider also needs to use 25 modifier.)
- **Medicaid will reimburse providers for CPT code 99420 to a maximum of two units per visit through December 31, 2016.**
- **After January 1, 2017, providers administering the HEEADSSSS must begin using CPT code 96160 which is administration of patient-focused health risk assessment instrument (e.g., 'health hazard**

appraisal'), with scoring and documentation per standardized instrument

- Please note that CPT 99420 **may not** be used to claim a stand-alone administration of a CRAFFT (CPT 96127) brief screen

Alcohol and Substance Abuse Screening and Brief Intervention (i.e., CRAFFT):

- The CRAFFT is a validated screening tool and is part of the Bright Futures tools.
- Physician, CHEERN or Advanced Practice Practitioners would use the CRAFFT screening tool if any positive risk factors for alcohol/substance abuse were identified in the HEEADSSS screening tool or in any other way during the visit.
- The Physician or Advanced Practice Practitioner will bill CPT Code 99408 plus EP and 25 modifiers for a CRAFFT with 2 positive risk factors and a minimum of 15 minutes of intervention/referral. CHEERN's can also bill this code but ideally should have received training in brief intervention and counseling related to alcohol and substance use.
- The Physician or Advanced Practice Practitioner will bill CPT Code 99409 plus EP and 25 modifiers for a CRAFFT with 2 positive risk factors and a minimum of 30 minutes of intervention/referral; additional revenue is generated if completed and billed;
- The Physician, CHEERN or Advanced Practice Practitioner should not bill for the CRAFFT using the CPT code 99408 if there is less than a score of 2 (i.e. Score of 0 or 1) which would require minimal or no counseling. In this case, the CPT code 96127 would be used.
- Providers may bill 99408 or 99409 codes (with 25 and EP modifiers) only when alcohol and/or substance abuse screening is done AND counseling is provided directly to the beneficiary
- As with any screen, the provider must document the screening tool used (i.e., CRAFFT), the results of the screening tool (score), the discussion with parents, and any referrals made.

Smoking and Tobacco Use Cessation and Counseling:

- The Physician, CHEERN or Advanced Practice Practitioner can bill CPT code 99406 and use the EP and 25 modifiers if at least 3-10 minutes of counseling has been provided to the client.

- The Physician or Advanced Practice Practitioner can bill CPT code 99407 and EP and 25 modifiers if greater than 10 minutes of more intensive counseling has been provided to the client.
- Providers may bill the 99406 or 99407 codes (with 25 and EP modifiers during well visits) only when counseling is provided directly to the beneficiary. Counseling cannot be billed if provided to the parent/guardian instead of the client. EERNs must document receipt of training using the 5A's or CEASE.
- Providers should always include documentation in the beneficiary's medical record noting the intervention (i.e., 5A's), patient response (i.e., contemplating quitting) and current status, follow up plan and referrals (i.e., referral to NC Quit Line)

H. Dental Screenings:

An oral screening must be performed at every *Health Check* well child visit. In addition, referral to a dentist to establish a dental home is *recommended* for every child by age one and *required* beginning at age three. The initial dental referral must be provided unless it is known that the child already has a dental home. An oral health risk assessment is recommended for all young children at well visits until age 3 ½ years. Oral risk screening tools include either the NC *Priority Oral Risk and Referral Tool* (PORRT) or the *Bright Futures Oral Health Risk Tool***.** When any screening indicates a need for dental services at an early age, referrals must be made for needed dental services and documented in the child's medical record. The NC Oral Health periodicity schedule for dental examinations, found in this section, *is a separate and independent schedule* for regular *dental care for children*.

Note: Physician or Advanced Practice Practitioners who perform a Health Check screening assessment and dental varnishing may bill for both services. Application of dental varnishing is not a required Health Check Well Child visit component. For billing codes and guidelines, refer to Clinical Coverage Policy # 1A-23, Physician Fluoride Varnish Services**,** on DMA's website at: https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1A23.pdf

I. Additional Billing Guidelines**:**

- **Referral Codes** for Health Check: ***All*** electronically submitted claims must list referral code indicator "E" when a referral is made for follow-up or an identified condition. Claim submissions should include referral code indicator "F" when a referral is made for Family Planning services.

- **Use ICD 10-CM Coding for all services provided after 10/1/2015**.
- **Capillary blood draws** are considered incidental to ***Health Check*** Early Periodic Screening and should not be billed.
- **CPT Code for Venous Blood Draws: Report 36415** for ***Venous*** blood draw when an external laboratory analysis is required. Capillary blood draws are considered incidental to the Health Check well child visit.

J. How to bill when CH and FP services interface

If the reason for visit is for a well child exam but the patient presents also wanting FP services, the visit is billed as follows:

a. Bill the Well Child Exam along with all required components under the CH program type. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.
b. REPORT all the FP portions of the visit, assuring that all required FP components have been completed. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.
c. In order to offer 340B medications, the visit must be documented separately so that it is clear a FP visit has been made therefore establishing the patient in FP.
d. Document using a separate encounter form.
e. If the reason for visit is for FP services but the patient is also in need of their CH visit, the visit is billed as follows:
f. REPORT the Well Child Exam along with all required components under the CH program type. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.
g. Bill all the FP portions of the visit, assuring that all required FP components have been completed. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.
h. In order to offer 340B medications, the visit must be documented separately so that it is clear a FP visit has been made therefore establishing the patient in FP.
i. Document using a separate encounter form.

General Reminders:

- 340B drug eligibility requires that the patient be a registered FP patient.
- If a patient is seen for FP services, all the assessments and education are completed and separately documented (separate from the CH documentation) and an encounter reflects that the patient received FP services, then the patient should be able to receive 340B drugs, even if the encounter is entered as "report only."
- Assure all CH service components are provided.

- DO NOT try to document both visits on the same program template. Neither the CH or FP templates are structured to comply with both program requirements.

The following information must be shared related to the provision of family planning services during a Health Check or Child Health visit:

1. General information that includes the health benefits of abstinence, and the risks and benefits of all contraceptive options;
2. Specific information related to the adolescent's contraceptive choice including effective use, benefits, and efficacy of the method, and possible side effects or complications;
3. Benefits of dual-method use (for example, condoms for STD prevention and a second method of contraception);
4. How to discontinue the method selected and information on backup methods and emergency contraception;
5. Emergency 24-hour number and location where emergency services can be obtained;
6. At subsequent visits, review this information with the recipient.

K. HMHC/Title V (Child Health funding):

Title V policy on applying sliding fee scale: any client whose income is at or less than 100% of the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service (per Peter Andersen, WCH Acting Section Chief). This means that all services for children MUST slide using the appropriate SFS.

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L. Billing Sports Physicals

From: Rocco, Phyllis M
Sent: Wednesday, April 19, 2017 6:59 PM
Subject: FW: Billing Sports Physicals
Importance: High

Good Afternoon:
Questions have re-surfaced regarding billing sports physicals. I want to again take an opportunity to summarize our guidance regarding how to provide and bill sports physicals.
The term, "Flat fee" is really a misnomer (in all fairness to LHDs, that term has been used widely by DPH and others with varying degrees of meaning). There really is no such fee as a "flat fee." LHDs have one fee for each CPT code. That fee either slides or is paid in full depending on the program requirements. In the past, providers conducted an "abbreviated sports physical". However, after clinical record reviews by nurse consultants from this Branch and the Children and Youth Branch these physicals were frequently found to be out of compliance with the standard of care, programmatic requirements and/or the American Academy of Pediatrics (AAP) recommendations. Therefore, the LU Code(LU208) for this service was retired on 1/15/15.
In order to determine a charge for a sports physical the agencies must first state in policy, which service components are required to assure a child is "cleared medically for sports participation". This policy should be based on AAP and Child Health program requirements. The second step is determining a charge. There are no "short cuts" to providing this service. There is no such CPT service definition for an "abbreviated sports physical." The standards of care must be followed. These visits can be billed to Medicaid as either a periodic or inter-periodic visit and to insurance companies using a preventive medicine code by age or an evaluation and management code (99201 – 99205 or 99212 – 99215). To be reimbursed, providers must complete all components per the most current Health Check Program Guide (HCPG) and the 351 AA Child Health Contract. The Enhanced Role Child Health Nurse may not perform a "sports physical" as it is outside the scope of nursing practice.
Please contact your regional Child Health Nursing Consultant for assistance in assuring your service description for a sports physical meets the requirements.
Also, I am attaching the two memoranda that were sent out in 2015 with guidance on how to bill various physicals including sports physicals when we retired many of the LU Codes used to bill these services. The content is still accurate with one exception. Please note, the *LU Code Set Cross Walk Document* dated April 6, 2015 directs the reader to Jean Vukoson who is retired. **Tara Lucas is the new State Child Health Nurse Consultant with the Division of Public Health, Children & Youth Branch. Ms. Lucas may be reached at: tara.lucas@dhhs.nc.gov**
Our Documentation, Coding and Billing Guidance Document Part II also lists guidance on the matter. This document is located at: http://publichealth.nc.gov/lhd/docs/REVISED-03-2017-

CodingandBillingGuidanceDocument.pdf (Pages 12- 13). Below is the excerpted section from the document. Please see highlighted sections below. I will request the "Flat Fee" language be removed at the next revision of the document because there is just one fee, which either slides or does not slide depending on the billing rules defined by state and federal guidelines.

"Identifying Program Type

1. "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 ***Physician or Advanced Practice Practitioner*** to determine which problem is driving the visit and to code it to the correct program.

2. Other Services (OS) program type and codes used within the program must be requested using the appropriate form and be approved by the LTAT Branch Head. This program is generally used for services that are billed at a flat rate. Services that you want to offer at a flat rate and that are not associated with another program can be billed under the OS program with approval of the LTAT Branch Head. **Note: If these services are billed to Medicaid or third party payers, the same flat rate must be billed to them all.** This cannot be used to circumvent sliding to zero for services for program guidelines that require the use of a sliding fee scale. Other Services Request Form

3. Primary Care (PC)

Children PC program type must be requested using the appropriate form and approved by the LTAT Branch Head, Phyllis Rocco. Services in this program must slide to zero for services to children. Adult PC program type must be requested using the appropriate form and approved by the LTAT Branch Head, Phyllis Rocco. Services in this program do not have to slide to zero; it is a health department decision. Primary Care Services Request Form"

If you have any questions, I can't stress enough the importance of contacting your regional Child Health Nursing Consultant for assistance. Thank you. pmr

For additional program guidance, please contact your Regional Child Health Consultant or visit the program website at http://www2.ncdhhs.gov/dph/wch/aboutus/childrenyouth.htm

L. **Health Choice:**

The North Carolina Health Choice (NCHC) Health Insurance Program for Children is a comprehensive health coverage program for low-income children. It is not Medicaid. The goal of the NCHC Program is to reduce the number of uninsured children in the State. If a family makes too much money to qualify for Medicaid, but too little to afford private or employer-sponsored health insurance, they may qualify for NCHC.

When billing NCHC, you should follow your procedures for billing third-party insurance programs. Health Choice claims must be billed using the **TJ** modifier.

NCTracks has indicated that they will no longer require the TJ modifier for NC Health Choice Family Planning patients. **The claims should only require an FP modifier and should pay at the usual rate** instead of $90. We have not been able to verify that this fix is working properly.

Immunization

A. It is very important to check the Health Check Program Guide published by NC DMA as a Special Bulletin usually between April and July. The most current document was published in 2016

B. Services to clients seen only for immunizations services should be coded to Immunization Program.

C. If a client presents for services in a program other than immunizations (e.g. CH, FP, MH, etc.) and receives immunizations (required as per Agreement Addenda or recommended), the immunizations should be coded to the program which brought them in that day. Remember that immunizations coded to CH, FP and MH programs are subject to sliding fee scale.

D. National Drug Codes (NDCs) should NOT be reported to Medicaid for vaccines. However, Tricare and United Health Care (and potentially others) requires NDC numbers to be included when billing for vaccines. NDC numbers are specific to drugs/medications and do not apply to immunizations/vaccines. These are two different things.

E. Immunization Administration (for Child Health/Health Check)

1. Administration Codes
   a. Effective with date of service July 1, 2011, the ONLY immunization administration codes covered for Medicaid recipients in the Health Check age range, 0 through 20 years of age, are CPT codes 90471 through 90474.
   b. Claims billed with CPT immunization administration codes 90460 and 90461 (effective for dates of service on and after January 1, 2011, for Medicaid recipients through 18 years of age) on and after July 1, 2011, will deny.
   c. Append modifier EP (Health Check) to all CPT immunization administration codes billed for Medicaid recipients in the Health Check age range, 0 through 20 years of age.
   d. Append the TJ modifier to all CPT immunization administration codes billed for Health Choice

e. recipients in the Health Check range, 0 through 20 years of age.
f. Do NOT append the EP or TJ modifier to the CPT vaccine product codes.
g. When billing Medicaid do NOT report the National Drug Code (NDC) with the CPT vaccine product code. However, Tricare, United Health Care and potentially others, requires NDC numbers to be included when billing for vaccines.
h. All of the units billed for CPT codes 90471EP/TJ, 90472EP/TJ, 90473EP/TJ and 90474EP/TJ must be billed on ONE detail to avoid duplicate audit denials.
    - 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.
    - Currently, 90474EP cannot be billed with 90473EP because there are no two oral/intranasal vaccines that would be given to a recipient. Only one unit of either 90473EP/TJ or 90474EP/TJ is allowed.
i. CPT vaccine codes for the vaccines administered **must** be reported or billed, as appropriate, even if administration codes are not being billed. Remember to use the SL modifier when reporting state vaccines.
j. **For Medicaid recipients 21 years of age and older (above the Health Check age range), the immunization administration codes have not changed. Bill the series of CPT codes 90471 through 90474 without the EP or TJ modifier.**
k. Refer to individual bulletin articles on specific vaccines for additional billing guidelines.
l. Physician or Advanced Practice Practitioners 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 Physician or Advanced Practice Practitioners for the vaccine product and the administration fee.
m. Note that some NCIP vaccines may be administered to recipients ages 19 and older, in which case Medicaid will cover the administration fee. Any time an NCIP vaccine is provided, the CPT vaccine code must be reported with $0.00.

n. Medicaid patients 21 years of age and over are responsible for the $3.00 copay when they receive immunizations.

o. Immunization billing guidelines are located on page 56 of the October 2016 Health Check Program Guide

2. **Denials for Preventive Medicine Codes Billed with Immunization Administration Services: (NCTracks Newsletter March 17, 2016)**
   Recent system updates resulted in NCCI edit denials (EOB 49270 - NCCI EDIT) of preventive medicine service codes submitted with EP modifier only and reported in conjunction with immunization administration service(s). These are accurate NCCI edit denials.

- CMS billing guidelines indicate Physician or Advanced Practice Practitioners may use modifier 25 with modifier EP or modifier TJ for preventive medicine service codes (99381 - 99397 and additional screening codes 99406-99409 and 96160) when reported in conjunction with immunization administrative services (90460-99474). Physician or Advanced Practice Practitioners may submit corrected replacement claims if appropriate. Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children. This issue has now been corrected by NCTracks and you should receive the correct reimbursement.
- Modifier 25 may be used with other non-preventive medicine E/M services when reported in conjunction with immunization administration when the E/M service is significant and separately identifiable. Exception: If a vaccine is billed with the same date of service as code 99211, NCCI edits do not permit the E/M code to be reimbursed. CMS has stated that an E/M code should not be billed in addition to the administration code(s) when the beneficiary presents for vaccine(s) only.
- "SL" Modifier- Beginning July 1, 2016, please add "SL" modifier to all state supplied vaccines billed or reported.

