1- **Q:** If it is a regular STI visit not Be smart, do you the z30.09 too.

   **A:** The ICD-10 code Z30.09 indicates encounter for other general contraceptive counseling. If the client is only being seen for STI then this code is not necessary. The client should be seen in the STI clinic and an appropriate diagnosis assigned.

   Just to clarify, if this was a BeSmart client being seen in STI by a provider then they would need to include the FP modifier, the appropriate birth control method diagnosis code and the AED.

2- **Q:** Can we bill for the counseling visit that is done in the FP clinic prior to referral for a vasectomy procedure (at an outside provider)?

   **A:** Yes, a consultation visit may be billed to Medicaid and BeSmart. BeSmart will pay for 2 sterilization consultations per lifetime.

3- **Q:** How is it billed when a patient returns to clinic for IUD string check?

   **A:** If your agency treats it as a “problem” visit and updates the patient’s history, completes an abbreviated ROS, and the provider puts them in stirrups to check for the strings, then you could bill an E&M visit level appropriate to the level of service provided.

4- **Q:** Do the 6 STI visits count toward the total 6 visits allowed for FPW? Or does the plan account for 6 STI visits AND 2 FP visits?

   **A:** BeSmart/FP Medicaid allows for a TOTAL of 6 visits in addition to the annual exam. This includes STI or FP visits provided in the FP clinic. This also includes any Provider level visit seen in the STI clinic. (refer to page 119 Q&A)

5- **Q:** Can Postpartum visits be scheduled before 6 wks. after delivery?

   **A:** Yes. A postpartum visit may be scheduled any time during the 6 weeks after delivery. However, keep in mind that if the client has Medicaid/MPW, then the postpartum will only be paid if performed up to 6 weeks after delivery.

6- **Q:** There was one slide where it was stated that the T1002 code 75 minutes = 5 units. I think that should be 3.

   **A:** Since each T1002 unit = 15 minutes, then 5 units would = 75 minutes. 3 units of T1002 would equal 45 minutes.
7. Q: Is there a modifier to the office code billing for a failed IUD insertion?

A: Yes (from page 92 of CBGD v14)
Modifiers with 58300: Use modifier -52 (Failed Procedure) to denote that you attempted insertion, but the procedure was incomplete due to anatomical factors (e.g. Stenosis) or -53 (Discontinued Procedure) to indicate that you had to stop because of concerns for client well-being (e.g. vaso-vagal, severe pain).

8. Q: Please clarify. Is an STI visit covered by MAFDN?

A: Yes. STI provided in the FP clinic is counted as one of the 6 allowable inter-periodic visits. In addition, a provider may bill MAFDN for an STI visit provided in the STI clinic. (see page 118 Q&A)

Should the FP modifier be submitted as well as the AED?

A: Yes, regardless of whether they are seen in FP or STI then the FP modifier and AED are required. In addition, they need to include the diagnosis code for the appropriate birth control method.

9. Q: Could you please clarify the difference between simple and extensive wart removal? Also are these codes okay for a STI ERRN to bill?

A: We have done some research and plan to discuss it at our next Coding & Billing Council meeting on 8/12/19. We will update this document after that.

10. Q: Was the Nexplanon code given - J7307?

A: Yes, to be billed as J7307 FP UD and include the NDC. Diagnosis code is Z30.017

11. Q: If the Depression Screening tool indicates a positive response, how and what do we bill?

A: Whether the screening is positive or negative you would bill the same using CPT 96127 and ICD- Z13.89

12. Q: So an STI patient would need 2 appointments - Depo and STI in order to use 340b?

A: 340B Depo cannot be administered outside of a FP Clinic visit. The only thing to do is give private Depo. If agency policy is to just bill the therapeutic injection (96372), then they could do that.
13. Q: FP Medicaid originally required the AED on the physical as well as the inter-periodic visits. They had removed the stipulation for the AED date to be on those inter-periodic visits and we have been getting paid. Are you saying we now have to put the AED back on those inter-periodic claims again?

A: Yes. We were able to verify with our BeSmart expert that the AED is and always has been required for inter-periodic visits. It is not a requirement for pregnancy test only visits.

14. Q: Where can we find the slides of the webinar?

A: The slides, recording and Q&A are all posted on the DPH/LHD website under the Documentation & Coding header.

15. Q: Does a presumptive need to be done for those that have FPW?

A: Yes. Since FPW would not cover any maternal health services you would want to complete the Presumptive Eligibility. In addition, you would want to send your client to speak with their caseworker about transitioning to MPW. If your client has already had their FPW changed to MPW then no PE would be needed.

16. Q: Can you please clarify if Medicaid covers MNT services for patients other than children, pregnant women?

A: At this time Medicaid will only reimburse for MNT services provided to children through age 20 and Pregnant/Postpartum women.