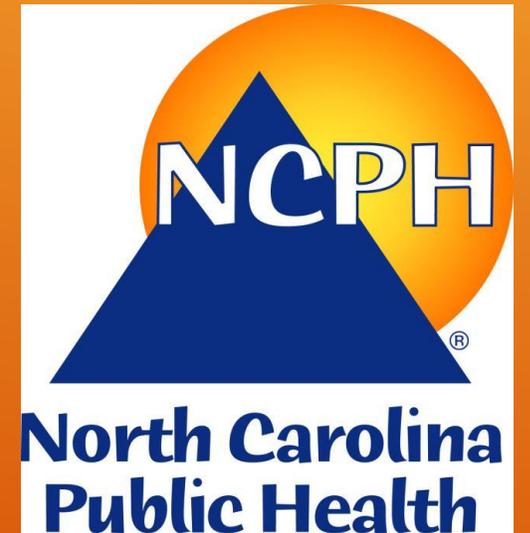


# CODING & BILLING GUIDANCE DOCUMENT

Updates from  
March 2018 Version 8



- ▶ Refer to Tracking Sheet for all changes
  - ▶ Additions and ~~deletions~~ are in the same color/highlight for easy reference
  - ▶ Version 9 will be published in June 2018
  - ▶ Next webinar to review updates is scheduled for July 25<sup>th</sup> & 26<sup>th</sup>
- 
- A decorative graphic consisting of several parallel white lines of varying lengths, slanted diagonally from the bottom right towards the top right, located in the lower right quadrant of the slide.

## ▶ **New vs Established (pg. 5)**

- ▶ A new client is defined as one who has not received any professional services from a physician/qualified health care professional working 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

**GENERAL UPDATES (PG 4)**

- ▶ **E&M and Preventative same day (pg. 9)**
  - ▶ When beneficiaries under 21 years of age receiving a preventative screen also require evaluation and management of a focused complaint, the provider may deliver all medically necessary care and submit a claim for both the preventative service and the E&M service (CPT 9920x/9921x) using the -25 modifier.

▶ **Additional language use of Title V funds (pgs. 12, 29, 71,94)**

- ▶ The guidance regarding Title V funding and sliding Child Health services to zero is as follows: Any Maternal and Child Health services (even outside of Child Health Clinics) must use a sliding fee scale that slides to “0” at 100% of the Federal Poverty Level per the NC Administrative Code – 10A NCAC 43B.0109 Client and Third Party Fees.
- ▶ The NC Administrative Code goes beyond the Title V/351 AA requirements, that all child health services, whether sick or well, no matter where delivered, must be billed on a sliding fee scale that slides to zero.

▶ **Non- STI ERRN billing (pgs. 10, 45 ,46)**

- ▶ Non-STI ERRNs may not bill **Medicaid** for STI treatment only visits Non-STI Enhanced Role Nurses providing STI services to **Medicaid** clients should use the nonbillable STI visit code LU242 for reporting services provided to the client since they cannot bill for the services provided.

## ► Other Services (OS) & Primary Care (PC) (pg. 13)

### 2) Changes in the Approval Process for Other Services (OS) and Primary Care (PC) Program Types

Local health departments no longer are required to have OS and PC program types approved by the Local Technical Assistance and Training (LTAT) Branch. This change is a result of the new data collection process, *Local Health Department – Health Services Analysis (LHD-HSA)* which began January 1, 2018. All services can be analyzed based on CPT or HCPCS codes. The Division does however want to be informed when local health departments implement a PC program. LHDs will need to assure the following when implementing a PC program:

- Establish a fee schedule approved by the county governing board,
- Establish policies, procedures and any standing orders that support PC services, inclusive of eligibility and billing,
- Establish a service description, describing the types of services that will be provided in PC,
- Inform your malpractice insurance carrier, and
- Notify Phyllis Rocco at: [phyllis.rocco@dhhs.nc.gov](mailto:phyllis.rocco@dhhs.nc.gov) when implementing PC.

Please address questions to your PHNPDU Nursing Consultant.

▶ **Will Medicaid pay for more than one preventive medicine code per 365 days?**

- ▶ Yes, in some certain circumstances.
- ▶ If the client has a FP Annual Physical at the health department which is billed using the FP modifier, then later in the year has an Adult Health Physical, as long as the second preventive medicine code used **does not include the FP modifier** then it should pay. Medicaid sees these as 2 different types of preventive medicine service. One just assesses the reproductive system for the benefit of providing a family planning method, the other assesses the entire body.



