Welcome

- You will be listening to this webinar via your computer speakers. **There is no call in number.**
- Please use the chat box to ask your questions; We will be compiling a Q&A document once we have all the answers to your questions.
- The webinar slides will be posted as soon as possible after Thursday’s presentation.

Thank you!
CODING & BILLING GUIDANCE DOCUMENT V 13, JUNE 2019 UPDATES

DPH PHNPDU LTAT Consultants
June 2019
NC DHB:
NORTH CAROLINA DIVISION OF HEALTH BENEFITS (FORMERLY
KNOWN AS NC DIVISION OF MEDICAL ASSISTANCE/DMA).
FP MEDICAID:

(ALSO KNOWN AS MAFDN OR BESMART)
T1002 is billed to Medicaid in units.

1-15 minutes = 1 unit
16-30 minutes = 2 units
31-45 minutes = 3 units
46-60 minutes = 4 units

A maximum of 4 units per day may be billed.
If your billing is delayed due to outstanding test results, and the client must return for treatment, the 4 units may be split between 2 separate days. All service components must be provided.

Reimbursement for additional units is considered when documentation supports medical necessity.

The time spent for each visit must be documented in the medical record.
You can bill for more than 4 units if the following are met.

Document the total time of the visit. 75 minutes = 5 units

Describe the services provided in detail in order to support the time spent.

Follow the billing instructions on page 8 of the STD Clinical Coverage Policy:
The 4 components of the STI exam do not have to be provided by the same STI ERRN in order to bill Medicaid for the provision of the STI service. The service can still be split across two different days and can be provided by a different STI ERRN on each day, billing T1002 per unit (Equals up to 15 mins) of care provided.
Coding and billing for wart treatment depends on the location (anus or male/female genitalia) and the type of wart.

This guidance is for: condyloma, papilloma, molluscum contagiosum, herpetic vesicle via chemical destruction.

- Anus – 46900 for simple (chemical) and 46924 extensive (any method)

- Male genitals – 54050 simple and 54065 extensive

- Female genitals- 56501 simple and 56515 extensive

The 17000-17250 are CPT codes for the destruction of benign or premalignant lesions and are generally used for non-genital/anal lesions.
**Q:** When a “FP Medicaid” client is schedule for STI ERRN visit and upon interview thinks the client has “BV again”, can the client be switched to a Physician or Advanced Practice Provider schedule and charged for the clinic visit?

**A:** We do not recommend switching the client to a Physician or Advanced Practice Provider. You should: See the client in STI clinic but do not bill “FP Medicaid”.

Keep in mind that if you use 340B drugs to treat not-reportable STIs this may significantly reduce your supply of 340B drugs available to treat clients that the health department is mandated to treat.
MATERNITY UPDATES
Clients covered by third-party insurance carriers should also have a Presumptive Eligibility (PE) completed. The policy may be inadequate therefore, MPW could be considered as secondary coverage.
Visits can be billed in the following manner:

- **Separate- Initial nurse and provider visit (only if this is the agency's routine practice):**
  - Cannot code as “NEW” client on the day of provider visit
  - Use 99211 to establish the client at the nurse visit if she has had 3 or fewer total visits.
  - Use 99211 in the total number of visits for the package if the client has been seen for 4 or more total visits.

- **Combined- Initial nurse and provider visit:**
  - Use 99211 for reporting purposes only, not billed or counted as a separate visit toward the total number of visits.
  - The Provider portion of the visit would be coded as “NEW” client visit if never having been seen in the agency for a nurse or provider E/M visit in the past 3 years.
NON-STRESS TEST (NST) BILLING GUIDANCE

59025 - Complete (the health department is billing for the professional/technical component)

59025TC - Technical Component - HD bills when solely performing the test.

5902526 - Professional Component (the provider supervises and/or interprets the NST them self)
IUD-KYLEENA HAS NEW CPT CODE
PAGE 68

Kyleena:
J7296 FP UD
NEXPLANON NEW ICD-10 CODES:  

Diagnostic ICD-10 Code - Z30.017
You may use the modifier 59 along with 58300 and 11981 when performing at the same time as a Postpartum Package, CPT 59430 because the package code is not an E&M. Modifier 25 cannot be used with the insertion CPT code.
Screenings should be performed with an approved tool/instrument 1x each trimester and postpartum.