F. Vaccines for Children (VFC) Program

1. The North Carolina Immunization Program works in conjunction with the federal vaccine supply program, called the VFC program, to provide vaccines free of cost to health care Physician or Advanced Practice Practitioners across the state.
2. Participating health care Physician or Advanced Practice Practitioners must administer these vaccines according to NC Immunization Program (NCIP guidelines).
3. Physician or Advanced Practice Practitioners may not charge patients for the cost of the vaccines, but they can charge an administration fee for each state-supplied vaccine given in an encounter. The administration fee may not exceed the rate established by the state's Medicaid program.
4. As of October 1, 2012, all state supplied vaccines appropriate for adults are to be used only for the uninsured adult. An adult is anyone 19 or older. Medicaid patients 21 years of age and older are responsible for the $3.00 copay when they

receive immunizations. There is never a co-pay for a Medicaid beneficiary under 21 years of age who are Medicaid or Medicare recipients are considered covered, or insured, for this purpose.) Details on which patients are currently covered by NCIP vaccine may be found at:

http://www.immunize.nc.gov/providers/coveragecriteria.htm

5. Health Departments must have a mechanism in place so that clinical staff can make the correct decision regarding VFC and Non-VFC eligible clients – who should receive state vaccine and who should receive purchased vaccine.

   a. Medicaid beneficiaries who are VFC age (0 through 18) are automatically eligible for VFC vaccine; regardless as to whether they are dually covered by Medicaid and another insurance plan. However, CDC recommends that Physician or Advanced Practice Practitioners ask the family their preference; if they want their insurance billed; privately purchased vaccine must be used. The decision should be whatever is least costly to the patient.

   b. 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. This would require financial eligibility be performed each time the client presents for immunizations in order to appropriately apply this rule. The vaccine code must be reported in order to get paid for the administration fee.

   c. **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.**

   d. 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.

*Health Choice is a comprehensive health coverage program for low-income children; it is not Medicaid. Children whose family income is too high to qualify for Medicaid and too low to afford private insurance may be eligible for Health Choice.

G. Purchased Vaccines

1. Health Check beneficiaries that are 19 & 20 years of age are **not** eligible for VFC vaccines so the physician or advanced practice practitioner must use purchased vaccines for this age group
2. Per the 2016 Health Check Billing Guide the physician or advanced practice practitioners must use purchased vaccines for this age group and bill Medicaid for the cost of the vaccine and the vaccine administration fee
3. Once a Medicaid recipient reaches the age of 21 years or older they are no longer eligible for any VFC vaccine doses. They would need to receive purchased doses and they would responsible for the $3.00 copay when they receive immunizations
4. Adults that are 19 years of age and older that are **Uninsured** are eligible for certain NCIP vaccines. Please refer to the most up to date edition of the NCIP Vaccine Coverage Criteria located on the NCIP website at http://www.immunize.nc.gov/providers/coveragecriteria.htm
5. 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. LHDs must inform the client of any charges before the service.

H. Travel Immunizations

At this time, Health Departments are restricted from billing Medicaid for counseling CPT codes 99401-99403, but you may be able to bill self-pay clients and third-party payors. Please check with other third-party payors regarding their policy on reimbursement for this series of codes. Regardless of which payor type you are billing, your documentation must support the service as well as the time spent.

I. Billing for multi-series vaccines-

Scenario/Question:

If client presents in FP and receives first dose of Twinrix, when they return for doses 2 & 3 do they go to STD or IMM?? The problem presents with the admin fee.

If they receive in FP then it must slide, if they receive subsequent doses in IMM they do not slide. Is this OK?

- The short answer depends on the funding source (public or private vaccine). For state supplied vaccine (including Twinrix) the NCIP Coverage Criteria must be followed (see attached pg 1 & 4)). Only uninsured adults can receive state Twinrix. Also, the maximum charge for the vaccine administration fee is $20.45 (current fee cap), which must be waived if the patient states an inability to pay regardless of the clinic in which the patient is seen, according to the billing brief and LHD Immunization Agreement signed by the Health Director (see below). Most LHD's for which I am familiar, do not charge a vaccine administration fee for state supplied vaccine.

- The Long answer and resources:
  - Only those 18 years and older that are **UN**insured are eligible for the VFC Doses of Twinrix. So, there is no 3rd party payor to bill. If they have Medicaid or Insurance they would need to receive private stock of Twinrix and follow your normal billing procedures. If these persons are covered by the ****Be Smart Family Planning Program—they are considered UNinsured for our purposes and would be eligible for the VFC Twinrix.
  - VFC Eligibility must take place at each visit so if they were on Medicaid for dose #1 they were not eligible for a VFC dose on that date of service. When they return for dose #2—they have lost their Medicaid and are now Uninsured—on that date of service they are VFC eligible and would get a VFC dose. (see excerpts from the Coverage Criteria below)

VACCINE	AGES COVERED	Cohort	ELIGIBITY CRITERIA FOR NCIP VACCINE USAGE
HepA/HepB Combination (Twinrix)	≥18 years	UNINSURED ADULT USE	**LHD/FQHC/RHC Only**: Any uninsured adult who meets one or more of the ACIP recommended coverage groups can receive a three-dose series of the combination Hep A/Hep B vaccine at the local health department or at Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). State-supplied Hep A/Hep B vaccine cannot be used for the accelerated schedule, four dose series **or** for persons with a documented history of a completed hepatitis A or B series.

- **** **LHD/FQHC/RHC only:** Persons covered by the Be Smart Family Planning Program are considered uninsured and may receive certain state-supplied vaccines as noted in this coverage criteria for uninsured adults if receiving services at a Local Health Department, Federally Qualified Health Center, or Rural Health Clinic.
- And this is the guidance from 2009 about LHD's being able to charge out of pocket admin. fees (see attached Billing Brief for the full document)

- A change in state law allows local health departments (LHDs) to charge the patient an out-of-pocket administration fee for state-supplied vaccine **unless:**

- the patient is uninsured or underinsured, **and**
- the family income is below 200% of the federal poverty level.

- If these two conditions apply, the patient's administration fee must be waived.

- If the LHD chooses to charge an out-of-pocket administration fee for state-supplied vaccine, the **maximum** amount is based on the state Medicaid rate on the date of service. LHDs should check the LHD rate table provided annually by the DPH. Patients who state an inability to pay should have the administration fee waived.

- If the LHD's do charge out of pocket fee to those that are not excluded by the criteria above—they can charge it for each vaccine at each visit. (see the attached Billing Brief- Elizabeth Draper is now the contact and not Janie Ward-Newton- contact information below).

  Elizabeth Tatum Draper, RN
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  Excerpts from LHD Agreement:

  6. I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $20.45 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.

  7. I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.

  - As far as the criteria for who can receive the vaccine in clinical terms—they need to refer to the Hepatitis A and Hepatitis B Chapters in the Pink Book—which ever adults that ACIP states needs Hep A/Hep B vaccines are eligible for the VFC doses if they are uninsured. It is no

longer restricted to the criteria in the 2008 memo. We always recommend to follow ACIP recommendations.

- https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/hepa.pdf He p A Chapter page 144

Twinrix

- Combination hepatitis A vaccine (pediatric dose) and hepatitis B (adult dose)
- Schedules
  - 0, 1, 6 months, or
  - 0, 7, 21to 30 days and a booster dose 12 months after first dose
- Approved for persons 18 years of age and older

Persons at Increased Risk for Hepatitis A or Severe Outcomes of Infection

- International travelers
- Close contact with an international adoptee from a country of high or intermediate endemicity
- Men who have sex with men
- Persons who use illegal drugs
- Persons who have a clotting factor disorder
- Persons with occupational risk
- Persons with chronic liver disease
- Healthcare workers: not routinely recommended
- Child care centers: not routinely recommended
- Sewer workers or plumbers: not routinely recommended
- Food handlers: may be considered based on local epidemiology

https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/hepb.pdf Hep B Chapter page 164

Adults at Risk for HBV Infection

- Sexual exposure
  - sex partners of HBsAg-positive persons
  - sexually active persons not in a long-term, mutually monogamous relationship*
  - persons seeking evaluation or treatment for a sexually transmitted disease
  - men who have sex with men
- Percutaneous or mucosal exposure to blood
  - current or recent IDU
  - household contacts of HBsAg-positive persons
  - residents and staff of facilities for developmentally disabled persons
  - healthcare and public safety workers with risk for exposure to blood or blood-contaminated body fluids
  - persons with end-stage renal disease
  - persons with diabetes mellitus
- Other groups
  - international travelers to regions with high or intermediate levels (HBsAg prevalence of 2% or higher) of endemic HBV infection
  - persons with HIV infection

*persons with more than one sex partner during the previous 6 months

For information regarding consent/authorization for immunizing minors, please refer to: http://www.sog.unc.edu/publications/bulletins/immunizations-children-and-adolescents-frequently-asked-questions-about-north-carolinas-laws

For additional program guidance, please contact your Regional Immunization Consultant or visit the program website at http://www.immunize.nc.gov/providers/index.htm

Sexually Transmitted Diseases

STD Clinical Coverage Policy- Treatment in Local Health Department
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1d2.pdf

1. The following Physician or Advanced Practice Practitioners in a LHD setting are eligible to provide STD services:
   - Physician (billed by E/M codes)
   - Nurse Practitioner* (billed by E/M codes)
   - Physician Assistant* (billed by E/M codes)
   - Enhanced Role Public Health Nurse (billed by T1002 to Medicaid; 99211 or T1002 to private insurance).

   ***Advanced Practice Practitioner**

   Every Physician or Advanced Practice Practitioner should receive an orientation to the STD Program and agree to provide services according to DPH STD Program guidelines.

2. Currently Rostered STD Enhanced Role Registered Nurses (STD ERRN) who have completed the STD Enhanced Role training course, may 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 or T1002 with the client's permission.
3. T1002 is billed in units. One unit = ERRN services for each full 15 minute increment. 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 or if no treatment is necessary. Service components include the following:
   a. Provide essential STD services which are defined as:
      - medical history,
      - sexual risk assessment,
      - a physical examination inclusive of the upper and lower body,
      - laboratory testing,
      - treatment (as needed),
      - counseling and referral necessary for the evaluation of individuals with an exposure to, or symptoms suggestive of, a sexually transmitted infection.

   b. In the public health setting, essential STD services would include primary prevention such as STD screening in asymptomatic clients based upon the client's site(s) of exposure.

c. 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 additional units are needed (beyond 4), refer to STD Clinical Coverage Policy for instructions.

4. If during a Child Health, Family Planning/Be Smart, Maternity or other program visit the Physician or Advanced Practice Practitioner 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 the program in which they were evaluated and/or treated (per CD Branch).

5. At the current time, most STD services cannot be charged to the client but can be charged to Medicaid and other third-party payers with the client's permission. If you bill insurance, you must use 99211 or T1002 for a nurse visit or a higher E/M code for Physician or Advanced Practice Practitioners. 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 not required by the DPH STD Program.

   Exceptions include:
   - You may charge a patient for any STD lab the patient requests that is not offered through NC SLPH. For example, the SLPH does not offer Chlamydia testing for males. Therefore if the patient requests the testing through a private lab, they can be charged.
   - Past legal guidance has stated that "screening and diagnostic testing still falls within the guidelines 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." If you have additional questions, please contact your PHNPDU Consultant.
   - Asymptomatic clients who request screening for non-reportable STDs (e.g., herpes serology, ~~Hepatitis C, BV~~)

- Clients who receive follow-up treatment of warts after the diagnosis is established.

6. 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 cannot bill for the services provided. *(By Agreement Addenda it is preferred that STD ERRN 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).* 7.
7. Physicians or Advanced Practice Practitioners should bill Medicaid and may bill third party payers (with the patient's permission) using the appropriate E/M codes for the level of service provided. Third party payers (Medicaid and private insurance) can be charged for STD services. *NOTE that in this case 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*.
8. Billing when two different Physician or Advanced Practice Practitioners (different NPI numbers) see client same day:
   a. When a client receives STD services billed with E/M or T1002 code and is also seen by another health department Physician or Advanced Practice Practitioner on the same date of service for a separately identifiable medical condition, the health department may bill both visits. There must be a separate diagnosis code and E/M code for the second procedure. No modifier is required in this circumstance since there are two separate Physician or Advanced Practice Practitioners involved (with two NPI numbers).

9. Billing Preventive and E/M visits to Medicaid on the same day
   a. Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (see exception). The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology. You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to Child Health Section, item F for changes from the 2016 Health Check Program Guide*
   b. If a client is seen by a Physician or Advanced Practice Practitioner for STD services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day,** and it is not a duplicate billing

c. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN in order to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across two different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals a full 15 mins.) of care provided.

d. STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.

e. The non- STD ERRN may bill insurance using 99211 ~~or T1002~~ for STD treatment only visits. Non-STD ERRNs may not bill ~~Medicaid~~ for STD treatment only visits

f. TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.

11. Additional Billing Scenario:

- When a "Be Smart" client is scheduled for the STD ERRN visit and upon interview thinks she has "BV again", can the client be switched to Physician or Advanced Practice Practitioner schedule and charged for the clinic visit? We do not recommend switching the client to the Physician or Advanced Practice Practitioner. You should:
  - See the client in STD clinic but do not bill "Be Smart".
  - If you switch a "Be Smart" client to a Physician or Advanced Practice Practitioner schedule, it will count towards the 6-visit limit for the year.
  - ***Keep in mind that if you use 340B drugs to treat non-reportable STDs this may significantly reduce your supply of 340B drugs available to treat clients that the health department is mandated to treat.***

12. Human Papilloma Virus (HPV):

a. Once HPV is diagnosed (in any clinic), the health department can see the patient and treat them in any appropriate clinic, and you can charge at that point for the treatment of HPV.

b. If the only reason you are seeing the patient for is the treatment of HPV, you can either bill the HPV treatment CPT or an E/M code, but not both.

c. If you are providing additional services that are unrelated to HPV treatment that would warrant an E/M code, then you could bill with the treatment CPT code and the E/M and append the -25 modifier to the E/M code. To bill for both services, the visit and documentation must meet all criteria for both CPT codes.

d. HPV treatment is billable to clients if they do not have Medicaid or prefer that their insurance not be billed. HPV is not a reportable STD and therefore does not fall under the "not billable to clients" stipulation.

e. An STD ERRN can apply TCA (HPV treatment) as long as the lesion they are treating has been diagnosed as a genital wart by a provider in that health department AND the STD ERRN has been adequately trained, observed, and signed off by a provider in that health department AND a standing order is current, signed, dated, etc. STD ERRN do not receive training on applying TCA in the STD ERRN Course.

12. STD Services Not Billable to Patients: please see memo from then Assistant Attorney General John Barkley, dated August 31, 2001 (Appendix C) regarding this topic.

STD LABS

<u>If the NC SLPH does not provide a test, insurance can be billed with the patient's consent and patients without insurance or who do not want to file with their insurance can choose to pay out of pocket if the LHD has policy to support it.</u>

1. 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 LHD 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.
2. <u>Modifiers with Labs</u>

   Valid billing with a modifier:
   - <u>Modifier-59:</u> Distinct Procedural Service, different site or organ system, for example, multiple sources collected for screening culture GC (modifier -59)
   - <u>Modifier-90:</u> Specimen sent to a reference laboratory for processing.
   - <u>Modifier-91:</u> Repeat Clinical Diagnostic Lab test. **Note:** This modifier may not be used when tests are:
     - **a)** rerun to confirm initial results;
     - **b)** due to testing problems with specimens or equipment;
     - **c)** for any other reason when a normal, one time, reportable result is all that is required.

   For example, when a Physician or Advanced Practice Practitioner requests a test be repeated on the same day. Modifier-91 indicates that it is not a duplicate billing.

Effective Jan. 1, 2015, four new modifiers more effectively identify **distinct services that are typically considered inclusive to another service**. Utilizing these modifiers will help with more accurate coding that better describes the procedural encounter. These modifiers are appropriate for NCCI procedure-to-procedure edits only

- **XE – Separate Encounter**: A service that is distinct because it occurred during a separate encounter.
- **XS – Separate Structure**: A service that is distinct because it was performed on a separate organ/structure.
- **XP – Separate Practitioner**: A service that is distinct because it was performed by a different practitioner.
- **XU – Unusual Non-Overlapping Service**: The use of a service that is distinct because it does not overlap usual components of the main service.

If you receive denials when using these "X" modifiers, continue to rebill the claims until current issues between DMA and NCTracks and electronic health record vendors can be resolved. We have been advised that that billing via the NCTracks portal works for these modifiers.

Use of these modifiers vs. modifier 59:

Do not use one of these modifiers with modifier 59 on the same claim line. According to CPT guidelines, modifier 59 should be used only when no other descriptive modifier explains why distinct procedural circumstances exist. Therefore, these new modifiers should be used instead of modifier 59 to describe why a service is distinct.

Medicaid will continue to accept modifier 59 when the X {ESPU} modifiers do not accurately describe the encounter. Documentation must support the use of modifiers.

"OB" Modifier- Beginning July 1, 2016, if you report or bill with a zero $0 charge office visits that are associated with an OB package code or OB global package code, please use the "OB" non-standard modifier for these OB office visits.

