Documentation, Coding and Billing Guidance Document, version 14

Public Health Nursing and Professional Development Unit (PHNPDU)

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This document replaces all prior versions of Coding & Billing Guidance Document

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Introduction

This document was developed to provide local health departments (LHD) with guidance and resources specific to public health coding and billing of services rendered. This information was developed using current program Agreement Addenda, Medicaid bulletins and Clinical Coverage Policies, and Current Procedural Terminology (CPT) and International Classification of Diseases or Diagnosis (ICD-10) code books. Although we have made every attempt to provide comprehensive and correct information, it is still advisable to contact your program consultants if this information is unclear or if you have specific questions.

General Information

Documentation

1. Documentation within the health record must support the procedures, services, and supplies coded.

2. Accuracy, completeness, and timely documentation are essential, and agencies should have a policy that outlines these details. Please refer to the Documentation Guidance from Local Technical Assistance and Training (LTAT) Branch Head (http://publichealth.nc.gov/lhd/) for additional information and guidelines.

3. If there is insufficient documentation to support claims that have already been paid, the reimbursement will be considered overpayment and a refund will be requested.

Medicaid payment process through NC Tracks: June 2015

Electronic adjustments are the preferred method to report an overpayment or underpayment to DHB. There are two separate actions that may be filed:

- A provider should use "void" when the client needs to cancel or submit a refund for a previously paid claim. The entire claim will be recouped under the void process.
- A provider should "replace" a claim if the client is updating claim information or changing incorrectly billed information. This term is interchangeable with adjusting a claim.
- The entire claim will be recouped and reprocessed under the replacement.

4. CMS guidelines require that the **chief complaint/reason for a visit is** documented in the record.

- In most cases it will be a complaint of a symptom but could be “annual Family Planning (FP) exam” or “Health Check exam”.
- Remember that the client may present on the day of a visit with a different reason/chief complaint from the one identified when the appointment was made.

- In some cases, the Physician or Advanced Practice Practitioner may change the "chief complaint" if, during the exam, a significant problem is identified that must be addressed during the visit.

5. **New versus Established client:**
   - 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.
   - This 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.

   If the client's only visit to the Health Department is WIC or immunizations without one of the above service codes
   - It does not affect the designation of the client as a new client; the client can still be NEW.
   - Remember that a client may be new to a program but established to the health department if they have received any professional services from a physician/qualified health care professional.
   - In this case, you would use the forms for a "new" client for that program even though the client is billed as "established" to the health department.

   Due to National Correct Coding Initiative (NCCI) edits the practice of billing a 99211, and then later billing a *new* visit code, has been eliminated.
   - Many LHDs have been billing a 99211 (usually an RN only visit) the first time they see a client and then, up to 3 years later, bills a 99201 – 99205 or 99381-99387 (New Visit).
   - Examples may include: billing the 99211 for pregnancy test counseling or head lice check by RN and then a new visit when the client comes in for their first prenatal, Family Planning or Child Health visit.
   - Now that the NCCI edits have been implemented, all of those "new" visits will deny because the LHD will have told the system (via billing a 99211) that the client is "established."

   Consult your PHNPDU Nursing Consultant if you have questions.

6. **Shared/split E/M Visits** (January 2017 Medicaid Bulletin- pg. 14)
   - A shared/split Evaluation and Management **(**E/M) visit is defined as a medically necessary encounter with a client where the physician and a qualified Non-Physician Practitioner (NPP) each personally perform a **substantive portion** of a face-to-face E/M visit with the same client on the same date of service.
   - A "substantive portion" of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of an E/M service.
   - The physician and the qualified NPP must be in the same group practice or be employed by the same employer. **Note:** [NPP includes the terms "mid-level provider", "Nurse Practitioner (NP)", "Physician Assistant (PA)" and Certified Nurse Midwife (CNM) *(also acceptable is APP-Advance Practice Practitioner)*.
   - Every party must document the work they performed. The documentation must show a face-to-face encounter with the physician, in which case the service is billed under the physician's National Provider Identifier (NPI).
   - If there is no face-to-face encounter with the physician, the NPP must bill the service using the NPP's National Provider Identifier (NPI).
   - A notation of "seen and agreed" or "agree with above" would not qualify the situation as a shared/split visit because these statements do not support a face-to-face contact with the physician. Only the NPP could bill for the services.