## ▶ New Link to Health Check Program Guide

### ▶ Health Check Program Guide

▶ Please review carefully for changes

▶ Other resources include:

▶ Periodicity Schedule

▶ Coding & Billing Guidance Document

NC DMA

# Health Check Program Guide

Revised 10.21.2017

# CHILD HEALTH (PG 17)

## ▶ **M-CHAT (pg. 21)**

- ▶ Providers may screen for developmental risk at ages greater than 30 months when the provider or caregiver has concerns about the child.
- ▶ The structured screening tool should be validated for the child's chronological age. One example of the screening tool that can be used for ages greater than 30 months of age is the Screening Tool for Autism in Toddlers and Young Children (STAT).



## ▶ Immunizations (pg. 23)

- ▶ All necessary immunizations must be administered by the billing provider delivering the Health Check periodic or inter-periodic Well Child care exam. The immunization portion of the well child visit *may not be referred to another provider, i.e. a private practice. It is not appropriate for a Well Child Care Visit to be provided in one location, and child referred to another location for immunizations.*

## ▶ Documentation for Immunizations (pg. 23)

- ▶ Paper chart: Include a copy of updated NCIR printout
- ▶ EHR: Note immunizations reviewed and up to date, or immunizations reviewed and needed, and reference NCIR
  - ▶ Example: Immunizations reviewed, needs 6-month vaccines, see NCIR
- ▶ See guidance document for additional information, pg. 23



▶ **HEEADSS Adolescent Health Risk Assessment (pg. 24)**

- ▶ Medicaid reimburses providers for CPT code 96160 to a maximum of two units per visit.
- ▶ When 96160 is billed with CPT code 96127: modifier 59 must be added to the EP modifier

▶ **To indicate Referrals use Z00.121 (pg. 27)**

- ▶ Encounter for routine child health exam with abnormal findings
- ▶ **Depression Screening (pg. 21)**
  - ▶ Billing 96161 with 96127 must add modifier 59 to the EP modifier

## ▶ 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 screening and brief intervention services/referral

## ▶ Dental Screenings (pg. 26)

- ▶ Use Bright Futures questions
- ▶ Need for dental services requires referral and documentation, or
- ▶ Explanation why referral is not feasible and a plan of care to address acute issues
- ▶ **To indicate Referrals use Z00.121**



▶ **Q: Is the Health Department responsible for any of the charges to a client (i.e. deductible) arising from when a client chooses to have their STD labs sent to a Private Reference Lab vs. the SLPH and use their insurance to pay? (pg. 49)**

▶ **A:** No. Any charges associated with using their private insurance is the responsibility of the client. Just remember no-copays may be accepted. We do think it would be a good practice to have the client sign a form stating they are aware that the health department is not obligated to pay for deductibles or other fees associated with billing insurance.

**SEXUALLY TRANSMITTED INFECTIONS-  
STI (PG 43)**

- ▶ **LU Codes** The following LU codes may be used to report TST given, not read:
  - ▶ LU124 was TST given, not read, for low risk
  - ▶ LU 123 was TST given, not read, contact

**TUBERCULOSIS CONTROL & TREATMENT**  
**(PG. 53)**

## ▶ **Uncomplicated Prenatal Care (pg. 57)**

- ▶ NC DMA Clinical Coverage Policy 1E-5, Section 3.2.1
- ▶ Every 4 weeks for the first 28 weeks of gestation
- ▶ Every 2- 3 weeks until the 36th week of gestation
- ▶ Weekly from the 36th week of gestation until delivery
  - ▶ The patient may be seen more frequently than the traditional care schedule if the provider determines and documents that the patient and/or pregnancy warrants additional care

<http://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf>

# **MATERNAL HEALTH (PG 54)**

▶ **Individual Antepartum Services (use of E/M codes) are covered if: (pg. 57)**

- ▶ Documentation supports the pregnancy as High-Risk (based on diagnosis) AND requires more than the traditional care schedule of services for gestational age; OR
- ▶ Antepartum care is initiated less than (3) months prior to delivery; OR
- ▶ Patient is seen for only (1-3) office visits

<http://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf> **section 3.2.2**



▶ **“O” and “Z” Codes (pg. 57)**

- ▶ ICD-10 diagnostic codes beginning with “O” are frequently used with high-risk pregnancies that are billed using individual E/M codes
- ▶ It may still be appropriate to bill an antepartum package (59425, 59426) for a patient with a high-risk diagnosis (“O” codes)
- ▶ ICD-10 Diagnostic codes in the “Z” and “O” categories may be billed together in some instances and is acceptable