Miscellaneous Billing Guidance:

1. At the current time, Medicaid only reimburses for STD services provided in the home setting when it is an extension of the clinical services. Use "71" as place of service.

2. The Q&A from the July 26 & 27, 2017 Coding & Billing Guidance Document Webinar- STD/CD/TB is posted on the DPH/LHD website at http://publichealth.nc.gov/lhd/ under the Documentation & Coding header.
3.

For additional program guidance, please contact your Regional STD/Communicable Disease Consultant or visit the program website at http://epi.publichealth.nc.gov/cd/lhds.html

Tuberculosis Control & Treatment

Clinical Coverage Policy- Tuberculosis Treatment in Local Health Department
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1d3.pdf
(guidance below as per TB Consultant 9-14-15)

1. The following Physician or Advanced Practice Practitioners in a LHD setting are eligible to provide TB service:
   - Physician (billed by E/M codes)
   - Nurse Practitioner* (billed by E/M codes)
   - Physician Assistants* (billed by E/M codes) Public Health Nurses* (billed by T1002 or reported by use of the appropriate LU code)
   - Public health nurses (RNs) supervised by the public health nurse (RN) who is responsible for the TB Control Program and shall complete the Introduction to Tuberculosis Management course.

   ***Advanced Practice Practitioner**

2. TB Disease or Contacts:

a. Per GS 130A-144 "the local health department shall provide, at no cost to the patient, the examination, and treatment for tuberculosis disease and infection..." As a result, TB services that deal with the examination and treatment of TB must be free or if billed to Medicaid or a third-party payer the LHD must assure that the patient is not being billed for anything. This becomes problematic because most insurance companies have in their contract with the health department that they must collect co-pay from the insured patient. Medicaid does not require that a co-pay be collected due to this law. If you bill private insurance, then you would need to negotiate the copay issue with the insurance company.

b. 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 guidance 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 LU121 or LU122). If your IT system does not accommodate the use of the LU Codes, please consult your vendor for further guidance. 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 = a full 15 minutes. Procedure code T1002 cannot be billed on the same day that a preventive medicine service is provided.

c. 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 TB service components provided should support the number of units billed.
d. Clients that are contacts to TB or are symptomatic <u>cannot be charged</u> for a TB skin test. Clients who need a TB skin test for reasons of employment or school <u>may be charged</u> if the health department uses purchased supply. (Reading the TB SKIN TEST is included as part of the total charge)
e. 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 TB SKIN TEST should go under the program that the client is in. The basic rule is that the TB SKIN TEST was then related to the program that brought the client in and is determined by the purpose of the visit.
f. To be able to separate purchased vs. state supplied TB SKIN TEST, use the LU114 code for state supplied TB SKIN TEST (report only) and the CPT code 86580 for purchased TB SKIN TEST, which can have a charge attached. If your vendor is unable to support the use of LU codes, you may need to work out a different mechanism for reporting state supplied TB SKIN TEST.
g. If the client has private insurance and an RN is providing monthly assessments, you can bill private insurance with the client's permission using 99211 or T1002 provided the components to support the 99211 or T1002 are necessary and documented. Other Physician or Advanced Practice Practitioners eligible to bill private insurance would use the appropriate E/M code for the level of service, provided the components to support the E/M code are necessary and documented.
h. When a client receives a billable TB service (billed using an E/M code) and is also seen by the **same health department Physician or Advanced Practice Practitioner** 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 that correlates to the primary reason for their visit to the

health department. If the client is seen by a different health department Physician or Advanced Practice Practitioner on the same date of service …… no 25 modifiers is needed.

i. It is permissible to bill for TB services rendered in the home for clients unable to come to clinic due to their disease. These services would be billed using the T1002 code with the appropriate number of units and Place of Service Code-71 Public Health Clinic. You must use the 71 as Medicaid does not have the T1002 code identified for Place of Service Code 12- Home. (as per Julie Luffman and Phyllis Rocco 2/17)

j. Billing Preventive and E/M visits to Medicaid on the same day
   1. Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (see exception). The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology. You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to Child Health Section, item F for changes from the 2016 Health Check Program Guide*.
   2. If a client is seen by a Physician or Advanced Practice Practitioner for STD services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing
   3. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.
   4. ~~**STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.**~~
   5. ~~**The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.**~~
   6. **TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.**

3. <u>TB Skin Test (TST) and Interferon Gamma Release Assays (IGRA's) for Employment, College or other non-mandated reasons</u>

a. Clients who need a TST or IGRA for reasons of employment or school may be charged if the health department uses purchased supply. (Reading the TB skin test is included as part of the total charge.) It is preferable to use symptom and risk screening questionnaires in lieu of placing a skin test for low risk individuals and to place the skin test or obtain an Interferon Gamma Release Assay (IGRA) if the person responds yes to any of the questions. IGRA's are preferred in this situation.
b. TST's and IGRA'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 does not have a required sliding fee scale.
c. If the only service that a client comes in for is a skin TST or IGRA 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 TST or IGRA, then that TST or IGRA should go under the program that the client is seen in. The basic rule is that the TST or IGRA was then related to the program that brought the client in and is determined by the purpose of the visit.
d. TB skin tests 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 does not have a required sliding fee scale.
e. 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 TB skin test should go under the program that the client is seen in. The basic rule is that the TB skin test was then related to the program that brought the client in and is determined by the purpose of the visit.

Communicable Disease

1. 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 using the appropriate CPT Ccde, and there are LU codes that can be used to report activities that don't fit into a CPT code.
2. EPI services cannot be charged to the client but if a clinical service is provided that is a billable service Medicaid may be charged. Other third-party payers may be charged with permission from the client.

For additional program guidance, please contact your Regional Communicable Disease Consultant or visit the program website at http://epi.publichealth.nc.gov/cd/lhds.html

Women's Health

Maternity/OB Billing

Clinical Coverage Policy- Obstetrics 1E-5
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf
Clinical Coverage Policy- Pregnancy Medical Home 1E-6
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E6_1.pdf
Fetal Surveillance 1E-4
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E4_1.pdf

1. Maternal Health (prenatal) clients may have health department prenatal services paid for in a variety of ways. Those include Medicaid, Medicaid for Pregnant Women (MPW), Presumptive Eligibility (PE), third party insurance, or self-pay (client pays for services). Details on how each of these is handled should be outlined in the health department Fee & Eligibility Policies & Procedures.

2. Medicaid for Pregnant Women
   Female recipients of all ages with Medicaid for Pregnant Women (MPW) coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that—in the judgment of their physician—may complicate pregnancy. The eligibility period for MPW coverage ends on the last day of the month in which the 60th postpartum day occurs. Not all clients will be eligible to receive MPW benefits; however, they may be eligible for Presumptive Eligibility (also a Medicaid program)

3. Presumptive Eligibility
   Presumptive Eligibility (PE) allows for a pregnant woman who is determined by a qualified Physician or Advanced Practice Practitioner to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined. Presumptive Eligibility extends from the date of approval through the end of the following month. For example, if a client applies for PE on 9/15/15 and is approved, they will be eligible through 10/31/15.

Presumptive eligibility should be completed as early as possible for all women with positive pregnancy tests. ***Applying for PE at the health department allows the client to attest to income.*** Language in the Maternal Health Agreement Addenda has been updated to include completion of presumptive eligibility determination early in pregnancy to ensure access to prenatal care services as soon as possible. Please see NCAPHNA WHNC Fall 2015 Report excerpt below:

Presumptive Eligibility – Email sent 9/28/15 from the Women's Health Branch to Local Health Directors

"As shared during the August Core Public Health Meeting, the FY15-16 Maternal Health Agreement Addenda includes the following language: "Completion of presumptive eligibility determination AND referral for Medicaid eligibility determination for all pregnant women, not just those who will remain in the Local Health Department for prenatal care services". This language has been included in previous agreement addenda with the exception of OR was replaced by AND.

The purpose of this language is to help ensure that pregnant women have access to prenatal care services as soon as possible in their pregnancy. This is regardless of their payer source. Note that the state's overall first trimester entry into prenatal care numbers are moving in the negative direction; fewer women are accessing prenatal services early in their pregnancy. The goal is to reduce this barrier to care for all pregnant women. Please make sure that completion of presumptive eligibility determination and referral for Medicaid eligibility determination is completed as early as possible for women accessing prenatal care services. "

4. Third Party Insurance

   Some health departments file third party insurance for many (if not all) of their services. This varies by health department and may depend on whether or not they participate (are in network) or do not participate with specific insurance carriers. Third party insurance is always billed at 100% of the charge, and any remaining balance (minus copays) is billed to the client based on where they fall on Sliding Fee Scale.

5. Self-Pay Clients

   Clients who do not have Medicaid, Presumptive or third-party insurance will have charges assessed based on their financial eligibility and where they fall on the Sliding Fee Scale.

6. Package vs Individual service billing

   Health Departments that do not provide full scope OB care must bill for antepartum 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 E/M 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 before delivery, or
  c. the recipient is seen by a Physician or Advanced Practice Practitioner between one (1) and three (3) office visits as specified in **Clinical Coverage Policy- Obstetrics**
  https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf

- As of 3/1/2012 *self-pay clients* seeking prenatal care from a LHD 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.
- LHDs cannot bill the prenatal package for visits until the client delivers, transfers care to another Physician or Advanced Practice Practitioner 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.
- If there was no pre-defined high-risk condition, then the termination of pregnancy date should be used as the end date/delivery date. This low risk pregnancy may be billed with a package code if four or more visits were completed before the termination. If less than four visits were provided an E&M code can be billed for each visit. If the client was previously diagnosed with a high risk condition this pregnancy all visits could be billed with E&M codes, *provided the documentation supports high-risk status based on the diagnosis and more than normal number of visits for the client's gestational age.
- If your agency keys Prenatal Visits as reportable services and uses the OB modifier (so they can be pulled out of the Medicaid Cost Study), the OB modifier goes on all services including labs that are included in the package billing, per Steven Garner.
  - If the labs are included in the package billing code, then "yes" they need an OB modifier.

- If the labs are not included in the package billing code and Medicaid pays for them separately, then "no" they do not need an OB modifier.

- Billing for Non-Stress Testing: If the provider reads the test while in your agency and is not submitting a separate billing for the reading of the test (26 modifier), then submit the 59025 without any modifier which would mean the health department is billing for the professional and technical component.

  The 59025 CPT code for non-stress testing can be separated into the professional and technical components for billing using modifiers.
  The modifier 26 is appropriate when the physician supervises and/or interprets a diagnostic test, even if he or she does not perform the test personally. Appending modifier TC *Technical component* indicates that only the technical component of a service/procedure has been provided. Generally, the technical component of a service/procedure is billed by the entity that provides the testing equipment.
  Your agency would bill 59025-TC for performing the test and the physician would bill 59025-26 for interpretation.

7. **Modifier -24 Complications of Pregnancy, Unrelated Issues**
   If a patient develops complications of pregnancy or the **provider treats the patient for an unrelated problem,** these visits are excluded from the maternity global package and can be reported separately. Append modifier 24 *Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues. Modifier 24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package

   Note: This can be a service provided in the office and is not specifically related to hospital services/care. These services must be billed after the OB package code is billed.

8. 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. Remember that PMH services must be billed under a rendering Physician or Advanced Practice Practitioner identified on the CCNC contract.

9. Billing for PMH services:

Incentive code S0280: Physician or Advanced Practice Practitioners shall bill this incentive code after the pregnancy risk screening tool has been completed.

Incentive code S0281: Physician or Advanced Practice Practitioners shall bill this incentive code after the postpartum visit is completed. The Physician or Advanced Practice Practitioner billing S0281 must be the same Physician or Advanced Practice Practitioner that bills the postpartum visit. DMA will only pay this incentive if an OB package code that includes postpartum care,* is billed. **In order for Physician or Advanced Practice Practitioners to receive reimbursement for incentive code S0281, they must bill within 60 days of the date of delivery.**

OB package and global codes that include postpartum care are as follows:

- **59400** – Global fee-Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care;
- **59510** – Global fee-Routine obstetric care including antepartum care, cesarean delivery, and postpartum care;
- **59410** – Postpartum package-Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care;
- **59515** – Postpartum package- Cesarean delivery only; including postpartum care, ***or***
- **59430** – Postpartum care only (separate procedure**). *typically used by most health departments due to not providing delivery.**

<u>Billing Scenarios for Postpartum Care & PMH</u>:

1. Patient who received a bilateral tubal ligation at the time of delivery returns to the LHD within 60 days of delivery for her postpartum visit in the Maternal Health clinic. There is no contractual arrangement for the LHD to bill for the delivery. Therefore, the LHD bills **59430** for the postpartum package and **S0281** for the PMH postpartum incentive, along with diagnosis code **Z39.2**. (AF modifier no longer required – do not use or you will not be paid). Service must be billed under the rendering physician name on the Pregnancy Medical Home contract with Community Care of NC (CCNC).
   If after 60 days postpartum, HCPCS code S0281 will not be reimbursed but the client may return for the postpartum visit using CPT code 59430 under MPW until the end of the month that the 60th postpartum day falls.

2. Patient returns to LHD within 60 days of delivery for her postpartum visit. She needs to begin a contraceptive method and is seen in the Family Planning

Clinic. Patient receives a Depo-Provera injection. LHD bills **59430** for the postpartum package, **S0281** for the PMH postpartum incentive with diagnosis code **Z39.2.** The depo injection **J1050 FP UD** billed with diagnosis **Z30.013** (initial injection) or **Z30.42** (surveillance of injection if the depo was provided at the hospital post-delivery).

3. Patient returns to LHD within 60 days of delivery for her postpartum visit. Patient has an IUD inserted at the postpartum visit in the Family Planning Clinic. The LHD can bill **59430**, **S0281** and **codes for the contraceptive device and insertion**. Billing is as follows:
   - "25" modifier cannot be used with the insertion code (58300) when 59430 is billed because 59430 is a package code.
   - The FP modifier must be used on the contraceptive device and insertion code 58300, if the LHD is using 340 B stock.
   - The Physician or Advanced Practice Practitioner must include an appropriate diagnosis code for the contraceptive method and method counseling.

   LHD bills **59430** for the postpartum package and **S0281** for the postpartum incentive with ICD-10 **Z39.2**. Also bill **58300 FP** for the IUD insertion with ICD-10 of **Z40.30** and the appropriate HCPCS code for the IUD. (**J7300 FP UD** for the ParaGard IUD, **J7301 FP UD** for the Skyla IUD, **J7297 FP** for the Liletta IUD **J7298 FP UD** for the Mirena IUD).

4. Incision Checks: If the agency is a Pregnancy Medical Home, they should not be billing separately for the incision checks or any other routine postpartum care they provide, since the 59430, billed with S0281 at the time of the comprehensive postpartum visit, represents a "package" of postpartum services and not a single visit. An incision check would be included in the 59430 package.

   For example, if the patient comes in for an incision check and then a BP check and then an MMR or Varicella vaccination before her "comprehensive postpartum visit," all those visits are covered by the 59430. Only the vaccinations/administration codes would be billed separately.

   For agencies that deliver babies and bill prenatal, intra-partum, and postpartum care with global codes, an incision check would be included in the global package as well.

Postpartum Care Services: Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs based on DMA Clinical Coverage Policy 1E-5"Obstetrics" https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf

5. This is when MPW coverage ends. Beneficiaries in other categories of Medicaid coverage may still be able to receive postpartum follow-up care after the end of the month which the 60th postpartum day occurs.
6. Postpartum visit now = AED for "Be Smart"!

   Patients who have their postpartum visit while insured under Medicaid for Pregnant Women (MPW) sometimes enroll in "Be Smart" Medicaid when their MPW expires. In the past these patients needed an annual exam appointment after their postpartum visit to meet "Be Smart" billing requirements. "Be Smart" claims require that the annual exam date (AED) be documented to be reimbursed for contraceptive and other services provided under this coverage.

6. Effective October 1, 2015, (per WH Consultants) DMA will now allow the CPT code 59430 (postpartum package code) to meet the annual exam date (AED) requirement for the "Be Smart" program. Physician or Advanced Practice Practitioners can list the date of the postpartum visit as the AED on "Be Smart" claims. DMA will include this change in a pending Medicaid Bulletin article (not published as of 2/1/16).
7. Additional information from DMA regarding postpartum home visit after miscarriage:

- The pregnant woman is eligible through the post partum period without a redetermination of eligibility.
- The post partum period is at least 60 days following termination of the pregnancy **for any reason.**
- The post partum period ends on the last day of the month in which the 60th day falls. For example, the delivery occurs on June 10. The post partum period ends on August 31.
- Exceptions to the post partum eligibility are:
  a. The pregnant woman moves to another state with the intent to live there on a permanent basis.
-

  b. The pregnant woman is an alien eligible only for emergency services.
  c. The pregnant woman is found eligible only for presumptive eligibility.
  d. The pregnant woman applies after the termination of the pregnancy, her income exceeds the MPW Poverty Level, and she is MAF-M.

