Coding & Billing Guide December 2018 Updates

DPH PHNPDU LTAT Consultants

January 2019

Child Health Program Updates

Health Check Program Guide pg 17

- The Health Check Program guide has been updated
- The most recent version was released in September 2018
- The Health Check Program Guide is referenced throughout multiple programs in the coding and billing guide- Please review the newest Health Check Program Guide for programmatic updates
- https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services

Additional clarification for requirements to provide Preventive and Problem-Focused E/M Visits on the same day pg 20

- If the provider creates one document for both services, he or she must clearly delineate the problem-oriented history, exam, and decision making from those of the preventative service.

Additional guidance related to Screening for Caregivers for Maternal Postpartum Depression During a Child Health Visit pg 22

- The American Academy of Pediatrics (AAP) recommends maternal postpartum depression screening at the 1, 2, 4, and 6-month well visits. The Centers for Medicaid and Medicare Services (CMS) directs use of CPT code 96161 (Health Hazard Appraisal), one (1) unit per administration, with EP modifier when billing for this service.

- North Carolina Medicaid will reimburse providers for up to 4 maternal depression risk screens administered to mothers during the infant's first year postpartum.

Screening for Emotional/Behavioral Health Risks pg 23

- Medicaid will reimburse providers for CPT Code 96127 to a maximum of two units per visit. The EP modifier should always accompany the code when a Medicaid beneficiary under 21 years old receives an emotional/behavioral health screen in a preventative service, sick child or E/M encounter.

Screening for Adolescent Health Risks, HEEADSSS Adolescent Health Risk Assessment pg 25

- For health risk screens in adolescents (youth aged 11 years and older) CPT Code 96160 (Health Risk Assessment) may be reported when conducting a health risk screen for an adolescent.
  - Medicaid reimburses providers for CPT code 96160 to a limit of 1 unit.
  - The EP modifier must append the code when a Medicaid beneficiary ages 11 – 20 years old receives a health risk screen in a preventative service or E/M encounter.
- CPT Code 96160 may not be used to claim a stand-alone administration of a CRAFFT (CPT Code 96127) brief screen.
- Refer to the current HCPG for examples of other scientifically validated screening tools for adolescent health risk.

Alcohol and Substance Abuse Screening and Brief Intervention (i.e., CRAFFT) pg. 25

- The Physician or Advanced Practice Practitioner will bill CPT Code 99408 plus EP and 25 modifiers for a CRAFFT with 2-positive risk factors for alcohol and/or substance (other than tobacco) abuse structured abuse screening and brief intervention services/referral; 15-30 minutes;

- The Physician or Advanced Practice Provider will bill CPT Code 99409 plus EP and 25 modifiers for a CRAFFT with 2 positive risk factors for alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services/referral; greater than 30 minutes.

Dental Screenings pg 27

- An oral screening must be performed at every *Health Check* well child visit.
- In addition, assessing for a dental home should occur at the 12-month and 18-month through 6-year visits.
- If no dental home is identified, perform a risk assessment and refer to a dental home. Per the AAPD, a dental home should be established no later than 12 months of age.
- If no dental home is identified by age 3, the PCP/Pediatrician must refer the child to a dentist for future dental care.
  - A referral must be done for any older child or adolescent that does not have a dental home.
- An oral screening performed during a physical assessment is not a substitute for an examination by a dentist that results from a direct referral. The initial dental referral must be provided unless it is known that the child already has a dental home

STI/Communicable Disease Updates

Billing T1002 Per Unit pg 10

- Clarification of previous guidance
- T1002 is billed in units: 1 Unit = up to 15 minutes
- T1002 is billable for up to 15 minutes rather than billable at a minimum of 15 minutes

Maternal Health Updates

Maternal Health: Clarification on Glucose Tolerance Testing

pg 61

- Glucose; quantitative, blood except reagent strip - 82948
- Glucose Tolerance; quantitative, blood reagent strip – 82950
- Gestational Screen (GTT); post glucose dose (includes glucose) - 82951
- Glucose Tolerance (GTT); post glucose dose, each additional beyond 3 specimens – 82952

Maternal Health: Billing Scenarios for Glucose Tolerance Testing pg 61

- Remember that it is only permissible to bill for services that have been completed
- If a client receives a fasting blood sugar (FBS) draw, consumes the Glucola, and the one-hour and two-hour specimens are successfully drawn, the agency would bill 82951. 82952 may be billed for the three-hour specimen, along with 82951.
- However, if the client doesn't tolerate (regurgitates) the Glucola after the initial fasting blood sugar has been drawn, then it is not permissible to bill 82951, since this code incorporates three blood draws plus the administration of Glucola.

Maternal Health: Billing Scenarios for Glucose Tolerance Testing pg 61

- The agency may bill CPT 82947 for the random/fasting blood glucose test, along with 36415, collection of venous blood by venipuncture if a venous FBS specimen was collected
  - If the FBS is collected using a capillary blood specimen, it is not billable to Medicaid

- If the client tolerates the Glucola until the one-hour specimen is drawn, and then regurgitates the Glucola so that the two-hour and three-hour specimens cannot be drawn, the agency may bill CPT 82947 for the FBS test, 36415 for the specimen collection, and CPT 82950 for the post-glucose test.