## ▶ **Depression Screening (current guidance pg. 75)**

- ▶ Screenings should be performed 1x each trimester and postpartum
- ▶ During the prenatal course of pregnancy, a provider may choose from the following:
  - ▶ Client Health Questionnaire (PHQ-2 or 9)
  - ▶ Edinburgh Postnatal Depression Scale (EPDS)
    - ▶ Can be used during both the antenatal, but preferred during the postpartum period
- ▶ Postpartum agency visit can occur in either
  - ▶ Maternal Health
  - ▶ Family Planning
- ▶ Depression screening is only reimbursable if completed in an agency setting

## Additional guidance (to be added in to version 9)

- ▶ May a Post Partum Depression screen be billed in addition to the:
  - ▶ Package code for those HDs that **are not** a PMH? **YES**
  - ▶ Global code for those HDs that are a PMH? **YES**

▶ **Ella & Plan B (ECP)**  
**(pg. 87)**

- ▶ Recommend using HCPCS code S5001 “prescription drug, brand name” instead of J3490
- ▶ Refer to page 87 for details

▶ **Additional Primary FP ICD-10 Codes**  
**(pg. 103)**

- ▶ Z01.411 – encounter for gynecological examination (general) (routing) with abnormal findings
- ▶ Z01.419 – encounter for gynecological examination (general) (routing) without abnormal findings

**FAMILY PLANNING**  
**(PG 81)**

▶ **BeSmart Wet Prep (p104)**

- ▶ Beginning April 1, 2018
- ▶ Use 87210
- ▶ Q0111 will be denied
- ▶ See page 104 for details

▶ **BeSmart and Sterilization (pg. 104)**

- ▶ DSS no longer allowed to ask questions regarding sterilization prior to determining eligibility for Medicaid
- ▶ LHD **MUST** ask questions regarding sterilization prior to performing any FP services

## PLEASE NOTE THE FOLLOWING CHANGE IN THE C&B GD:

- ▶ ~~For Family Planning clients you may only charge the client for services provided. You may not charge for:~~
  - ▶ ~~Returned check fees~~
  - ▶ ~~Credit Card fees~~
  - ▶ ~~Late charges~~

- ▶ YOU MAY USE TITLE V OR TITLE X FUNDS TO “PAY/OFFSET” THESE PROCESSING FEES AS LONG AS THEY ARE SPECIFICALLY CONNECTED TO A TITLE V OR TITLE X SERVICE.

- ▶ Local Health Departments may bill if these services are provided as outlined in the DMA Clinical Coverage Policy 1-H
- ▶ Only the provider that provides the care or counseling for the client may bill for the actual E&M or counseling visit.



- ▶ The agency that facilitates the transaction between the client and the off-site provider may bill the “ facility fee” once per beneficiary/day, regardless of how many off-site providers participate in the care. Please read the DMA Clinical Policy 1-H carefully prior to initiating this service. Special equipment and security is required.

- ▶ **DMA Clinical Coverage Policy**  
<https://files.nc.gov/ncdma/documents/files/1-H.pdf>

# TELEMEDICINE & TELEPSYCHIATRY (PG. 116)

- ▶ Most have been eliminated
- ▶ Please see memo from Phyllis Rocco dated 2/1/18 on the DPH/LHD website

<http://publichealth.nc.gov/lhd/docs/Discontinuation-LU-CodeSet-020118.pdf>

- ▶ Updated LU code list may be found at

<http://publichealth.nc.gov/lhd/docs/LU-CodesRevised2016List-010518.pdf>

# LOCAL USE (LU) CODES (PG. 117)

- ▶ **The adult annual health assessment** is not covered when the medical criteria listed in **Section 3.0 of the Clinical Coverage Policy** <https://files.nc.gov/ncdma/documents/files/1A-2.pdf> are not met.
- ▶ The annual health assessment is not covered when the recipient has an illness or specific health care need that results in a definitive medical diagnosis with medical decision-making and the initiation of treatment, and when the policy guidelines listed in **Section 5.0 of the Clinical Coverage Policy** are not met

**ADULT HEALTH (PG. 118)**



## ▶ Limitations

- ▶ a. Medicaid beneficiaries 21 years of age and older may receive one annual health assessment per 365 days.
- ▶ b. The annual health assessment is not included in the legislated 22-visit limit per year.
- ▶ c. Injectable medications and ancillary studies for laboratory and radiology are the only CPT codes that are separately billable when an annual health assessment is billed.
- ▶ **d. An annual health assessment and an office visit cannot be billed on the same date of service.**