Additional Clarification- end of Postpartum coverage

MPW coverage extends to the last day of the month in which the 60th postpartum day falls. Example: Patient delivers a baby on May 15, 2017. 60th postpartum day is July 14, 2017. MPW coverage extends through July 31, 2017. A postpartum exam that occurs on or before July 31, 2017 will be covered by MPW.

The postpartum incentive code, S0281, is only paid for postpartum visits that occur within 60 days postpartum. In the example above, if the patient is seen for her postpartum visit on July 10th, the PMH practice can bill for the 59430 postpartum package AND the S0281 incentive code. If, however, the patient is not seen for her postpartum visits until July 20th, the 59430 postpartum package would be covered because the MPW extends through to the last day of the month in which the 60th postpartum day occurs, but the S0281 would not be covered because the patient was more than 60 days postpartum at the time of the postpartum visit.

For additional guidance, please see Pregnancy Medical Home Clinical Coverage Policy at http://www.ncdhhs.gov/dma/mp/1E6.pdf

- Most health departments bill using package CPT codes (59425 or 59426) following delivery. Since it is not unusual for a maternity client to be seen by more than one Physician or Advanced Practice Practitioner during her pregnancy, it is recommended that the agency use the NPI of the last Physician or Advanced Practice Practitioner seen by the client. Agencies billing using global codes that include delivery should bill under the delivering physician. Just a reminder that prenatal care billed using E&M codes should reflect the NPI number of the Physician or Advanced Practice Practitioner who saw the client at each individual visit.

10. Billing Preventive & E/M visits to Medicaid on the same day:

a) Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (*see exception*). The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology. You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to Child Health Section, item F for changes from the 2016 Health Check Program Guide* https://dma.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt

If a client is seen by a Physician or Advanced Practice Practitioner for STD services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing.

b) Modifier -24 Complications of Pregnancy, **Unrelated Issues**
If a patient develops complications of pregnancy or the **provider treats the patient for an unrelated problem,** these visits are excluded from the maternity global package and can be reported separately. Append modifier 24 *Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues. Modifier 24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package. Note- these services must be billed after the OB package code is billed.

For example: A prenatal patient presents to clinic with strep throat. This is unrelated to the pregnancy and the E&M visit may be billed using the -24 modifier. Note: this can be a service provided in the office and is not specifically related to hospital services/care.

c) Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals a full 15 mins.) of care provided.

d) STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.

e) **The non- STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.**

f) TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.

11. HMHC/Title V (Well Child funding):

Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly

or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service. (as per Peter Anderson, WCH Acting Section Chief).). This means that all services for children MUST slide using the appropriate SFS.

12. Birthing Classes

Refer to **Birthing Classes-Clinical Coverage Policy 1M-2**
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1m2.pdf

13. Smoking and Tobacco Use Cessation and Counseling

- The Physician or Advanced Practice Practitioner can bill CPT code 99406 if at least 3-10 minutes of counseling has been provided to the client.
- The Physician or Advanced Practice Practitioner can bill CPT code 99407 if greater than 10 minutes of more intensive counseling has been provided to the client.
- Note: Counseling cannot be billed if provided to the parent/guardian instead of the client.
- Local health departments can bill for these services (except in the *Be Smart* Program) when provided by an RN who has demonstrated competence in tobacco cessation counseling. These services are being provided under the supervision of the MD, NP or PA. For more information go to http://www.ncpublichealth.com/lhd/ and click under Tobacco Cessation.

In order for RNs to bill for tobacco cessation screening and counseling the following requirements apply:

1. **Complete a qualified 5A's tobacco cessation training program.** A list of training options is available at the Division of Public Health website http://publichealth.nc.gov/lhd/.
2. **Provide a Certificate of Training Completion** to their agency. The agency is responsible for maintaining this list for audit purposes.
3. **Operate Under Standing Orders** – Each local health department must develop Standing Orders. A sample template for Tobacco Cessation Counseling Standing Orders is available at http://publichealth.nc.gov/lhd/.

14. Vaccines administered during prenatal care or during the postpartum period:

- The only vaccines that are recommended to be routinely administered during prenatal care are Influenza and Tdap. These vaccines may be

billed during a routine prenatal visit using an administration code (90471) and the vaccine code itself as per immunization program rules.

- If the agency is billing a Pregnancy Medical Home package or global code for services, **report the office visit (E&M CPT code) using the "OB" modifier and only bill the vaccine administration code and the immunization specific code.**
- If the client is self-pay or Medicaid is billed using individual E&M codes, the agency can bill the office visit (E&M code), an administration fee and the vaccine code. Self-pay clients will be billed on sliding fee scale
- MMR and Varicella are both only administered postpartum as they are live vaccines. If the postpartum visit is provided in Family Planning or Maternal Health it is required that staff assess for immunization compliance and refer to immunization clinic for recommended vaccines.
- If the patient came to clinic only to receive an immunization, not to receive routine prenatal care, then it would make sense for the agency to bill an administration code with the vaccine code.
- If Rhogam and 17P are administered during a routine prenatal visit, then the agency may bill the therapeutic injection code (96372) and the HCPCS code for Rhogam. Rhogam (J2790- full dose or J2788 - mini dose) or 17P (J1725). If the agency received the 17P free it cannot be billed to the client or third-party payor. Only bill for 17P if the agency is purchasing the medication.

    - If the agency is billing a Pregnancy Medical Home package or global code for services, **report the office visit with the "OB" modifier and only bill the injection code and the medication specific CPT code.**
    - If the client is self-pay or Medicaid is billed using individual E&M codes, the agency can bill the office visit (E&M code), an administration fee and the vaccine code. Self-pay clients should be billed on sliding fee scale.

- For health departments that do not provide prenatal care or are not the assigned pregnancy medical home, but administer 17P by physician order, services delivered may be billed. The 17P medication cannot be billed to the client or third-party payor if received free by the local health department. Only bill for 17P if the agency is purchasing the medication. The recommended billing process is as follows:

- The therapeutic injection administration (96372) and 99211 nurse office visit CPT codes cannot be billed on the same day of service. Either bill the therapeutic injection administration or the office visit along with the 17P medication. In order to bill the 99211 CPT code for a nurse office visit, documentation must support a nursing assessment.
- The agency may bill a 99211 CPT code if a nursing assessment is completed along with the 17P medication CPT code (J1725).
- If there is not documentation to support a nursing assessment, then bill a therapeutic injection fee (96372) and the 17P medication (J1725).
- The health department cannot bill a prenatal package code (59425 or 59426) if the RN provided multiple visits for 17P injections with documentation to support billing a 99211 CPT code. This service must be billed with the 99211 CPT code each visit because the agency is not the assigned prenatal care provider. The 17P medication is also billed at each visit if purchased by the health department. **Again, the therapeutic injection (96372) and 99211 CPT codes cannot be billed on the same day of service**.

For additional program guidance please contact your Regional Maternal Health Consultant or visit the program website at http://whb.ncpublichealth.com/. Additional guidance on coding & billing is contained in the following document Maternal Health Billing and Coding Webinar - May 12, 2017 located at N.C. DPH: WHB: Training

Family Planning

Clinical Coverage Policy- Family Planning/Be Smart 1E-7
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E-7.pdf

1. General Tips regarding Family Planning Billing

a. Specific Criteria Covered by Medicaid FP, NCHC and "Be Smart":

Medicaid FP, NCHC and "Be Smart" shall cover family planning services, nurse midwife, or nurse practitioner, or furnished by or under the physician's

supervision. Family planning services include laboratory tests, and FDA-approved methods, supplies, and devices to prevent conception, as follows:

1. The "fitting" of diaphragms;
2. Birth control pills;
3. Intrauterine Devices (IUD's) (including Mirena, Paragard, Liletta and Skyla);
4. Contraceptive injections (including Depo-Provera);
5. Implantable contraceptive devices;
6. Contraceptive patch (including Ortho Evra);
7. Contraceptive ring (including Nuva Ring);
8. Emergency Contraception (including Plan B and Ella);
9. Screening, early detection and education for Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS);
10. Treatment for STIs; and
11. Lab services (refer to **Attachment A, Section C, Item 1 of the Clinical Coverage Policy)**

b. Sliding fees apply to all FP services according to Family Planning Program guidelines.
c. If a local health department has not been approved to offer pregnancy testing under "Other Services" using a flat fee, and if they offer pregnancy testing in General Clinic and/or Family Planning clinic, then they must offer pregnancy testing on the Sliding Fee Scale.
d. Family planning diagnosis (DX) codes Z30.0 –Z30.9 (except Z30.8) must be the 1st Dx for all Medicaid clients when family planning services are provided (except postpartum exams); you may use Z01.41 Gynecological exam for private insurance.
e. If the client has Medicaid and is receiving postpartum clinical follow-up in the FP clinic, instead of an E/M or preventive code; use the routine postpartum follow-up CPT code 59430 (postpartum exam) and S0281 (postpartum incentive code) if the is a Pregnancy Medical Home without any modifiers and pair with the Z39.2 diagnosis. The Family Planning diagnosis is coded second using the appropriate ICD-10 (Z30.0 – Z30.9, except Z30.8) diagnosis code along with the appropriate CPT code for the method provided, using both the FP and UD modifiers
f. Providers may bill (both regular Medicaid and "Be Smart" Family Planning Medicaid) for both insertion/removal of an intrauterine device or contraceptive implant and an E/M office visit if there is a separate, identifiable issue that would warrant an office visit. The office visit is billed with a 25 modifier, and the ICD-10 diagnosis must support the reason for billing the additional office visit with an additional diagnosis other than contraceptive insertion. Beneficiaries covered under "Be Smart" are only eligible for family planning services as described in DMA's 1E-7 Clinical Coverage policy, and are not eligible for any other Medicaid program.

g. **Annual exam & IUD:** If during an annual exam, the beneficiary requests an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), or during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and the IUD insertion or IUD removal. An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service. The provider's documentation should support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

h. **Inter-Periodic Visit & IUD:** If the only reason that the beneficiary is seen in the office is to request an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), providers should not bill a separate inter-periodic office visit. An office visit component is included in the reimbursement for CPT procedure codes 58300 and 58301. However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the inter-periodic visit and the IUD insertion or IUD removal. The provider's documentation should support that the service rendered was a separately identifiable service.

i. DMA requires that the Annual Exam Date (AED) be placed in the "initial treatment date" area on the claim form for the initial annual exam and accompanying laboratory procedures and all inter-periodic visits, except pregnancy tests.

   In an effort to ease the transition to the "Be Smart" program, prevent duplication of services and minimize the burden for Medicaid beneficiaries, the N.C. Division of Medical Assistance (DMA) is now allowing beneficiaries, transitioning to the "Be Smart" program from other Medicaid programs, to use the comprehensive annual, physical or postpartum exams received under these programs to meet the "Be Smart" annual exam requirement. To meet the comprehensive annual or physical exam requirement, the beneficiary is allowed one of the three options below:

   1. Receive the MPW postpartum exam in the 365 days prior to enrollment as the required comprehensive annual or physical exam; or,
   2. Receive the regular Medicaid comprehensive annual or physical exam in the 365 days prior to enrollment; **or,**
   3. Receive the comprehensive annual or physical exam under the "Be Smart" program prior to receiving other "Be Smart" services.

   The list of procedure codes that meet the comprehensive annual or physical exam requirement under the "Be Smart" Family Planning Medicaid program now contains procedure codes that include the postpartum exam – 59400, 59410, 59430, 59510, and

59515 – in addition to the comprehensive annual or physical exam codes: 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, and 99397.
Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information.
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_Bulletin_2016_02.pdf

Effective October 1, 2015, (per WH Consultants) DMA will now allow the CPT code 59430 (postpartum package code) to meet the annual exam date (AED) requirement for the "Be Smart" program. Physician or Advanced Practice Practitioners can list the date from the postpartum visit as the AED on "Be Smart" claims. DMA will include this change in a pending Medicaid Bulletin article (not published as of 2/1/16)

a. The annual preventive exam should be age appropriate and services provided as medically necessary. Only one preventive exam is billable per 365 days.
b. 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 and a handling fee (99000) 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. If the Pap smear is not completed with the preventive visit, it must be completed within 30 days of the preventive visit to be covered.
c. 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 but is instead performed by a Physician or Advanced Practice Practitioner 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 Physician or Advanced Practice Practitioner. When a client presents for that same type visit and sees a Physician or Advanced Practice Practitioner, and it is noted in the history that the client is having severe headaches or other problems requiring the judgment of the Physician or Advanced Practice Practitioner, then the visit should be billed at the appropriate higher level
d. Physician or Advanced Practice Practitioners 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 BeSmart. ~~Do not charge both an~~

~~administration fee and an office visit for Depo-Provera.~~ There are ~~two~~ several ways to bill for Depo-Provera:

- If you only administer Depo-Provera, you should bill J1050 FP UD, for Depo and the administration fee 96372 FP
- If you evaluate and document the client condition, then you may bill the appropriate office visit code, based on documented components completed and J1050 FP UD, for Depo-Provera.
- It is permissible to bill 96372 (injection fee) for contraceptive injections (Depo) with an E&M visit code (99212-99215) or with a preventive visit code when 1) a provider sees the patient, and 2) the RN clearly documents that he/she administered the injection

e. 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 Physician or Advanced Practice Practitioner. For example, Sue comes for her annual FP exam and the Physician or Advanced Practice Practitioner writes a new prescription for Depo for the next 12 months. Each time Sue returns during those 12 months, the Depo should be billed under the Physician or Advanced Practice Practitioner who prescribed it and not the Physician or Advanced Practice Practitioner/nurse who gives it. This should remain constant until a new prescription is written (whether it is for Depo or a different method.)

   If the originating physician or APP has left the practice, a new prescription would need to be written and billing would then be under the new prescribing physician or APP's NPI number.

f. Effective January 1, 2007, National Drug Codes (NDCs) must be used when billing/reporting HCPCS codes (drugs/medications i.e. Depo, Implantable Device, etc.) to Medicaid. When billing Medicaid do not use NDC numbers when billing/reporting immunizations/vaccines. However, Tricare, United Health Care and potentially others, requires NDC numbers to be included when billing for vaccines. NDC numbers are specific to drugs/medications and do not apply to immunizations/vaccines. These are two different things. **Note:** National Drug Codes are a universal drug identification number. They identify the manufacturer of the drug and are assigned by the FDA.

g. It is recommended that the nurse/Physician or Advanced Practice Practitioner administering the drug be responsible for documentation of the NDC number required for billing purposes.

h. LHDs should follow the guidance below in billing Medicaid for methods/devices:

- **Annual exam & IUD:** If during an annual exam, the beneficiary requests an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), or during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and the IUD insertion or IUD removal. An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service. The provider's documentation should support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.
- **Inter-Periodic Visit & IUD:** If the only reason that the beneficiary is seen in the office is to request an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), providers should not bill a separate inter-periodic office visit. An office visit component is included in the reimbursement for CPT procedure codes 58300 and 58301. However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the inter-periodic visit and the IUD insertion or IUD removal. The provider's documentation should support that the service rendered was a separately identifiable service.
- **Family Planning & STD services:**

  Q- if a patient comes in for std treatment (to STD) and then is seen for depo shot and patient is FPW how should that be billed since you have use the 99211.

  A#1 – The agency renders and documents the STD treatment within the STD program. There is no charge to the patient, and Be Smart cannot be billed for STD program encounters. The agency renders and documents the contraceptive injection (Depo) services within the Family Planning program. The agency bills Be Smart for these Family Planning program services, including a 99211, if applicable.

  A#2 – The agency renders and documents both the STD treatment and the contraceptive injection (Depo) services within the Family Planning program. The agency bills Be Smart for these Family Planning services, including a 99211, if applicable.

