Q: Does Health Choice require the provider to use the TJ modifier for a well child visit as HCPG requires for the EP modifier?
   ▶ Per guidance received from NC DMA, Health Choice would require the use of a TJ modifier in the place of when the EP Modifier is used.
   ▶ Per the HCPG, when CPT code 96160/EP or 96161/EP are billed with CPT Code 96127/EP, modifier 59 must be appended to 96160/96161. Would the same hold true for Health Choice, except the provider would use the TJ Modifier?
   ▶ Per guidance received from NC DMA, Health Choice would require the use of the TJ modifier in the place of when the EP Modifier is used as well as appending the modifier 59 when CPT Code 96160 or 96161 are billed with CPT Code 96127.

Q: Just want to make sure about 2 preventative codes in the same year- does that apply for someone:
   ▶ Yes, in some 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, if the second preventive medicine code used does not include the FP modifier then it should pay. Medicaid sees these as 2 distinct 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.

Q: Can a TB clinic charge for skype services to provide DOT?
   ▶ You may be able to charge for the technical aspects of the service but not the DOT. See the Telemedicine Clinical Coverage Policy at https://files.nc.gov/ncdma/documents/files/1-H.pdf

Q: Does Medicaid cover Telemedicine or Telepsychiatry?
   ▶ Yes. Please refer to the Clinical Coverage policy found at the following link-https://files.nc.gov/ncdma/documents/files/1-H.pdf

Q: How is it suggested that we distinguish HR maternity pts now? Unable to distinguish by DX or number of visits.
   ▶ The diagnosis code and the number of visits (outside of the uncomplicated prenatal visit schedule) should allow you to distinguish any High-Risk Maternity client.
   ▶ **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
Q: If a patient with family planning waiver has had sterilization and is moved to adult health will FP pay for these services?
   ▶ No, FP will not pay for the services in Adult Health.

Q: It was my understanding that if we have started a family planning visit and it is disclosed within the visit once started that the client has been sterilized that we must complete the physical. We cannot change them after visit started.
   ▶ ...if the client discloses during the nurse interview, they can be brought back up to the front desk and proper financial documentation can be done to inform the client that they are now going to be considered a well woman and not eligible for family planning and the financial implications that requires. The client can then chose to continue on as a well woman or discontinue visit. However, if it is not discovered until they client is in with the dr during the physical exam, we cannot change it well woman.
   ▶ If the provider has already started the physical exam, the agency may not change the visit type and may not charge the patient. However, if just screening/counseling has commenced, and the provider has not yet begun a physical exam, then the visit type may be changed.

▶ Additional references may be found below:

The DMA January Bulletin, p. 8, item 1 specifically instructs agencies to verify that BeSmart beneficiaries are able to bear children before commencing a family planning appointment:

“The following guidance will prevent providers from rendering family planning services to beneficiaries for which the provider cannot be reimbursed.

1. Providers shall verify each beneficiary’s type of coverage prior to each visit. Though DSS workers cannot ask beneficiaries questions about their ability to bear children during the application process, providers must do so before rendering services. (Beneficiaries do receive a letter with their card that informs them of the limitations of their coverage.)”

Page 9, items 5 & 6 further clarify what an agency should do if they discover that a client has been sterilized during the screening process before the exam commences (5) or after the Family Planning exam has been provided (6):

“5. If it is discovered during screening that the beneficiary has no need for Family Planning Services (permanently sterilized, post-menopausal, sterile, post-hysterectomy, not capable of having children, etc.), Medicaid shall not be billed for
the service. **Providers should inform the beneficiary that the visit can continue but that the beneficiary would be responsible for the cost of the services provided on that day. The beneficiary should be informed of the cost of the visit and be told that they can choose to leave at that point and not be charged for the appointment.**

6. Comprehensive screening prior to exam should prevent the discovery – during the exam – that the beneficiary does not need family planning services. However, if the discovery does occur during the exam, the provider cannot bill the beneficiary or Medicaid. The provider should inform the beneficiary that future visits will not be covered under Family Planning Medicaid because they are not eligible for family planning services. The beneficiary will be responsible for payment of any future services. If the provider is seeking payment from the beneficiary, the provider shall inform the beneficiary prior to rendering the service (see 10A NCAC 22J. 0106). The provider shall not bill Medicaid for family planning visits, when the beneficiary has no need for family planning services.”

**Q:** For Adult Health physicals when billing Medicaid, are providers to only use the physical Dx code and no other codes?

> The provider would document the ICD-10 code for the physical exam as required by the Clinical Coverage policy.

**Q:** If the client is an established Blood Pressure Client in Adult Health, do you still complete an annual physical.

> The wording in the clinical coverage policy is:
> a. Medicaid beneficiaries 21 years of age and older **may** receive one paid AH 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.

> The provider would be responsible to determine and recommend an annual exam, however, I would assume it would be best medical practice to do so especially if they are following the client for a specific diagnosis/chronic condition.
Q: Will Medicaid pay for more than one preventive medicine code per 365 days?

- Yes, but only in certain circumstances.
  - The child Medicaid beneficiary (0-up to 21) can get a FP and a EP well child physical both within 365 days
  - An adult Regular Medicaid beneficiary may get a FP and an OB physical, or an
  - AH annual assessment and an OB assessment, or an
  - AH and a FP physical
  **as long as one of the 2 physical assessments has a modifier.**
  - There is no modifier for Adult Health annual assessment therefore submission of two AH physicals within 365 days would cause the last service to reject.

However, if for some reason a Medicaid client desires a 2nd physical in a 365 day time period that does not fall into the combinations described above then the local health department may either provide that service at no cost to the individual by discounting the service to “0” or they may place the client on the appropriate sliding fee scale based on income and charge the client.

Clients with BeSmart Family Planning Medicaid are only eligible for Family Planning related services and should be screened for eligibility like all clients for other health department services.

Q: Do NCIR printouts need to be scanned into EMR to verify review for all programs?

- A requirement to scan the NCIR report into your electronic health record depends on your agency policy. Since there are periodic changes to the NCIR depending on the immunization schedule, this may not be the most efficient way to document review of immunizations. A better way would be to review the NCIR electronically and make a notation in the record such as “Up to date per NCIR” with the date reviewed and initials or a signature.
BeSmart & Sterilization- Guidance from the Women’s Health Branch (page 104 C&B document March 2018) as requested:

**Be Smart and Sterilization**

Providers have been seeking clarification from N.C. Medicaid about sterilization and eligibility under the “Be Smart” program. The Centers for Medicare and Medicaid Services (CMS) notified N.C. Medicaid that it is **not** acceptable to ask questions related to a beneficiary’s sterilization status during the Medicaid application process. Therefore, some beneficiaries will be approved for Family Planning Medicaid who have no need for family planning services.

Though Department of Social Services (DSS) staff cannot ask beneficiaries questions about sterilization status during the application process, providers **must** do so before rendering services. It is imperative that providers determine if Medicaid beneficiaries need family planning services prior to providing any other services under the program (e.g., annual or physical exams). Providers shall **not** bill Medicaid for **any service** rendered under Family Planning Medicaid for a beneficiary who does not have family planning needs. Claims may be subject to audit to ensure proper billing.