Effective July 1, 2019 the PHQ-9 must be used during the antenatal period of pregnancy.

Effective July 1, 2019, the PHQ-9 OR the EPDS may be used during the postpartum period of pregnancy.
Obstetric Providers:

- May be reimbursed for the (3) units using CPT code 96127 (Depression Screening) during the first year after the delivery date or until the recipient’s eligibility ends (MPW the last date of the month in which the 60th post-delivery day occurs) in addition to the global obstetrics and postpartum package services.” The intent is that depression screening (CPT code 96127) is to be performed **IN AN OFFICE SETTING**.

- Pregnancy Medical Home providers may bill CPT code 96127 in addition to S0281.
During the prenatal course of pregnancy, a provider **Must Complete** from the Following:

- **Screening Questions**
- **Maternal Health History- Part C-2 DHHS 4160**
  - Questions #1 and #3
- **Agency cannot bill for completion of the screening questions on this form.**
- **If screening questions are positive, then a PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) is completed and may be billed.**
Ortho Evra has been replaced with Xulane transdermal patch.
If the client has Medicaid or insurance, they may be given a script to take to the pharmacy to be filled.

If there are barriers to the client using their Medicaid or Insurance, 340B stock from the LHD may be used, but there is no mechanism for LHD to bill Medicaid for ECP at this time.

If the client does not have Medicaid the agency can set fees using HCPCS codes S5000 (Generic) and S5001 (Brand Name).
Use CPT Code J7307
CANNOT BILL MEDICAID AT THIS TIME FOR THE FOLLOWING:

<table>
<thead>
<tr>
<th>Patch</th>
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<tbody>
<tr>
<td>Ring</td>
</tr>
<tr>
<td>ECP</td>
</tr>
</tbody>
</table>

Medicaid does not have these CPT codes on the Medicaid Reimbursement fee schedule for health departments.
An annual examination must be completed on all FP Medicaid (also known as MAFDN or BeSmart) program beneficiaries. AED date needs to be prior to the rendering of any other family planning services. One annual examination is allowed per 365 calendar days. The AED is required on all claims for inter-periodic visits with the exception of a Pregnancy test.

Providers who bill on the CMS-1500 must enter the AED in the appropriate location on the claim form.
# AED CPT Codes

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
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<td>99387</td>
<td>RC0510</td>
<td>99393</td>
<td>RC0519</td>
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The following laboratory procedures are only allowable for FP Medicaid (also known as MAFDN or BeSmart) program when performed "in conjunction with" or pursuant to an annual examination. For the purpose of “BeSmart”, “in conjunction with” has been defined as the day of the procedure or 30 days after the procedure. Testing performed after 30 days will not be reimbursed by FP Medicaid (also known as MAFDN or BeSmart).

LHD must enter the AED in their claims and submit the claims in a timely fashion for NCSLPH to submit its claims and receive payment.

1. Urinalysis
2. Blood count
3. Pap test
Providers 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. (CPT codes in RED font are used by NCSLPH for FP Medicaid (also know as MAFDN or BeSmart))
<table>
<thead>
<tr>
<th>HIV Screening</th>
<th>General STI Screening</th>
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<td>Miscellaneous</td>
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<td>86701</td>
<td><strong>Chlamydia</strong></td>
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<tr>
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<td>86592</td>
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<td>86593</td>
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BE SMART-HIV & STI LAB CPT CODES

**Gonorrhea**
- 87590 87592
- 87591 87850

**Herpes**
- 86694 87274
- 86695 87528
- 86696 87529
- 87207 87530
- 87273

**Treponema**
- 86780 87285

**Papillomavirus**
- 87623
- 87624
- 87625
<table>
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<tr>
<th>Tests</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>STD</td>
<td>Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission (excludes HPV and HIV)</td>
</tr>
<tr>
<td></td>
<td>Z30.09 Encounter for other general counseling and advice on contraception</td>
</tr>
<tr>
<td>HIV</td>
<td>Z11.4 Encounter for screening HIV</td>
</tr>
<tr>
<td></td>
<td>Z30.09 Encounter for other general counseling and advice on contraception</td>
</tr>
</tbody>
</table>
If the client was due for her administration of depo during the visit, 340b stock cannot be administered in the STD clinic. Agency may use non-340B stock or refer the client to the FP clinic for her Depo.
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