FAQs related to above FP Billing Guidance 5/18/17:

1. Does this guidance only apply to local health departments, or does it also apply to private providers and other clinics?
   - The guidance applies to **all Medicaid billers**, not just to local health departments.
2. Does this guidance also apply to contraceptive implants?
   - Yes, the guidance sent on 5/18/17 pertains to how to bill for both IUD **and implant** procedures associated with annual exams and inter-periodic visits.
   - Please read the highlighted sentences below to see how the first part of the guidance **(annual exams)** applies to implants:
     - If during an annual exam, the beneficiary requests an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301), or during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and the IUD insertion or IUD removal. An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service. The provider's documentation should support that the service rendered was a separately identifiable service provided by the same provider on the same day of service. **The above has always been the billing guidance for contraceptive implants at the annual exam. What is new is that the above guidance now also applies to IUDs.**
   - Please see the highlights below to see how the second part of the guidance **(inter-periodic visits)** applies to implants:
     - If the only reason that the beneficiary is seen in the office is to request an IUD/implant insertion (CPT procedure code 58300 or 11981) or an IUD/implant removal (CPT procedure code 58301 or 11982 or 11983), providers should not bill a separate inter-periodic office visit. An office visit component is included in the reimbursement for CPT procedure codes 58300 and 58301, as well as procedure codes 11981, 11982 and 11983). However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may

bill for the inter-periodic visit and the IUD/implant insertion or IUD/implant removal. The provider's documentation should support that the service rendered was a separately identifiable service.

3. Does this guidance mean that Medicaid no longer pays for IUD and implant devices?
   - No, Medicaid will continue to pay for IUD and implant devices at both preventive and inter-periodic visits.
4. When will the Division of Medical Assistance (DMA) change their Clinical Coverage Policy 1E-7 (Family Planning Services) to reflect this new guidance?
   - Our understanding is that DMA sees this guidance as further clarification of their current policy rather than information that would necessitate a policy change.
5. Can agencies back bill based on this guidance?
   - No, agencies may not back bill. The guidance takes effect on 5/18/2017.
6. When our agency has tried to bill as per the guidance related to inter-periodic visits, the claim has either denied, or the claim has gone through only to be recouped within a few weeks.
   - Please contact your Regional Women's Health Nurse Consultant with examples. They can assist you with sending them TCNs via password-protected documents, so that the Division of Public Health and the Division of Medical Assistance can further evaluate the issue.

- LHDs that operate and dispense through an outpatient pharmacy (either a contract pharmacy or a LHD operated pharmacy that fills contraceptive prescriptions written by any community Physician or Advanced Practice Practitioner, not just LHD Physician or Advanced Practice Practitioners) can either bill using the Medicaid Outpatient Pharmacy Rules or can use the Physician Drug Program (PDP) process. If the Pharmacy is a Medicaid Pharmacy provider (outpatient pharmacy), then standard dispensing fees (as established by Medicaid) can be billed to Medicaid along with the cost of the method/device.
- LHDs that bill for IUDs, Implantable Devices, and Depo through the Family Planning Clinic/PDP process must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.

- LHDs that dispense and bill for other Family Planning contraceptives through the Family Planning Clinic/PDP process (LHDs that fill contraceptive prescriptions only for clients seen in the LHD Family Planning Clinic) must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.
- 340B stock Emergency Contraception may only be prescribed/dispensed/ administered via the Family Planning clinic. Therefore, if pregnancy testing is done in NON-Family Planning clinics (i.e. in General Clinic), and if it is appropriate to offer Emergency Contraception with a negative pregnancy test, then a Family Planning encounter must be opened before prescribing/ dispensing/administering the Emergency Contraception from 340B stock.
- Since 340b prices change regularly, we suggest that you determine your average cost for a year for each 340b method or device. This amount can then be used for billing using the UD-modifier and FP-modifier. As this methodology is updated annually, this should provide the least amount of risk as it will be the closest to your actual cost. Your purchase cost for each device should be reviewed and updated at least annually.
- There should not be 3 different fees/charges for billing 340b medications or devices. You should follow the guidance below:
  a. LHDs are required to bill Medicaid the acquisition cost of medication or devices purchased via the 340b drug program. Therefore, their fee/rate for Medicaid must be the purchase cost.
  b. LHDs may charge insurances and self-pay clients at a different fee/rate than what they charge Medicaid for the same medications or devices purchased via the 340b drug program.
  c. LHDs may choose to charge all payors the acquisition cost of medication or devices purchased via the 340b drug program.
  d. However, LHDs (due to Title X funding) are required to slide the fee/rate of the medication or device on the SFS for all self-pay Family Planning clients.

- Billing scenario for client with insurance and Medicaid with device purchased with 340b funds:

Jane has both BCBS and Medicaid. Her family planning appointment includes an IUD that costs $300 at 340B/acquisition cost. That same IUD costs $600 at the usual and customary cost. The agency bills BCBS $600, and BCBS reimburses the agency

$200. The agency then bills Medicaid $100 in the hopes of being reimbursed for $300 total – the 340B acquisition cost.
So our (WHB) advice is that it's okay to bill Medicaid the remainder of the 340B/acquisition cost if private insurance reimburses an amount that's less than the 340B/acquisition cost.

If, however, the device was **purchased privately (NOT via 340B pricing),** you would bill Medicaid the $400.00 difference between the billed price **($600)** and what BCBS paid **($200)**.

1. IUD CPT Code Changes

Effective January 1, 2016, CMS will discontinue use of the HCPCS code J7302 for 52mg levonorgestrel-releasing IUDs and begin using the following codes:

HCPCS	Long Description	Short Description	Brand Name
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration	Levonorgestrel iu 52mg 3 yr	Liletta®
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 5 year duration	Levonorgestrel iu 52mg 5 yr	Mirena®

- HCPCS codes for the 13.5mg levonorgestrel-releasing IUD (J7301) (brand name Skyla®) and the intrauterine copper contraceptive (J7300) (brand name ParaGard®) remain unchanged. Physician or Advanced Practice Practitioners should consult all third-party payers to confirm specific coding requirements.
- Effective with date of service Oct. 1, 2016, the N.C. Medicaid and N.C. Health Choice (NCHC) programs cover levonorgestrel-releasing intrauterine system (Kyleena™) for use in the Physician's Drug Program (PDP) when billed with HCPCS code J3490 – Unclassified Drugs. Kyleena is currently available as a single intrauterine system consisting of a T-shaped polyethylene frame with a steroid reservoir containing 19.5 mg levonorgestrel, packaged within a sterile inserter.
  Kyleena is indicated for prevention of pregnancy for up to five years.
  The release rate of levonorgestrel (LNG) is 17.5 mcg/day after 24 days and declines to 7.4 mcg/day after five years; Kyleena must be removed or replaced after five years. Kyleena is to be inserted by a trained healthcare provider using

strict aseptic technique. Follow insertion instructions exactly as described (see full prescribing information). The patient should be re-examined and evaluated 4 to 6 weeks after insertion; then yearly or more often if clinically indicated.

For Medicaid and NCHC Billing

- The ICD-10-CM diagnosis codes required for billing Kyleena are:
- Z30.430 - Encounter for insertion of intrauterine contraceptive device,
- Z30.433 - Encounter for removal and reinsertion of intrauterine contraceptive device.
- Providers must bill Kyleena with HCPCS code J3490 – Unclassified Drugs.
- One Medicaid unit of coverage for Kyleena is 1 sterile intrauterine system. For NCHC claims, follow the Medicaid billing guidance. The maximum reimbursement rate per one unit is $909.83.
- Providers must bill 11-digit National Drug Codes (NDCs) and appropriate NDC units. The NDC for Kyleena is 50419-0424-01.
- The NDC units for Kyleena should be reported as "UN1".
- NC Medicaid and NC Health Choice cover the Kyleena IUD as of October 2016. Please see page 17 of the January 2017 DMA Bulletin for more detailed information on this coverage: https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/medicaid_bulletin_2017_01.pdf
  While Kyleena is covered by regular NC Medicaid and NC Health Choice, the Division of Medical Assistance has informed us that **Kyleena is not covered by Be Smart Family Planning Medicaid** (formerly known as the Family Planning Waiver).
- For additional information on NDC, refer to the January 2012, Special Bulletin, *National Drug Code Implementation Update*.
- For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on DMA's website.
- Providers shall bill their usual and customary charge for non-340-B drugs. Medicaid Bulletin January 2017
- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA). Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.
- The fee schedule for the PDP is available on DMA's PDP web page.
- Physician or Advanced Practice Practitioner(s) shall follow applicable modifier guidelines. Family planning services billed to Medicaid must

be billed with the appropriate code using the FP modifier (not just method related services). If you bill insurance it is recommended that you contact each carrier to find out what the procedure is for using program related modifiers. For guidance on billing Health Choice for Family Planning services please see below.

- *NOTE: Modifiers with 58300: Use modifier -52 (Failed Procedure) to denote that you attempted insertion but the procedure was incomplete due to anatomical factors (e.g. Stenosis) or -53 (Discontinued Procedure) to indicate that you had to stop because of concerns for patient well-being (eg. vaso-vagal, severe pain). [According to the 2016 LARC Quick Coding Guide Supplement at http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement.pdf]
- 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. **See decision-making flow charts at the end of this document for additional guidance (Appendixes A and B).**
- 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 agencies 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)
- Family planning diagnosis code must always be in the first position when billing for FP clinic services.
- The UD modifier indicates that the contraceptive was purchased through the 340B Drug Pricing Program.
- **Clarification from WHB regarding billing 340b for clients with commercial insurance:**

Q: *If an agency has a client with commercial insurance, and the agency is not contracted with that commercial insurance but bills for a device, and the reimbursement is less than the fee, what happens to the rest of the charge?*

A:
The agency may set two fees for Family Planning devices/medications:
1. The 340B/acquisition fee, which is also the fee billed to Medicaid. This is the lower of the two allowable fees.

2. The usual and customary fee. This is the higher of the two allowable fees.

The fee for Medicaid-insured clients must be set at the acquisition cost.
The fee for uninsured, self-pay clients may be set EITHER at the acquisition cost or at the usual and customary fee.
The fee for commercially-insured clients may be set at EITHER the acquisition cost or at the usual and customary fee.

Agencies may opt to either charge all commercially-insured clients the 340B/acquisition fee, or to charge all commercially-insured clients the usual and customary fee. Any charges that are not fully reimbursed by the commercial insurance carrier must be charged to the client on the SFS.

- If the agency opts to charge all commercially-insured clients the usual and customary fee, and if the agency is not contracted with clients' insurance carrier, then the agency should inform clients prior to rendering services that they may be charged less at a facility that is in-network with their commercial insurance carrier. If clients make an informed decision to be seen at the agency's family planning clinic, the agency should bill clients on the SFS for any amount not reimbursed by their commercial insurance carrier.

Example 1: The agency decides to set the two fees for Family Planning devices/medications as above, and to charge commercially-insured clients the usual and customary fees. Client Beth has BCBS, and comes to the agency's family planning clinic requesting an IUD. Beth is informed that her visit may cost less with an in-network provider, since the agency is not contracted with BCBS. Beth makes an informed decision to be seen at the agency. The provider inserts a Liletta IUD. The agency purchased the Liletta IUD at the $50 340B/acquisition fee. The agency bills BCBS their usual and customary Liletta IUD fee of $600. BCBS reimburses the agency $300. The agency then bills Beth the remaining $300 on the SFS. Since Beth falls at 20% on the SFS, her charge for the Liletta device is $60.

- Pro = Agency receives higher reimbursement from commercial insurance
- Con = Client is charged higher fee

Example 2: The agency decides to only set one fee for Family Planning devices/medications – the 340B/acquisition fee. Client Beth has BCBS, and comes to the agency's family planning clinic requesting an IUD. The provider inserts a Liletta IUD. The agency bills BCBS the $50 340B/acquisition fee for Liletta. BCBS reimburses the agency $25. The agency then bills Beth the remaining $25 on the SFS. Since Beth falls at 20% on the SFS, her charge for the Liletta device is $5.

- Pro = Client is charged lower fee

- Con = Agency receives lower reimbursement from commercial insurance

How to bill when CH and FP services interface

If the reason for visit is for a well child exam but the patient presents also wanting FP services, the visit is billed as follows:

a. Bill the Well Child Exam along with all required components under the CH program type. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.
b. REPORT all the FP portions of the visit, assuring that all required FP components have been completed. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.
c. In order to offer 340B medications, the visit must be documented separately so that it is clear a FP visit has been made therefore establishing the patient in FP.
d. Document using a separate encounter form.
e. If the reason for visit is for FP services but the patient is also in need of their CH visit, the visit is billed as follows:
f. REPORT the Well Child Exam along with all required components under the CH program type. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.
g. Bill all the FP portions of the visit, assuring that all required FP components have been completed. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.
h. NCTracks has indicated that they will no longer require the TJ modifier for NC Health Choice Family Planning patients. **The claims should only require an FP modifier and should pay at the usual rate** instead of $90. We have not been able to verify that this fix is working properly.

General Reminders:

- 340B drug eligibility requires that the patient be a registered FP patient.
- If a patient is seen for FP services, all the assessments and education are completed and separately documented (separate from the CH documentation) and an encounter reflects that the patient received FP services, then the patient should be able to receive 340B drugs, even if the encounter is entered as "report only."
- Assure all CH service components are provided.

- DO NOT try to document both visits on the same program template. Neither the CH or FP templates are structured to comply with both program requirements.

Additional guidance can also be found in the following Physician's Drug Program Clinical Coverage Policy under the reimbursement section: http://www2.ncdhhs.gov/dma/mp/1B.pdf

- If a Health Check 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 Health Check CPT and diagnosis codes). Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

  If you bill other third-party payers it is recommended that you contact them individually for guidance on use of the FP modifier.

- 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 health department, 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 Physician or Advanced Practice Practitioner or a specialist, the referral can be made after that evaluation. If you have questions, please contact your Women's Health Nursing Consultant.

Billing Preventive & E/M visits to Medicaid on the same day:

- Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (see exception). The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology. You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to Child Health Section, item F for changes from the 2016 Health Check Program Guide.* If a client is seen by a Physician or Advanced Practice Practitioner for STD services and an

additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day,** and it is not a duplicate billing.

- ~~Billing STD services provided by the STD ERRN The four (4) components of the STD exam do not have to be provided by the same STD ERRN in order to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.~~
- ~~**STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.**~~
- ~~**The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.**~~
- ~~**TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.**~~
- **HMHC/Title V (Well Child funding)**:

  Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service. (as per Peter Anderson, WCH Acting Section Chief).
- Smoking and Tobacco Use Cessation and Counseling
  - The Physician or Advanced Practice Practitioner can bill CPT code 99406 if at least 3-10 minutes of counseling has been provided to the client.
  - The Physician or Advanced Practice Practitioner can bill CPT code 99407 if greater than 10 minutes of more intensive counseling has been provided to the client.
  - Note: Counseling cannot be billed if provided to the parent/guardian instead of the client.
- Pap Test Fee
  - If the client has insurance or is self-pay, the reference lab bills the health department (based on negotiated rate) and the health department bills the client using the appropriate CPT code and 90 modifier based on SFS. There would not be a claim filed with the insurance company by anyone in this case. The health department would be required to notify the client about this prior to services being rendered.

- **Do Not** charge clients with Medicaid for Pap test processing. The lab that performs & interprets the test is responsible for billing Medicaid directly.
- Health Departments should negotiate rates with their reference lab.

BeSmart

BeSmart Physician or Advanced Practice Practitioners can bill for a limited set of CPT codes. The complete list of these codes may be found in Attachment A, C1 of the Clinical Coverage Policy.
https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E-7.pdf

1. Annual Examination

   An annual examination must be completed on all "Be Smart" program beneficiaries. **The annual examination must be performed for all beneficiaries prior to the rendering of any other family planning services.** However, for established patients, if emergent or urgent contraceptive services are needed, beneficiaries are allowed limited office visits prior to their annual examination. **BeSmart allows for one (1) annual exam/preventive visit per 365 days.**

2. **Six medically necessary inter-periodic visits are allowed per 365 calendar days under the "Be Smart" option.** The purpose of the medically necessary inter-periodic visits is to evaluate the beneficiary's contraceptive program, renew or change the contraceptive prescription and to provide additional opportunities for counseling as follow-up to the annual exam. **The AED is required on all claims for inter-periodic visits with the exception of pregnancy tests. For a list of components that should be included during the inter-periodic visit with pelvic exam refer to Clinical Coverage Policy- Attachment B, section B**
   https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E-7.pdf
   The primary purpose of the 6 inter-periodic visits is to provide contraceptive services which are why it is not recommended the health department use the 6 inter-periodic visits for STD services on a routine basis. It is recommended that the health department prioritizes method-related concerns for the six inter-periodic visits.