   According to the Centers for Medicare & Medicaid Services (CMS), shared/split visits are applicable for services rendered in the following settings:
     - Hospital inpatient or outpatient
     - Emergency department
     - Hospital observation
     - Hospital discharge
     - Office or clinic

   According to the Centers for Medicare & Medicaid Services (CMS), shared/split visits are not allowed:
     - In a skilled nursing facility or nursing facility setting
     - For consultation services
     - For critical care services (99291-99292)
     - For procedures
     - In a client's home or domiciliary site

NOTE* Shared/split visits are not considered "incident to" services.

Billing

1. LHDs bill for services using the NPI of the Physician or Advanced Practice Practitioner who provided services to the client or for the Medical Director who signed the standing orders for the nurse to provide the service.

2. Services provided by nurses (including Enhanced Role Registered Nurses) should be **billed** using the NPI of the physician who wrote the standing order to provide the examination.

3. Nurses providing services for which they would bill a 99211 should **bill** that visit under the Medical Director's NPI unless there is a specific order from another physician for that client to support the visit.

4. To be eligible to bill for procedures, products, and services related to this policy, Physician or Advanced Practice Practitioners shall:

- meet Medicaid or NCHC qualifications for participation;
- be currently Medicaid - enrolled; and
- bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

5. Place of Service: Local Health Department = 71
Home Visit = 12

6. Physician or Advanced Practice Practitioners may not charge for an office visit unless they are face to face with the client.

- Writing an order in the medical record does not constitute a Physician or Advanced Practice Practitioner office visit.
- Remember the highest-level Physician or Advanced Practice Practitioner **providing services to** the client determines the level of service billed.
- If the RN/ERRN sees the client and then asks the Physician or Advanced Practice Practitioner to come in and see the client, the visit is billed at the code for the level of visit done by the Physician or Advanced Practice Practitioner and the LU code would be for the RN/ERRN contact.
- If an RN/ERRN consults with a Physician or Advanced Practice Practitioner during a visit with a client but the Physician or Advanced Practice Practitioner does not see the client, it is billed using the code appropriate to the RN/ERRN visit.

7. Copays:
    - LHDs should charge Medicaid copay for Adult Health /Primary Care and Adult Dental and Adult Immunizations only. Other health department programs are exempt from collecting any Medicaid copay.

    - For other insurance copays, you would collect the copay on the insurance card IF you are in-network with the insurance carrier. Otherwise, you are not obligated to do so.

    - For FP, you may collect the copay or their SFS amount due: whichever is lower (a Title X requirement). OPA- Title X Program Requirements April 2014, http://www.hhs.gov/opa/pdfs/ogc-cleared-final-april.pdf section 8.4.6.

    - ***LHDs should include specific negotiations in their insurance company contracts.*** NC Law prohibits LHDs from charging clients for STI screening services. This includes collecting insurance copays. We are also prohibited by Family Planning from charging a client more than they would pay on the sliding fee scale. These items, and others like them, should be included in the contract between the Health Department and the insurance company to ensure no out-of-compliance issues with the insurance company

8. Encounter Forms:
    - All services provided should be indicated on the Encounter Form/Superbill whether reportable or billable.

    - All encounter forms should reflect the individual staff member's identification number assigned by the health department's billing system, whether reported or billed, for statistical purposes.

    - The **Rendering Physician or Advanced Practice Practitioner's** (different then the Billing Physician or Advanced Practice Practitioner) NPI is the person who provided the service.
        - If the person who provided the service was an RN or LPN then we use the NPI of the physician who wrote the standing order or Medical Director (may be the same)
        - In addition to the **Billing Physician or Advanced Practice Practitioner** NPI, you must also include the NPI of the health department when billing.
        - Health Departments also use the health department's taxonomy code. NCTracks requires each LHD to have a health department NPI.
        - All Physician or Advanced Practice Practitioners, (except nurses who are not eligible to obtain an NPI), are required to use their own NPI.
        - Every Physician or Advanced Practice Practitioner should get credentialed and obtain an NPI. Advanced Practice Practitioners do not work under standing orders.
        - Only RN's and LPN's work under a physician's standing order.

- If a procedure or test that is commonly provided as part of a service is not provided please note "not done" so that billing staff will not think that it was just forgotten.
    - The Physician or Advanced Practice Practitioner providing the service is responsible for marking the encounter form with everything they provided to the client.
    - Correct CPT and ICD codes must be used; make sure that all digits required are used with the ICD codes.

