PLEASE DO NOT PUT YOUR PHONE ON HOLD

USE THE CHAT BOX TO ASK YOUR QUESTIONS
WE WILL BE COMPILING A Q&A DOCUMENT ONCE WE HAVE ALL THE ANSWERS

THE SLIDES FROM TODAY’S PRESENTATION WILL BE POSTED ON THE DPH/LHD WEBSITE AFTER THURSDAY’S WEBINAR
CODING & BILLING GUIDANCE DOCUMENT, VERSION 10

Updates
Who may choose codes?

- There are no rules/laws that stipulate clinicians must be the person to select CPT, ICD-10 or HCPCS codes.
- Requiring that all coding and billing be conducted by the clinician may limit the ability of the clinician to maximize their service capacity.
- DPH’s as issued new guidance regarding medical coding & billing.
1. The key to correct coding and billing is being able to understand the medical documentation and correlate it to a matching diagnosis and/or CPT code.
2. While the provider is ultimately responsible for the codes (ICD-10, CPT, HCPCS) upon audit, coding selection authority may be delegated to other trained staff if that is the agency’s practice and it is captured in policy.
3. Training and periodic competency validation should be included with any policy/process change and upon new hire orientation.
4. Work flow should be considered as policies/processes are evaluated and changed.
5. Consideration of whether the clinical provider is available on site to interpret documentation or assist in clarifying diagnosis choices may assist in agency decisions regarding changing policies/processes.
6. The LHD should consider risk management policies and consultation with the medical director and providers in planning these changes.
7. The LHD should have routine billing/coding audits to assure quality and risk management.
8. For health departments with certified coder(s):
   a. It is a relatively common and established practice in private practice and 
      hospitals for certified coders to select CPT, HCPCS, and/or ICD-10 codes 
      based upon the provider’s documentation.
   b. Agencies may use the certified coder as a resource for clinicians and other 
      billing staff when there are complicated services and diagnoses.
   c. Some or all code selection may be delegated to a certified coder.

9. For health departments without certified coder(s):
   a. Agencies may still opt to either only let providers select codes.
   b. Nurses or clinical providers may be appropriate in the LHD work flow to 
      assign additional codes based on the provider’s documentation.
   c. Non-clinical staff may be identified to add codes from a specified list in 
      specific instances determined by the agency. For example, trained billing 
      staff may be allowed to add a vaccine administration procedure code when 
      the chart reflects a vaccine was administered.
Be Smart and Retroactive Coverage

- Be Smart Medicaid coverage is retroactive for 90 days.
- Family Planning preventive visit within the 90 days preceding her receipt of Be Smart Medicaid coverage, the service should be reimbursed by Be Smart,
- The Client must notify her Department of Social Services (DSS) case worker of the date of the visit and the need for retroactive coverage.
- Once Be Smart Medicaid eligibility is confirmed, the health department may bill for a Family Planning preventive visit that occurred within the 90 days before the BeSmart coverage was issued.
- That visit date would then be the Annual Exam Date (AED) in NC Tracks.
- If more than 90 days have passed, then the local health department would not be able to bill retroactively for the visit.
Question: Can you review specific labs covered under family planning?

Answer: Laboratory services covered under the “Be Smart” Family Planning Medicaid Program include:

- a) Hematocrit or hemoglobin;
- b) Urinalysis for sugar and protein;
- c) Papanicolaou tests (including repeat tests for insufficient cells);
- d) Screening for Gonorrhea, Syphilis, Chlamydia, Herpes, Treponema, Papillomavirus, Destruction, Benign or Pre-malignant lesion(s), General STI screening; and screening for HIV.
- e) Pregnancy testing

Please note that urinalysis, blood count, and Pap tests may only be performed on the day of the annual exam or up to 30 days after the annual exam. One repeat pap test may be performed for insufficient cells within 180 calendar days of the first pap test.
Question: Are ER visits covered?
Answer: The “Be Smart” Family Planning Medicaid Program does not cover Hospital Emergency room or emergency department services.

Question: We are working with a local health department to increase the demand for services. Do you have data that shows the percent of the county population that would qualify for Be Smart services?
Answer: For data questions related to this program, please contact Shahnee.haire@dhhs.nc.gov directly.
Question: What kinds of service can be offered to a 4-year-old or an 80-year-old in Family Planning?

Answer: “Be Smart” Family Planning Medicaid services are for patients who are currently able to conceive and who are currently trying to delay or avoid pregnancy. No services are indicated for patients who are not capable of achieving pregnancy (including a 4-year-old and an 80-year-old female), and “Be Smart” Family Planning Medicaid should not be billed for any such services. However, an 80-year-old male is still eligible to receive service through “Be Smart”.
Question: What does a provider say if a client was given Medicaid but cannot use it?

Answer: Individuals that are eligible for “Be Smart” due to income but are not clinically eligible can be concerning to both parties. A script to assist health agencies on informing individuals, that they are unable to use their “Be Smart” Medicaid is being finalized. Until our script is published, please refer to the Division of Medical Assistance January 2018 Medicaid Bulletin for provider guidance.

Lab 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 STI 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 or third party insurance;
- For all self-pay outside lab bills the LHD based on negotiated/contracted rate. The LHD may then bill the client at their fee based on SFS (including 36415 for venipuncture and 99000 for handling).
- 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 STI 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. We recommend the following:
  - Ensure that in their contract, they include a statement that if the insurance does not pay (i.e. unmet deductible) that the lab bill the agency and not the client.
  - Or
  - Just have any client with insurance identified as “self pay” (agency billed by lab) and the agency would bill them on SFS.
Scenario C:

- If a client has both inside and outside labs requiring a venipuncture (36415), the agency may bill for the venipuncture.
Newborn Screening Fee Increase

- In reference to the memo from the State Lab for Public Health, June 19, 2018, the fee for Newborn Screenings has increased from $44.00 to $128.00. Local health departments are not able to bill for this service, however you may include a Medicaid ID number on the requisition form so that the lab may bill Medicaid directly. Local health departments should use program funds to cover non Medicaid clients.