   The contraceptive method may necessitate an evaluation in FP clinic, so health department policy may specify methods like IUD or vaginal rings are automatically brought back into the FP clinic for any complaints of discharge and patients on pills, patches and Depo may be sent to the STD clinic for complaints of discharge. If the six inter-periodic visits have been exhausted, and the patient returns to the FP clinic for a method related concern (not caused

by an STD), then the health department can bill the patient on the SFS for those services.

Physician or Advanced Practice Practitioners 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 BeSmart. Do not charge both an administration fee and an office visit for Depo-Provera. There are two ways to bill for Depo-Provera:

- If you only administer Depo-Provera, you should bill J1050 FP UD, for Depo and the administration fee 96372 FP
- 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 FP UD, for Depo-Provera.

3. Contraceptive Services, Supplies and Devices
   a. **Emergency Contraceptives**
      Emergency contraceptives are a covered service. The appropriate office visit code may be billed separately.
   b. **Pharmaceutical Supplies**
      All eligible drugs for "Be Smart" Family Planning will have a family planning indicator (modifier) on the drug file (including birth control pills, Depo-Provera, Ortho Evra, Nuva Ring). Even though most local health departments provide prescriptions to clients with insurance and Medicaid for pills, patch, ring and emergency contraceptives to take their pharmacy of choice, there are rare circumstances (e.g., issues of confidentiality) where LHDs may provide these drugs in house and bill Medicaid using the appropriate UD and FP modifiers. The dispensing fee is based on regular Medicaid rules. **There is a 6 (six) prescription limit per month with no override capability.** Physician or Advanced Practice Practitioners are not allowed to distribute "brand medically necessary" (DAW1) drugs, if a generic is available. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-10-CM code.
      Note: The AED is not required on "Be Smart" Family Planning program prescriptions.
   c. **Birth Control Pills**
      Birth control pills may be dispensed through a pharmacy. A beneficiary may receive up to a 3-month supply. When provided in by a clinic, the clinic Physician or Advanced Practice Practitioner may bill **S4993**.
   d. **Diaphragms**

"Be Smart" Family Planning beneficiaries can choose a diaphragm as a birth control method. A Physician or Advanced Practice Practitioner can fit the patient and bill using the appropriate CPT code for diaphragm fitting. However, the program does not cover the actual diaphragm

e. **Injectable Drugs**

Depo-Provera contraceptive injection is a covered service. Use the diagnosis code for contraceptive management. The appropriate office visit code may be billed separately.

f. **Intrauterine Devices (IUDs) and Implantable Devices**

The "Be Smart" Family Planning program covers only the removal of Norplant. The global period for 11976 is one (1) pre-care day and ninety (90) post-operative days.

Physician or Advanced Practice Practitioners **should not** bill a separate inter-periodic office visit code for CPT codes 57170 (Diaphragm), 58300 (Insertion IUD), 58301 (Removal of IUD) except in the circumstances below; an office visit component is included in the reimbursement. CPT codes 57170, 58300, 58301 are included in the six inter-periodic visit limitation.

*NOTE: Modifiers with 58300: Use modifier -52 (Failed Procedure) to denote that you attempted insertion but the procedure was incomplete due to anatomical factors (e.g. Stenosis) or -53 (Discontinued Procedure) to indicate that you had to stop because of concerns for patient well-being (eg. vaso-vagal, severe pain). [According to the 2016 LARC Quick Coding Guide Supplement at http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement.pdf

Providers may bill (both regular Medicaid and "Be Smart" Family Planning Medicaid) for both insertion/removal of an intrauterine device or contraceptive implant and an E/M office visit if there is a separate, identifiable issue that would warrant an office visit. The office visit is billed with a 25 modifier, and the ICD-10 diagnosis must support the reason for billing the additional office visit with an additional diagnosis other than contraceptive insertion. Beneficiaries covered under "Be Smart" are only eligible for family planning services as described in DMA's 1E-7 Clinical Coverage policy, and are not eligible for any other Medicaid program.

When diaphragm fitting, intrauterine device insertion, or removal of an intrauterine device occurs during an annual examination, Physician or

Advanced Practice Practitioners must only bill the appropriate annual examination procedure code.

4. Laboratory Procedures

The following laboratory procedures are **only allowable for the "Be Smart" program when performed "in conjunction with" or pursuant to an annual examination**. For the purpose of "Be Smart," "in conjunction with" has been defined as the day of the procedure or 30 days after the procedure. Pregnancy tests and sexually transmitted infection/HIV screening can be performed during an annual examination visit **and** any of the six (6) inter-periodic visits allowed under the program.

Urinalysis, Blood count, and Pap test may only be performed once during an annual or inter-periodic visit.

a. Pap Test

Physician or Advanced Practice Practitioners are allowed one Pap test procedure per 365 calendar days in conjunction with an annual examination. **The Annual Exam Date is required on all claims for Pap tests.**

If you are unable to obtain a Pap specimen at the time of the preventive visit (i.e. client is on menses), and they return within the allowable 30-day timeframe, you may bill for the Pap (with the appropriate code) and the handling fee (99000).

If they return for the Pap after 30 days has passed, you may bill the handling fee 99000 only (BeSmart will not cover the Pap test after 30 days)

Collection of Pap Test

Pap test CPT codes should not be used to bill collection of a specimen. Collection of the Pap test is included in the reimbursement for office visits, and no separate fee is allowed. Physician or Advanced Practice Practitioners who do not perform the lab test should not bill the Pap tests. Only the Physician or Advanced Practice Practitioner who actually performs the lab test should bill the Pap test codes.

Repeat Pap Test for Insufficient Cells

One repeat Pap test is allowed due to insufficient cells. Physician or Advanced Practice Practitioners shall perform the repeat Pap test within 180 calendar days of the first Pap test. **Physician or Advanced Practice**

Practitioners shall include the ICD-10-CM diagnosis R87.615 as the secondary diagnosis on the appropriate claim.

5. HIV and Sexually Transmitted Infections Screenings

   Physician or Advanced Practice Practitioners are allowed to screen a total of any combination of six (6) HIV or sexually transmitted infections per beneficiary per 365 days. Screening for HIV and sexually transmitted infections can be performed during the annual examination or during any of the six (6) inter-periodic visits allowed under the program, when an annual exam has been in paid history.

   a. HIV Screening

      The "Be Smart" Family Planning program allows screening for HIV during the annual examination or the six inter-periodic visits allowed under the "Be Smart" program. **This is a recommended screening and should be completed as necessary and appropriate**. Physician or Advanced Practice Practitioners must include the **ICD-10-CM Diagnosis Z11.4** as the secondary diagnosis on the appropriate claim.

      Physician or Advanced Practice Practitioners must include the Annual Exam Date on all claims submitted for "Be Smart" Family Planning services. The AED is the date of the annual examination.

   b. STI Screening

      A total of no more than six (6) STI screenings per 365 days are also covered under the "Be Smart" Family Planning program performed in conjunction with an annual examination or after an annual exam has been in paid history.

      Physician or Advanced Practice Practitioners must include the AED on all claims submitted for "Be Smart" Family Planning services. The AED is the date of the annual examination.

6. Consultation for Sterilization

   The "Be Smart" Family Planning program will cover consultation for a sterilization procedure. When a Physician or Advanced Practice Practitioner refers a beneficiary to **another Physician or Advanced Practice Practitioner** for a sterilization procedure, then the Physician or Advanced Practice Practitioner performing the sterilization procedure must select one of the following codes when providing consultation to the beneficiary. **Beneficiaries are allowed two consultations for sterilization per lifetime**.

7. Miscellaneous Billing Instructions
    a. Inter-periodic & Non-biodegradable drug delivery Implant (i.e. Implantable Devices): Physician or Advanced Practice Practitioner shall not bill a separate inter-periodic office visit code when billing for CPT codes 11981 (Insertion), 11982 (removal), 11983 (insertion & removal); an office visit component is included in the reimbursement for "Be Smart" beneficiaries. You may also be reimbursed for the device using the appropriate HCPCS code.
    b. Interperiodic & Diaphragm fitting: Physician or Advanced Practice Practitioner shall not bill a separate inter-periodic office visit code when billing for CPT code 57170 (Diaphragm fitting); an office visit component is included in the reimbursement for "Be Smart" beneficiaries.
    Providers may bill (both regular Medicaid and "Be Smart" Family Planning Medicaid) for both insertion/removal of an intrauterine device or contraceptive implant and an E/M office visit if there is a separate, identifiable issue that would warrant an office visit. The office visit is billed with a 25 modifier, and the ICD-10 diagnosis must support the reason for billing the additional office visit with an additional diagnosis other than contraceptive insertion. Beneficiaries covered under "Be Smart" are only eligible for family planning services as described in DMA's 1E-7 Clinical Coverage policy, and are not eligible for any other Medicaid program.
    c. Annual exam & Non-biodegradable drug delivery Implant (i.e. Implantable Devices): Physician or Advanced Practice Practitioners can be reimbursed for insertion, removal, and removal with reinsertion of implantable device in addition to the annual exam. You may also be reimbursed for the device using the appropriate HCPCS code.
    d. Annual exam & Diaphragm: Physician or Advanced Practice Practitioners must only bill the appropriate annual examination procedure code.
    e. Annual exam & IUD: Physician or Advanced Practice Practitioners must only bill the appropriate annual examination procedure code. You may also be reimbursed for the device using the appropriate HCPCS code.
    f. If a Physician or Advanced Practice Practitioner discovers that a beneficiary is pregnant, a referral to the local Department of Social Services (DSS) for enrollment in the Medicaid for Pregnant Women (MPW) program should be made for **"Be Smart" program beneficiaries.**
    g. **Physician or Advanced Practice Practitioners must include the AED on all claims for an annual examination and laboratory procedures, with the exception of the pregnancy test.**
    h. Postpartum visit now = AED for "Be Smart": Patients who have their postpartum visit while insured under Medicaid for Pregnant Women

(MPW) sometimes enroll in "Be Smart" Medicaid when their MPW expires. In the past, these patients needed an annual exam appointment after their postpartum visit to meet "Be Smart" billing requirements. "Be Smart" claims require that the annual exam date (AED) be documented to be reimbursed for contraceptive and other services provided under this coverage.

i. To ease the transition to the "Be Smart" program, prevent duplication of services and minimize the burden for Medicaid beneficiaries, the N.C. Division of Medical Assistance (DMA) is now allowing beneficiaries transitioning to the "Be Smart" program from other Medicaid programs to use the comprehensive annual, physical or postpartum exams received under these programs to meet the "Be Smart" annual exam requirement. To meet the comprehensive annual or physical exam requirement, the beneficiary is allowed one of the three options below:

   1. Receive the MPW postpartum exam in the 365 days prior to enrollment as the required comprehensive annual or physical exam; or,
   2. Receive the regular Medicaid comprehensive annual or physical exam in the 365 days prior to enrollment; **or,**
   3. Receive the comprehensive annual or physical exam under the "Be Smart" program prior to receiving other "Be Smart" services.

   The list of procedure codes that meet the comprehensive annual or physical exam requirement under the "Be Smart" Family Planning Medicaid program now contains procedure codes that include the postpartum exam – 59400, 59410, 59430, 59510, and 59515 – in addition to the comprehensive annual or physical exam codes: 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, and 99397.
   Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information. https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_Bulletin_2016_02.pdf

j. An ICD-10-CM diagnosis related to family planning services must be the primary diagnosis on the claim form.

8. Billing Preventive & E/M visits to Medicaid on the same day:

a. Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (see exception). The only additional CPT codes that can be included in the service are CPT codes for injectable

medications or ancillary studies for laboratory or radiology. You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to Child Health Section, item F for changes from the 2016 Health Check Program Guide*. If a client is seen by a Physician or Advanced Practice Practitioner for STD services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing

~~b. Billing STD services provided by the STD ERRN The four (4) components of the STD exam do not have to be provided by the same STD ERRN in order to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.~~

~~**c. STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.**~~

~~**d. The non- STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.**~~

e. ~~**TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.**~~

9. Local Health Departments (excerpt from Clinical Coverage Policy)
   a. All services must be billed with the appropriate CPT or HCPCS code, ICD-10-CM diagnosis, and FP modifier. N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.
   b. The AED must be entered as the "initial treatment date" on the CMS-1500. The AED is required on all claims.
   c. Indicate "Yes" on the HIS Service Screen data field for "Be Smart" Family Planning Program Services.
   d. All approved antibiotic treatment and pain medications must have the appropriate ICD-10-CM diagnosis written on the prescription.
   e. No "brand medically necessary" (DAW1) medications are allowed, if a generic is available.

f. All Local Health Departments must adhere to all applicable North Carolina Medicaid policies and procedures for the "Be Smart" Family Planning program.

9. North Carolina Health Choice & Family Planning Programs

If a Health Choice 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) Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

a. If a Health Check 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 Health Check CPT and diagnosis codes). Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

If you bill other third-party payers it is recommended that you contact them individually for guidance on use of the FP modifier.

For additional program guidance, please contact your Regional Women's Health Consultant or visit the program website at http://whb.ncpublichealth.com/

Pharmacy

1. 340b Drugs

Although the following section is specific to FP and birth control methods, the same methodology should be followed for all 340b drugs.

a. LHDs should follow the guidance below in billing Medicaid for methods/devices.
b. LHDs that operate and dispense through an outpatient pharmacy (either a contract pharmacy or a LHD operated pharmacy that fills contraceptive prescriptions written by any community Physician or Advanced Practice Practitioner, not just LHD Physician or Advanced Practice Practitioners) can either bill using the Medicaid Outpatient Pharmacy Rules or can use the Physician Drug Program (PDP) process. If the Pharmacy is a Medicaid Pharmacy Physician or Advanced Practice Practitioner (outpatient pharmacy), then standard dispensing fees (as established by Medicaid) can be billed to Medicaid along with the cost of the method/device.

c. LHDs that bill for IUDs, Implantable Devices, and Depo through the Family Planning Clinic/PDP process must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.
d. LHDs that dispense and bill for other Family Planning contraceptives through the Family Planning Clinic/PDP process (LHDs that fill contraceptive prescriptions only for clients seen in the health department Family Planning Clinic) must bill Medicaid the actual (or acquisition) cost which they paid for the method/device and no dispensing fee is allowed.
e. **N.C. Medicaid requires the UD modifier to be billed with the applicable HCPCS code and NDC to properly identify 340B drugs. All non-340-B drugs are billed using the associated HCPC and NDC pair without the UD modifier.**
f. 340B stock Emergency Contraception may only be prescribed/dispensed/ administered via the Family Planning clinic. Therefore, if pregnancy testing is done in NON-Family Planning clinics (i.e. in General Clinic), and if it is appropriate to offer Emergency Contraception with a negative pregnancy test, then a Family Planning encounter must be opened before prescribing/ dispensing/administering the Emergency Contraception from 340B stock.
g. Since 340b prices change regularly, we suggest that you determine your average cost for a year for each 340b method or device. This amount can then be used for billing using the UD-modifier and FP-modifier. As this methodology is updated annually, this should provide the least amount of risk as it will be the closest to your actual cost. Your purchase cost for each device should be reviewed and updated at least annually.

2. Administering medication from an outside source is a practice **we do not support** based on being able to assure medication integrity. If the health department chooses to engage in this practice, they should have policy and procedures in place and record the lot number and prescription information from the bottle/syringe.

   Additional guidance can also be found in the following Physician's Drug Program Clinical Coverage policy under the reimbursement section: http://www2.ncdhhs.gov/dma/mp/1B.pdf .

Laboratory

- An on-site or in-house laboratory is one where the LHD is the owner/responsible party for the CLIA certificate. The LHD may employ testers or contract them from some other entity.

- A reference lab is one where someone other than the LHD is the owner/responsible party for the CLIA certificate.
- A collection-only site does not require a CLIA certificate.
- Tests are categorized into *waived* and *non-waived*. Non-waived includes Physician or Advanced Practice Practitioner performed microscopy procedure (PPMP), moderate & high complexity designations.
- QW is used for waived tests, and you only have to use it if you have more than one way of doing a test. If the only way to perform it is WAIVED, then do not put the QW.