- ICD codes used on the billing form are to justify the CPT codes.
    - Remember that the CPT code identifies what you did and the ICD code identifies why you did it.
    - The biller needs to be able to link the ICD code to the respective CPT code which means the Physician or Advanced Practice Practitioner should mark the encounter form in such a way that the biller can easily identify the paired ICD and CPT codes.
    - Only one ICD code may be required to justify any CPT code.
    - However, there may be multiple ICD codes required to provide detailed justification of the service(s) provided.
    - ICD codes do not affect the amount that is paid for the CPT code; they are used only to justify the CPT code.

9. Billing Preventive and E/M visits to Medicaid on the same day

- Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit for most programs; however, refer to (exception) in this guidance included in current Health Check Program Guide.
    - When beneficiaries under 21 years of age receiving a preventative screen also require evaluation and management of a focused complaint.
    - In this situation, the provider may deliver all medically necessary care and submit a claim for both the preventative service (CPT 9920x/9921x)
- The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology.
    - You will need to consult with each insurance carrier for their plan specific billing rules.
- If a client is seen by a Physician or Advanced Practice Practitioner for STI services and an additional problem on the same day
    - Two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code.
    - This will identify that two “separately identifiable services” were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing.

- Billing STI services provided by the STI ERRN (*Medicaid STI Clinical Service Policy. Effective 3/30/2016*
    - The four (4) components of the STI exam do not have to be provided by the same STI ERRN to bill Medicaid for the provision of the STI service.
    - The service can still be split across 2 different days and can be provided by a different STI ERRN on each day, billing T1002 per unit (equals up to 15 mins) of care provided.
    - STI ERRN- must bill T1002 for Medicaid clients and use 99211 to bill insurance clients. Some third-party insurance companies will also accept the T1002. Local Health Departments will need to check with each third-party payer to see how they would like the LHD to bill them for services.

- Billing STI services provided by the Non- STI ERRN
    - May bill insurance using 99211 for STI treatment only visits.
    - 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.

- TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 **or T1002**.

10. Denials for Preventive Medicine Codes Billed with Immunization Administration Services: (NCTracks Newsletter March 17, 2016)

- Recent system updates resulted in NCCI edit denials (EOB 49270 - NCCI EDIT) of preventive medicine service codes submitted with EP modifier only and reported in conjunction with immunization administration service(s). These are correct NCCI edit denials.

- CMS billing guidelines indicate Physician or Advanced Practice Practitioners may use modifier 25 with modifier EP or modifier TJ for preventive medicine service codes (99381 - 99397 and additional screening codes 99406-99409 and 96160) when reported in conjunction with immunization administrative services (90460-99474).
    - Physician or Advanced Practice Practitioners may submit corrected replacement claims if appropriate.

- Modifier 25 may be used with other non-preventive medicine E/M services when reported in conjunction with immunization administration when the E/M service is significant and separately identifiable.
    - Exception: If a vaccine is billed with the same date of service as code 99211, NCCI edits do not permit the E/M code to be reimbursed.
    - CMS has stated that an E/M code should not be billed in addition to the administration code(s) when the beneficiary presents for vaccine(s) only.

11. Use of NDC identifiers when billing/reporting 340b drugs/devices and Immunizations: (Excerpt from NC Tracks Bulletin March 29, 2018)

- ALL providers are required to submit the proper NDC that corresponds to the physician administered LARCs and Vaccines used for administration and corresponding procedure code as the new pricing is based on a procedure code/NDC match.

- If the procedure code/NDC combination is not found, the claim line will deny and post EOB 02047: "RATE NOT FOUND. CONTACT THE M&S HELPDESK AT (1-800-591-1183) or email at ncpharmacy@mslc.com ."
    - Myers and Stauffer (M&S) is the current actuary who maintains these drug prices for Pharmacy and Professional claims. Please contact Myers and Stauffer with any questions or concerns; NCTracks will not be able to assist with these issues.

12. A County Health Department may not offer services to Health department employees free of charge if they charge all other clients, including other county employees.

- The employees and/ or their families should be assessed and charged the same way the HD charges the general public.
- If county government contracts with the HD to provide an "employee clinic for acute care and or preventive care" then the HD can work out a contract with the county on how the county wants to compensate the HD for the care they provide.

13. Will Medicaid pay for more than one preventive medicine code per 356 days? Yes, but only in certain circumstances.

- The child Medicaid beneficiary (0-up to 21) can get a FP and an EP well child physical both within 365 days
- An adult Traditional 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 FP Medicaid are only eligible for Family Planning related services and should be screened for eligibility like all clients for other health department services.