Maternal Health: Childbirth Education pg 72

- May not be billed as Telehealth (virtual participation)
- https://files.nc.gov/ncdma/documents/files/1M-2.pdf

Maternal Health
Depression Screening During Maternal Health Visit pg 73

- This section contains new guidance and additional clarification related to depression screenings completed during the maternal health visit
- PHQ-9
  - Bill on the date of service using CPT code 96127
    - ICD 10 code Z13.89
- EPDS
  - Can be used during both the antenatal, but preferred during the postpartum period
  - Bill on the date of service using CPT code 96127
    - ICD 10 code Z13.89

Maternal Health
Billing for Antepartum Care-Therapeutic Injections 17-P pg 75

- 17P – J1726 Makena®
  - Only if the medication has been purchased by the agency; billed per 25 units/10mg)
  - Multi-Dose and single dose vial 250mg/ml
  - Auto Injector 275mg/1.1 ml

- 17P – J3490
  - Only be used for Compounded at pharmacy if the medication has been purchased by the agency; billed per 1 unit/250mg)
  - Multi Dose vial (5 ml) 250mg/ml
  - Regardless of the manufacturer (e.g., Prasco, American Region, etc.)

Family Planning Updates

Family Planning- BeSmart
Revised Clinical Coverage Policy IE-7

- As you are aware Physician and Advanced Practice Practitioners can bill Be Smart Family Planning Medicaid for a limited set of CPT codes.
- ***New Codes have been added!***
- The complete list of these codes may be found in Attachment A, C1 of the Clinical Coverage Policy.
- **https://files.nc.gov/ncdma/documents/files/1E-7_2.pdf**

Family Planning- BeSmart
Revised Clinical Coverage Policy IE-7

- Clinical Coverage Policy Section 3.2.1-I (page five):

  "Ultrasounds are covered when the intrauterine contraceptive device (IUD) is malpositioned or the strings are missing. Ultrasounds are not intended for the purpose of routine checking of placement after IUD insertion."

- Newly approved CPT code for MAFDN (BeSmart):

  - **36415 WOOHOO!!!!**

- Prior authorization (PA) will not be required for the following ultrasound codes if the beneficiary has MAFDN eligibility.

  76830 – ultrasound, transvaginal

  76856- ultrasound, pelvic (nonobstetric), real time with image documentation;

  76857- ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (e.g., for follicles)

Family Planning - BeSmart
Revised Clinical Coverage Policy IE-7

- Newly added ICD-10 diagnosis codes :
  - N76.0, N76.1, N76.2, N76.3,
  - T83.32XA,
  - Z00.01, Z01.411, Z01.419, Z30.015, Z30.016, Z30.017, Z30.44, Z30.45, Z30.46, Z31.69, Z32.01, Z32.02

Family Planning - BeSmart Revised Clinical Coverage Policy IE-7

- From November 2018 NC Medicaid Bulletin (**https://files.nc.gov/ncdma/documents/files/Medicaid-Bulletin-2018-11.pdf**):

  "Effective Nov. 1, 2018, bacterial vaginosis (BV) testing and treatment will be covered for beneficiaries with MAFDN eligibility. The following CPT codes diagnoses and medications have been added to Clinical Policy 1E-7, Family Planning Services:"

- CPT codes
  - 87480 – Candida species, direct probe technique
  - 87510 – Gardnerella vaginalis, direct probe technique
  - 87660 – Trichomonas vaginalis, amplified probe technique

Family Planning - BeSmart
Revised Clinical Coverage Policy IE-7

- Diagnosis codes
  - N76.0 – acute vaginitis
  - N76.1 – subacute and chronic vaginitis
  - N76.2 – acute vulvitis
  - N76.3 – subacute and chronic vulvitis

- Medications
  - Metronidazole 250mg, 500mg
  - Metronidazole gel 0.75%
  - Clindamycin cream 2%
  - Clindamycin oral 150mg
  - 300mg, Clindamycin ovules100mg
  - Tinidazole 2gm, 1 gm, 500mg, 250mg

Family Planning
Billing for Nurse-Only Depo Visits

- Agencies may decide which of the two, above ways to bill for nurse-only visits for Depo injections.
- However, once an agency decides how they will bill this type of visit, they must bill all patients in the same manner.
- To decide which way to bill, agencies should factor in both the different reimbursement rates of 99211 and 96372, and also how many patients with Be Smart use many or all of their six, allotted inter-periodic visits per year.

Family Planning
Updated 340B Guidance pg 92

- **Billing Scenario 3:**
- **Question:** When a Be Smart client has a Mirena® inserted and the next week has another inserted due to the initial Mirena® fell out, they billed for the 2nd insert & 2nd Mirena®. The insertion was paid for & the Mirena® itself was denied. Reason: 00069 – Denied due to not in accordance with medical policy guidelines. The code used to re-bill was z30.433. Just checking to see if we should be paid for the 2nd Mirena®.

- **Answer: Updated Answer:**
- The "30 day rule" is now defunct, so now a second IUD insertion within 30 days should be covered. Per the 11/2018 NC Medicaid Bulletin: "Effective Nov. 1, 2018, when it has been confirmed that an intrauterine device (IUD) has been expelled, providers may reinsert a replacement IUD without any waiting period." **(**https://files.nc.gov/ncdma/documents/files/Medicaid-Bulletin-2018-11.pdf**)**

Family Planning
Billing Be Smart in the STD Clinic pg 113

- **Question**: Can LHDs bill Be Smart in the STD clinic?
- **Answer:** LHD providers may bill Be Smart from the STD program. LHD nurses (included ERRNs) cannot bill Be Smart from the STD program, since they are not allowed to bill 99211 or T1002 to Be Smart. LHD nurses may continue to bill Be Smart with a 99211 from the LHD Family Planning program as indicated.

- 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 today's presentation.