1. Billing Scenarios:

   - Scenario A:
     - Lab specimen is collected
     - Lab performs test in house
     - LHD may bill Medicaid or insurance for the test. If there is a balance remaining after insurance, the LHD bills client based on SFS. (w/ exception of STD labs)
     - If no Medicaid or insurance- the LHD may bill the client based on their charge for the test and SFS. The LHD may not bill for collection (i.e. 36415) since this should be included in the LHD fee for the lab test

   - Scenario B:
     - Lab specimen is collected
     - Lab staff sends specimen to outside lab (including state lab)
     - Outside lab bills Medicaid;
     - For all non-Medicaid, outside lab bills the LHD based on negotiated/contracted rate. The LHD may then bill the client at their fee based on SFS.
     - SLPH- The State Lab does not bill the LHD for any lab tests they perform. SLPH does bill Medicaid directly if applicable. The LHD may bill the client for the lab test and specimen collection, based on their charge on the SFS (w/ exception of STD labs).
     - If the client is considered to be Indigent (0%pay): The LHD may have an indigent client clause with the outside lab. This means that the outside lab agrees to perform the test and does not bill the LHD or the client. Not all contracts include this clause.

   - Scenario C:

- If the SLPH doesn't provide a specific test, insurance can be billed with the patient's consent and patients without insurance or who do not want to file *with their insurance can choose to pay out of pocket if the LHD has policy to support it. If lab test requested under any WCH program, then the fee must slide.

2. Modifiers with Labs

Valid billing with a modifier:

- Modifier-59: Distinct Procedural Service, different site or organ system, for example, multiple sources collected for screening culture GC (modifier -59)
- Modifier 90: Specimen sent to a reference laboratory for processing.
- Modifier-91: Repeat Clinical Diagnostic Lab test. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, on-time, reportable result is all that is required. -e.g. Physician or Advanced Practice Practitioner requests test be repeated on the same day. Modifier required do indicate that it is not a duplicate billing (modifier -91)

Effective Jan. 1, 2015, four new modifiers more effectively identify **distinct services that are typically considered inclusive to another service**. Utilizing these modifiers will help with more accurate coding that better describes the procedural encounter. These modifiers are appropriate for NCCI procedure-to-procedure edits only

- **XE – Separate Encounter**: A service that is distinct because it occurred during a separate encounter.
- **XS – Separate Structure**: A service that is distinct because it was performed on a separate organ/structure.
- **XP – Separate Practitioner**: A service that is distinct because it was performed by a different practitioner.
- **XU – Unusual Non-Overlapping Service**: The use of a service that is distinct because it does not overlap usual components of the main service.

If you receive denials when using these "X" modifiers, continue to rebill the claims until current issues between DMA and NCTracks and electronic health record vendors can be resolved. We have been advised that that billing via the NCTracks portal works for these modifiers.

Use of these modifiers vs. modifier 59:

Do not use one of these modifiers with modifier 59 on the same claim line. According to CPT guidelines, modifier 59 should be used only when no other descriptive modifier explains why distinct procedural circumstances exist. Therefore, these new modifiers should be used instead of modifier 59 to describe why a service is distinct.

Medicaid will continue to accept modifier 59 when the X {ESPU} modifiers do not accurately describe the encounter. Documentation must support use of modifiers.

3. Venipuncture/Specimen Collection

   a. The physician or lab shall bill directly for lab fees.
   b. The only fee that a physician may bill, if the physician sends the lab work to an independent lab, is for venipuncture collection 36415. One collection fee is allowed for each beneficiary, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test, the series is treated as a single encounter.
   c. CPT code 36416 may be used to bill for capillary blood collection. However, it is not payable by 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
   d. The amount you bill the client for a CPT code for lab work done in your LHD 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.

4. Handling Fee

   Use CPT code 99000 for Handling, transfer and/or conveyance of specimen from the physician's office (LHD) 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.

5. Pap Test Fee

   For non-Medicaid covered Pap tests that are sent to an outside lab for processing, the LHD may bill the appropriate CPT code with the 90 modifier and appropriate CPT Code (with HPV co-test) with the 90 modifier. **Do Not** charge for Pap test processing to clients with Medicaid. The lab that performs & interprets the test is responsible for billing Medicaid directly.

6. Fern Test
   a. The fern test is used for PROM (premature rupture of membranes) in a prenatal patient by applying vaginal fluid to a slide and allowing it to dry. If placental fluid is present, then the fluid will dry in a pattern that looks like a fern branch when examined under the microscope.
   b. Currently, counties that participate in the state lab's CLIA contract program should **NOT** be performing the fern test because it is not on the test menu.
   c. CMS categorizes the fern test as a Physician or Advanced Practice Practitioner performed microscopy procedure (PPMP) that can be performed if the lab has a CLIA PPMP certificate, a certificate of Accreditation (CoA), or certificate of compliance (CoC) but **cannot** be performed if the lab has a CLIA certificate of waiver. If the lab has a PPMP certificate only a Physician or Advanced Practice Practitioner can perform the test, **not** a lab tech or nurse.
   d. CMS lists Q0114 as the **only** CPT code for the fern test in the list of approved PPMPs.

To bill or report for the fern test it is necessary to use HCPCS Q0114. Although Medicaid does not reimburse this code you would still bill Medicaid and receive a denial and can then bill the patient as long as they are aware that they may be responsible for payment because it is a non-covered service.

Update- NCSLPH Requisition Forms
NPI numbers are now required on all NCSLPH requisition forms. Please see full memo at the link below.
http://slph.ncpublichealth.com/doc/NPI-SubmissionForms-08-18-16.pdf

For additional program guidance, please contact your Regional NC State Lab for Public Health Consultant or visit the program website at http://slph.ncpublic.com/

Medical Nutrition Therapy (MNT)

Clinical Coverage Policy- Dietary Evaluation & Counseling (MNT)

https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1-I.pdf

1. Dietary evaluation and counseling provided in public agencies, private agencies, clinics, physician or medical diagnostic clinics, and physician offices shall be performed by:
   a. Dietitian/Nutritionist, currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable); OR
   b. a registered dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

   It is the responsibility of the Dietician's/Nutritionist's agency to verify in writing all staff qualifications for their staff's provision of service. A copy of this verification (current licensure or registration) shall be maintained by the Dietician's/Nurtritionist's agency.

2. Dietary Evaluation and Counseling (Medical Nutrition Therapy) offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and protocol. Individualized care plans provide for disease-related nutritional therapy and counseling. Refer to Clinical Coverage Policy for specific diagnoses that are covered.
   1. Children through 20 Years of Age

      Dietary evaluation and counseling is covered for children through 20 years of age receiving Medicaid and for children receiving NCHC ages 6 through 18 years when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management
   2. Pregnant and Postpartum Women

      Medicaid covers dietary evaluation and counseling for pregnant women when the pregnancy is threatened by chronic, episodic, or acute conditions for which nutrition therapy is a critical component of medical management, and for postpartum women who need follow-up for these conditions or who develop such conditions early in the postpartum period.
   3. Service Setting

      Dietary evaluation and counseling shall be provided as an individual, face-to-face encounter with the beneficiary or the beneficiary's caretaker.
   4. Service Limitations

      The initial assessment and intervention is limited to four units of service per date of service and cannot exceed four units per 270 calendar days by the same or a different Dietician/Nutritionist. The re-assessment and intervention is limited to four units of service per date of service and cannot exceed 20 units per 365 calendar days by the same or a different Dietician/Nutritionist.
   5. Medical Record Documentation

Medical record documentation shall be maintained for each beneficiary, in the medical records of the beneficiary's primary care Physician or Advanced Practice Practitioner for at least six (6) years, and shall include, at a minimum:

- The date of service.
- The presenting problem.
- A summary of the required nutrition service components.
- The signature of the qualified nutritionist providing the service.
- The beneficiary's primary care or specialty care Physician or Advanced Practice Practitioner's order for the service.

Billing Units

Dietician/Nutritionist(s) shall report the appropriate code(s) used which determines the billing unit(s).

1. CPT code 97802 MNT: initial assessment & intervention

a. Each 15 minutes of service equals 1 billing unit.

- Service is limited to a maximum of 4 units per date of service.
- Service cannot exceed 4 units per 270 calendar days.

2. CPT code 97803 MNT: reassessment & intervention

a. Each 15 minutes of service equals 1 billing unit.

- Service is limited to a maximum of 4 units per date of service.
- Service cannot exceed a maximum of 20 units per 365 calendar days.

WIC Program

All individuals categorically eligible for the Women, Infants, and Children (WIC) Program shall be referred to that program for routine nutrition education and food supplements.

Note: For agencies that also administer a WIC Program, the nutrition education contacts required by that program shall be provided prior to billing Medicaid for dietary evaluation and counseling. Staff time utilized to provide a Medicaid-reimbursable nutrition service shall not be charged to WIC program funds.

Dietitians/Nutritionists providing dietary evaluation and counseling are encouraged to refer eligible clients to the Pregnancy Care Management (PCM) or CC4C programs as appropriate.

Local Use Codes

Local Use Codes (LU codes) are designated and controlled by The LTAT Branch Head. Additions to the LU codes list may be requested through by emailing phyllis.rocco@dhhs.nc.gov. The current list is available on the HIS Library Website: **Approved LU Codes** https://wss01.dhhs.state.nc.us/sites/dhhs/DPH/HIS%20Library/Training%20%20System%20Manuals/LU%20Codes%20Revised%20Effective%205%201%2015.pdf

1. 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 payer 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 payer source. Local codes may not be used to differentiate fees for the same service billed to clients versus those having a third-party payer. Your fee for a service must be billed with the same code and same fee to everyone, **"Your charge is your charge".**

2. Do **NOT** use any modifiers with the LU codes. This includes the Medicaid only EP and FP modifiers.

3. LU Codes that have historically been used to bill for limited physicals, nurse only visits or for other services that mirror a CPT definition have been retired. The decision to retire these codes was based on; increased liability for offering an abbreviated service, changes in best practice at the national level, standards of care and correct coding initiative requirements. Please visit the HIS web address above to view the retired codes.

4. New LU Codes for capturing non-billable ERRN services have been added to the LU code set. These codes are to be used to report the ERRN services when the visit results in a higher-level Physician or Advanced Practice Practitioner seeing the patient. Example: STD ERRN provides an STD assessment and discovers an abnormal finding of rash. The ERRN calls in the Physician or Advanced Practice Practitioner who diagnoses the rash. The visit is now billed under the Physician or Advanced Practice Practitioner's name and to give credit the ERRN for seeing the patient, an LU code is used to report the service provided by the ERRN.

5. If your system does not accommodate the use of the LU Codes, please consult your vendor for further guidance.

Adult Health

1. Procedures and E/M codes

   When providing a procedure, you will bill the procedure code alone (i.e. colposcopy). If you are providing additional components and have the documentation to support an office visit in addition to the procedure that was performed, then you can bill an E/M code as appropriate and append the -25 modifier to the E/M code.

2. Pre-Employment Physicals

   LHDs may perform pre-employment physicals provided they follow appropriate clinical and billing guidelines. The CPT code selected should best align with a complete adult physical and must be provided by a Physician or Advanced Practice Practitioner. An ERRN is not qualified to perform a physical exam for a commercial driver's license or for pre-employment with The Department of Corrections (DOC). The LHD is permitted to have a "flat fee" in an agreement with an organization that is different from the fee charged to individuals. You would still follow "your charge is your charge" mantra, but you can accept different levels of reimbursement.

WISEWOMAN/Breast & Cervical Cancer Control Program (BCCCP)

If you have any questions regarding BCCCP, please contact your BCCCP/ WISEWOMAN Regional Consultant.

Dental Services

Guidance for Billing of Procedure Codes D0145 and D1206

Claims that include procedure codes D0145 (Oral evaluation for a patient under three years of age and counseling with primary caregiver) and D1206 (Topical application of fluoride varnish) must be billed in a particular order for both to pay correctly. Procedure code D1206 must be billed on the detail line before D0145. NCTracks is designed to adjudicate one detail line at a time, beginning

with the first detail line on the claim and proceeding through the last. NCTracks must verify that D1206 has been paid before D0145 can be paid for the same date of service. Ensuring that claims are billed with the procedure codes in this order will expedite processing and payment. If the claim is originally submitted to NCTracks with the procedure codes in the wrong order and only D1206 is paid, the Physician or Advanced Practice Practitioner must submit a new claim for D0145 only.

Medicaid Specific Modifiers

Local 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 for Health Choice covered children. Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children. . This issue has now been corrected by NCTracks and you should receive the correct reimbursement.
- **UD** modifiers are used to identify contraceptives purchased with 340b pricing.

  N.C. Medicaid requires the UD modifier to be billed with the applicable HCPCS code and NDC to properly identify 340B drugs. All non-340-B drugs are billed using the associated HCPC and NDC pair without the UD modifier.

Additional Modifiers that may be used:

- **Modifier -24 Complications of Pregnancy, Unrelated Issues**
  If a patient develops complications of pregnancy or the provider treats the patient for an unrelated problem, these visits are excluded from the maternity global package and can be reported separately. Append modifier 24 *Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues. Modifier 24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package

  Example: An established patient at 22-weeks' gestation is admitted to hospital observation with pre-term labor. The patient's OB/GYN visits the patient in observation and performs a comprehensive history, exam, and MDM of moderate complexity. The next day, the OB/GYN returns and determines the patient has

improved. The patient is discharged from observation care with orders to follow up in the OB/GYN's office in one week. Note: this can be a service provided in the office and is not specifically related to hospital services/care.

> **Remember:** The global maternity package includes uncomplicated care. Because this patient was diagnosed with pre-term labor and admitted to observation, this is not uncomplicated care and, thus, it is separately reportable with the observation E/M codes. Modifier 24 is needed to indicate these encounters are unrelated to the global maternity package. Note- these services must be billed after the OB package code is billed.

- **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 E/M service by the same Physician or Advanced Practice Practitioner or other qualified health care professional is done on the same day as a procedure or other service. The physician may need to indicate that the patient's condition required a service above and beyond what is expected for other services provided on the same day. The modifier 25 is attached to the E/M code, not the procedure code.

- **Modifier 51 - Multiple Procedures.** Modifier 51 indicates several procedures were performed during the same encounter, for the same patient, on the same date by the same Physician or Advanced Practice Practitioner. Medicaid will not determine the major procedure for the Physician or Advanced Practice Practitioner. It is the Physician or Advanced Practice Practitioner's responsibility to identify the primary and secondary procedures correctly to be reimbursed appropriately. Code the primary procedure first and add 51 to the 2nd and other subsequent procedures.

- **Modifiers 52 & 53-** *NOTE: Modifiers with 58300: Use modifier -52 (Failed Procedure) to denote that you attempted insertion but the procedure was incomplete due to anatomical factors (e.g. Stenosis) or -53 (Discontinued Procedure) to indicate that you had to stop because of concerns for patient well-being (eg. vaso-vagal, severe pain). [According to the 2016 LARC Quick Coding Guide Supplement at http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement.pdf

- **Modifier 59- Modifier 59 Guidance from Centers for Medicare and Medicaid Services (CMS)** Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. **Modifier 59** is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

- **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 Physician or Advanced Practice Practitioner 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 CPT code for the laboratory test. (e.g. LHD obtains sample but sends to outside laboratory for processing; in this case, the 90 modifier would be appended to the laboratory test)

- **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 CPT code 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.)

Modifier 59 is used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances. A health

care Physician or Advanced Practice Practitioner may need to use modifier 59 to indicate that a procedure or service was distinct or independent from other services performed on the same day. This means a different location, different anatomical site, and/or a different session.

"OB" Modifier- Beginning July 1, 2016, if you report or bill with a zero $0 charge office visits that are associated with an OB package code or OB global package code, please use the "OB" non-standard modifier for these OB office visits.

"SL" Modifier- Beginning July 1, 2016, please add "SL" modifier to all state supplied vaccines billed or reported.

Effective Jan. 1, 2015, four new modifiers more effectively identify **distinct services that are typically considered inclusive to another service**.* Utilizing these modifiers will help with more accurate coding that better describes the procedural encounter. These modifiers are appropriate for NCCI procedure-to-procedure edits only

- **XE – Separate Encounter**: A service that is distinct because it occurred during a separate encounter.
- **XS – Separate Structure**: A service that is distinct because it was performed on a separate organ/structure.
- **XP – Separate Practitioner**: A service that is distinct because it was performed by a different practitioner.
- **XU – Unusual Non-Overlapping Service**: The use of a service that is distinct because it does not overlap usual components of the main service.

If you receive denials when using these "X" modifiers, continue to rebill the claims until current issues between DMA and NCTracks and electronic health record vendors can be resolved. We have been advised that that billing via the NCTracks portal works for these modifiers.

Use of these modifiers vs. modifier 59:

Do not use one of these modifiers with modifier 59 on the same claim line. According to CPT guidelines, modifier 59 should be used only when no other descriptive modifier explains why distinct procedural circumstances exist. Therefore, these new modifiers should be used instead of modifier 59 to describe why a service is distinct.

Medicaid will continue to accept modifier 59 when the X {ESPU} modifiers do not accurately describe the encounter. Documentation must support use of modifiers.

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 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 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 NC Division of Medical Assistance https://dma.ncdhhs.gov/
- Contact your program consultants or PHNPDU Nursing consultant for coding questions.

Contacts:

PHNPDU Nurse Consultants:

Lynn Conner: (336) 207-3300 lynn.conner@dhhs.nc.gov
Carolynn Hemric (919)801-0727 carolynn.hemric@dhhs.nc.gov
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Phyllis Rocco, RN – Branch Head, Public Health Nursing and Professional Development Unit, Local Technical Assistance & Training
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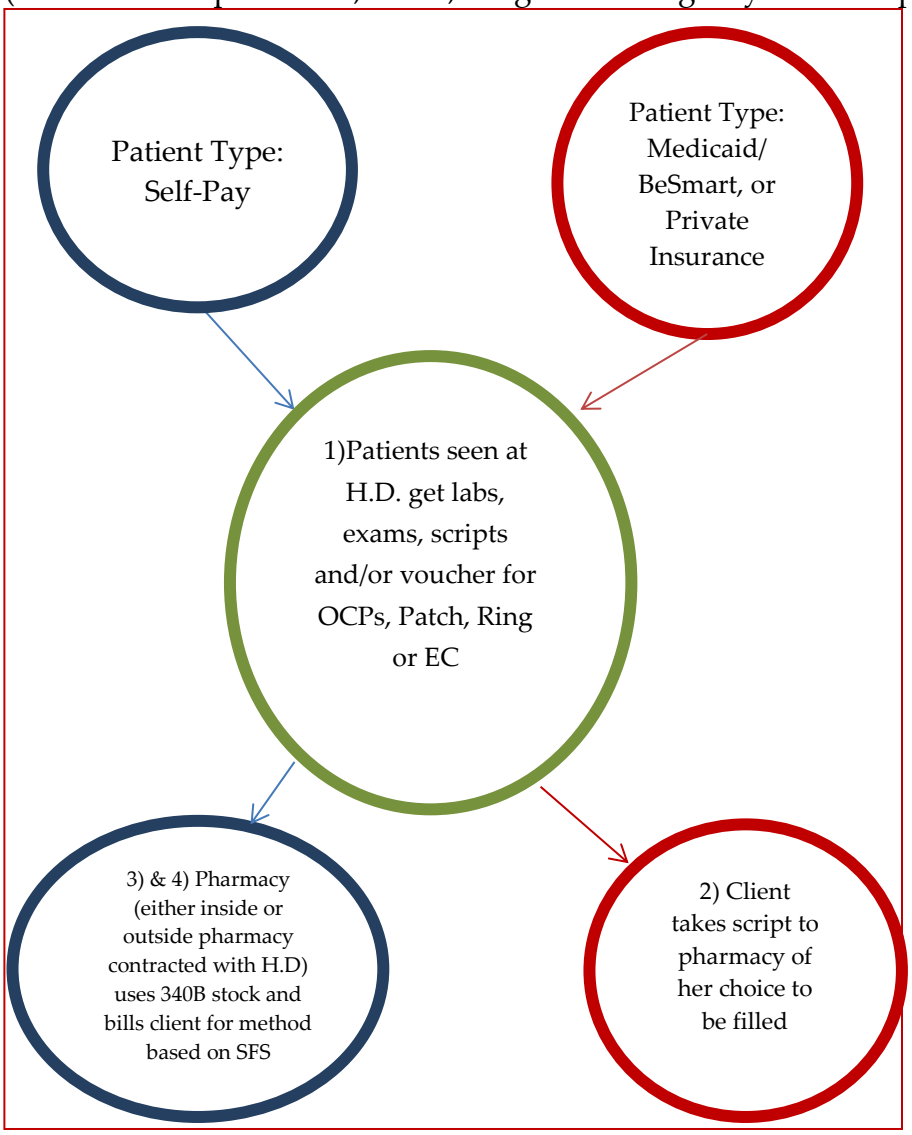
NCDPH Regional Nurse Consultant Directory http://ncpublichealthnursing.org/phn_dirc.htm

Appendices

Appendix A Flow Chart for LHD Billing by Patient Types
(Oral Contraceptive Pills, Patch, Ring and Emergency Contraception)



1) H.D. bills financial source for labs, exam, visit, etc. (i.e., DMA/private insurance or self-pay on sliding fee scale) using appropriate ICD-10 codes with FP modifier.
2) Clients who have Medicaid and/or private insurance take prescription (not voucher) to pharmacy of their choice and that individual pharmacy will bill DMA/private insurance directly using their **OWN** stock and **NOT the** LHD's 340B purchased inventory.
3) Self pay clients will receive their supply from the LHD's 340B purchased inventory and will pay the LHD based on their sliding fee scale (SFS) percentage (%).

Appendix B Flow Chart for LHD Billing by Patient Types (Depo, IUDs: Mirena/Paragard and Implants:)

1

1) H.D. bills financial source for labs, exam, visit, etc. (i.e., DMA/private insurance or self-pay on sliding fee scale) using appropriate ICD-10 codes with FP modifier.

2) Clients who have Medicaid/FPW and/or private insurance receive method from H.D. 340B purchased inventory and H.D. bills using FP and UD modifiers to DMA (no UD modifier for private insurance).

3) Self pay clients will receive their supply from the LHD's 340B purchased inventory and will pay the LHD based on their SFS category.

Appendix C:

State of North Carolina
Department of Justice
P. O. Box 629
RALEIGH
27602-0629

FOY COOPER
ATTORNEY GENERAL

Reply to:
John P. Barkley
Health & Public Assistance
Tel.: (919) 716-6864
Fax: (919) 716-6758

August 31, 2001

Ms. Evelyn Foust
HIV/STD Prevention and Care Branch
1902 Mail Service Center
Raleigh, NC 27699-1902

Re: STD Services at No Charge to Patient

Dear Evelyn:

15A NCAC 19A .0204 (a), requires that "diagnosis, testing, treatment, follow-up and preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale ... be provided upon request and at no charge to the patient." The HIV/STD Prevention and Care Branch in DHHS has prepared a guidance document on billing for STDs that states that screening or diagnostic testing services for all sexually transmitted diseases (STDs) must be provided at no charge to the patient, even for patients who do not have one of the STDs specifically identified in the Rule .0204(a). The Division of Medical Assistance (DMA) asked how services for diagnosis and testing can be provided at no charge to the patient for diseases other than those specified in Rule .0204(a)?

When screening or diagnostic testing is done, it is not known which STDS will be found. It is only after the screening or testing is done that the non-specified diseases are discovered. Therefore, the screening or diagnostic testing still falls within the rubric of services provided at no charge to the patient because they are designed to either diagnose or rule out both specified and unspecified STDs. However, once a STD that is not specified in the rule, such as venereal warts, has been diagnosed, treatment and follow-up services may be charged to the patient.

Sincerely,

John P. Barkley
Assistant Attorney General

cc: Judy Owen O'Dowd
Steve Cline
Chris Hoke

This is an advisory letter. It has not been reviewed and approved in accordance with procedures for issuing an attorney general's opinion.

Glossary

- **AED-** Annual Exam Date
- **AH-** Adult Health- Program type typically used for adult preventive or sick care visits. An adult preventive medicine health assessment consists of a comprehensive unclothed physical examination, comprehensive health history, anticipatory guidance/risk factor reduction interventions, and the ordering of gender- and age-appropriate laboratory and diagnostic procedures. Some LHDs use this program code for BCCCP and WISEWOMAN services.
- **CH-** Child Health- Pediatric primary care at LHDs. Children may be treated for common illnesses, and their long-term health needs can be managed. Doctors will refer children as necessary to specialists.
- **CPT-** Current Procedural Terminology; codes & descriptions for reporting/billing medical services, procedures, supplies and materials. Accurate CPT coding provides an efficient method of communicating medical services and procedures among health care Physician or Advanced Practice Practitioners, health care facilities, and third-party payers and enhances the health care Physician or Advanced Practice Practitioner's control of the reimbursement process.
- **DMA-** Division of Medical Assistance
- **DPH-** Division of Public Health
- **DSM-** Diabetes Self-Management
- **E/M-** Evaluation & Management (CPT codes)
- **EP-** Modifier required on all Medicaid claims to identify services rendered to recipients under the age of 21
- **EPI-** Communicable Disease
- **ERRN-** Enhanced Role Registered Nurse-

  CHERRN: At the completion of the CHERRN program, Rregistered nurses will be able to independently:

  - perform EPSDT (Health Check) screenings using AAP Bright Futures evidence-based recommendations as the clinical framework.
  - Complete all components of a Health Check screening visit, focusing on the comprehensive pediatric history and the complete physical assessment.
  - identification of problems, assuring appropriate consultation, referral and/or treatment of identified problems, along with documentation to support quality of care and billing requirements

  STDERRN: At the completion of the STD Nurse ERRN program, Registered Nurses will be able to independently:

  - Perform and document an STD assessment.

- Identify and treat specified STDs by standardized protocols and standing orders.
- Develop a working knowledge of specimen collection and laboratory procedures as they relate to STD assessment and treatment.
- Provide STD patient education, risk reduction counseling and follow-up for STDs, utilizing a client-centered approach.
- Integrate STD risk assessment into the patient assessment process.

- **Flat Fee**- a charge that does not slide. Often used for services provided in Adult health and Other Services.
- **FP-** Family Planning- provision of family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies
- **HC**- Health Check- The Health Check program facilitates regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. There is no separate enrollment in Health Check. If someone is eligible for Medicaid and is under the age of 21, they automatically receive Health Check services. Together, Health Check and EPSDT provide for the complete care of children and youth in Medicaid
- **Health Choice-** N.C. Health Choice for Children (NCHC) provides free or low-cost health insurance for children and teens from age 6 through the end of the month of their 19th birthday. The benefits covered by NCHC are equivalent to the benefits covered by the Medicaid program with four broad exceptions: 1) No EPSDT; 2) No long-term care; 3) No non-emergency medical transportation; and, 4) Restricted dental and orthodontic benefits.
- **HCPCS-** Healthcare Common Procedure Coding System. It was established in 1978 as a way to standardize identification of medical services, supplies and equipment.
- **ICD-** International Classification of Diseases
- **Inter-periodic/Periodic -** The **2016 HCBG** defines Periodic and Interperiodic well visits as follows:

  Periodic: Encounter for routine child health exam with abnormal findings – Z00.121 Encounter for routine child health exam without abnormal findings – Z00.129

  Routine Interperiodic: Encounter for other administrative exam – Z02.89

The NC *Health Check* Program recommends regular medical screening assessments (well child visits) for beneficiaries as indicated in the following table. North Carolina Medicaid's periodicity schedule is only a guideline. Should a beneficiary need to have screening or assessment visits on a different schedule, the visits are still covered.

While frequency of visits is not a required element of reimbursement by NC *Health Check*, this schedule of visits for eligible infants, children and adolescents is strongly recommended to parents and health care providers.

Please Note: Completion of all elements of the *Health Check* well-child visit as indicated for each age group in the periodicity schedule is *required* for Medicaid provider reimbursement.

- **LU-** Local - (codes) LU codes may be used to **report or bill** services that are NOT billable by a CPT or HCPCS code
- **MH-** Maternal Health/Obstetrics/Prenatal Care- Obstetrics is a branch of medical science that deals with maternity care, including antepartum care, labor and delivery, and postpartum care. Standards of care are published by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and the American College of Nurse Midwifery (ACNM) for the perinatal care of the mother.
- **MNT-** Medical Nutrition Therapy
- **Modifiers- additions** to CPT codes to identify that something additional/different was performed at the same time.
- **NCIP-** The North Carolina Immunization Program works in conjunction with the federal vaccine supply program, called the Vaccines for Children (VFC) program, to provide vaccines free of cost to health care Physician or Advanced Practice Practitioners across the state. Participating health care Physician or Advanced Practice Practitioners must administer these vaccines according to NCIP guidelines.
- **NCTracks-** Medicaid Contractor. Processes and pays Medicaid claims.
- **NDC**- National Drug Code
- **OS-** Other Services; used to record services not identified with another program type
- **PC-** Primary Care; may be used to record primary care services to Adults or Children.
- **PMH-** Pregnancy Medical Home
- **SFS-** Sliding Fee Scale; required by most programs
- **STI/STD-** Sexually Transmitted Infections/Diseases- diagnosis and treatment of sexually transmitted diseases (STD) provided in the LHD setting. Service includes medical history, diagnostic examinations for sexually transmitted diseases, laboratory tests as medically indicated, treatment as indicated, and referral as appropriate
- **TB SKIN TEST-** Tuberculin Skin Test
- **Title V-** Federal funding for Women's & Children's Health programs
- **Title X-** Federal funding for Family Planning

- **VFC-** The Vaccines for Children (VFC) Program helps provide vaccines to children whose parents or guardians may not be able to afford them. This helps ensure that all children have a better chance of getting their recommended vaccinations on schedule. Vaccines available through the VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines protect babies, young children, and adolescents from 16 diseases.

  Funding for the VFC program is approved by the Office of Management and Budget (OMB) and allocated through the Centers for Medicare & Medicaid Services (CMS) to the Centers for Disease Control and Prevention (CDC).

  CDC buys vaccines at a discount and distributes them to grantees—i.e., state health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC Physician or Advanced Practice Practitioners.
- **WIC-** The **Special Supplemental Nutrition Program for Women, Infants and Children** (**WIC**) is a federal assistance program of the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA) for healthcare and nutrition of low-income pregnant women, breastfeeding women, and infants and children under the age of five.
- **340-B-** Federal program for purchasing drugs/medications at a reduced rate

Quick Links

General Information

Documentation
Documentation Guidance from LTAT Branch Head

Billing
OPA- Title X Program Requirements April 2014

Standing Orders
http://www.ncbon.com/myfiles/downloads/position-statements-decision-trees/standing-orders.pdf

www.ncpublichealthnursing.org

PC/Primary Care
(to be added)

ICD Coding Resources
http://publichealth.nc.gov/lhd/icd10/training.htm

http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10QuickStartGuide20150622.pdf

http://www.roadto10.org/

Child Health

Health Check Program Guide

http://www2.ncdhhs.gov/dph/wch/aboutus/childrenyouth.htm

Medicaid

Immunization

Health Check Program Guide

http://www.sog.unc.edu/publications/bulletins/immunizations-children-and-adolescents-frequently-asked-questions-about-north-carolinas-laws

http://www.immunize.nc.gov/providers/coveragecriteria.htmhttp://www.immunize.nc.gov/providers/index.htm

Sexually Transmitted Diseases
STD Clinical Coverage Policy- Treatment in Local Health Department

http://epi.publichealth.nc.gov/cd/lhds.html

Tuberculosis Control & Treatment
Clinical Coverage Policy- Tuberculosis Treatment in Local Health Department

Communicable Disease
http://epi.publichealth.nc.gov/cd/lhds.html

Women's Health
Maternity/OB Billing
Clinical Coverage Policy- Obstetrics

Clinical Coverage Policy- Pregnancy Medical Home 1E-6

Fetal Surveillance 1E-4

NCAPHNA_WHNC_Fall_2015 Report

http://www.ncdhhs.gov/dma/mp/1E6.pdf

Birthing Classes-Clinical Coverage Policy 1M-2

http://whb.ncpublichealth.com/

Family Planning
Clinical Coverage Policy- Family Planning/Be Smart

Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information.

http://www2.ncdhhs.gov/dma/mp/1B.pdf

Attachment A, C1 of the Clinical Coverage Policy

Clinical Coverage Policy- Attachment B, section B

http://whb.ncpublichealth.com/

Pharmacy
http://www2.ncdhhs.gov/dma/mp/1B.pdf

Laboratory
http://slph.ncpublic.com/

Medical Nutrition Therapy (MNT)
Clinical Coverage Policy- Dietary Evaluation & Counseling (MNT)

Local Use Codes (LU Codes)
phyllis.rocco@dhhs.nc.gov

Approved LU Codes

Medicaid Specific Modifiers
NC Division of Medical Assistance