Note new terminology throughout this document (June 2019) includes:

- NC DHB- North Carolina Division of Health Benefits (formerly known as NC Division of Medical Assistance)
- FP Medicaid (also known as MAFDN or BeSmart)

Standing Orders

The only level of E/M service that may be billed by an RN is 99211 since they are not allowed to be enrolled with Medicaid and do not have NPI numbers. All visits done by RNs are billed under the NPI of the medical director who signs health department policy/standing orders, writes an order, or writes a prescription.

- Standing Orders must be in place for a nurse to provide or order medical services such as ultrasounds or any other procedure/lab tests not previously ordered for the client by a Physician or Advanced Practice Practitioner Physician or Advanced Practice Practitioner.
- For more information visit NC BON Standing Orders Position Statement or www.ncpublichealthnursing.org

Sliding Fee Scale

1. A sliding fee scale can be attached to any program type, except STI and TB. Wherever a sliding fee scale is used, it must be consistently applied to all clients.
2. Not every program provided by LHDs must include a sliding fee scale (SFS). When a health department provides Adult Health Primary Care, Other services, it is their choice to apply a SFS (it is not required).
3. Health Department Dental Clinics are required to apply a SFS but it does not have to slide to zero.
4. Some DPH programs require that if their monies are used to provide a service, the fee for that service must slide to zero (e.g. Maternal Health, Family Planning, and Child Health).
5. **Healthy Mothers Healthy Children (HMHC)/Title V (Well Child funding)**

   Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client

participation in the cost of the service (as per Peter Andersen, (Women's and Children's Health (WCH) Acting Section Chief).

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.

Administrative Code: 10A NCAC 43B .0109 CLIENT AND THIRD-PARTY FEES

(1) If a local provider imposes any charges on clients for maternal and child health services, such charges:
   (a) Will be applied according to a public schedule of charges;
   (b) Will not be imposed on low-income individuals or their families;
   (c) Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
(2) If client fees are charged, providers must make reasonable efforts to collect from third party payors.
(3) Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.

History Note: Authority G.S. 130A-124; Eff. April 1, 1985; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017

Identifying Program Type

- General Rule" for **Program Type**: What brought the client to the Health Department is the primary reason for that visit.
- Clients may present with more than one problem. It is up to the Physician or Advanced Practice Practitioner to determine which problem is driving the visit and to code it to the correct program

Establishing Fees

1. North Carolina law allows a LHD to charge fees for services as long as:
    - Service fees are based on a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, or the appropriate governing entity;
    - The health department does not provide the service as an agent of the State (i.e. Vaccines for Children (VFC) immunizations); and
    - The fees are not against the law in any way; North Carolina General Statute 130A-39(g)

2. How do we set fees?
    - Health Department fees are set based on the cost to provide the service. If you need assistance with this process, contact your Administrative Consultant.
    - Documentation of the methodology used for setting fees is a required piece of evidence for reaccreditation. Include any minutes from meetings held during the process.

3. A LHD cannot have a "free" service unless law mandates it, this includes pregnancy testing.
    - Rather than having a "free" service, LHDs should slide those services to "0", keeping in mind they must comply with program rules which are governed by state and federal guidelines.

4. One rule to consider when setting fees is that "your charge is your charge"
    - You may not vary your charge by payer source but you may accept a variety of reimbursements as full payment for that service
    - You might have a charge of $100 for a service, but accept as full payment: $92 from Medicaid; $85 from a particular industry in your community with whom you have negotiated a discounted rate; and $0, $20, $40, $60, $80 or $100 from self-pays, depending on where they fall on the sliding fee scale.)
    - For exception regarding 340b drugs, please see guidance on page 33.

5. For all women's and children's health services, <u>Administrative Code 15A NCAC 21B .0109 (a)(2) and (3)</u> may apply:
    - If a local Physician or Advanced Practice Practitioner imposes any charges on clients for maternal and child health services, such charges:
        - not be imposed on low-income individuals or their families
        - will will be adjusted to reflect the income, resources, and family size of the individual receiving the services." (3)

- This means that, in all cases for WCH Programs, the sliding fee scale must be applied and it must slide to zero ($0.00). Services may not be denied due to an unwillingness/inability to pay.

6. Charges for the same **procedure/test** would be the same fee regardless of the Program type.
    - For example, an 81025-pregnancy test would have the same fee in Family Planning (FP), Maternal Health (MH) and Other Services (OS) because it is a standard service with no variation in the degree of complexity.
    - There are a few exceptions to this rule such as contracted rates and programmatic regulations specific to each program.

7. Situations may exist where LHDs must bill services to Medicaid one way and third-party insurance a different way.
    - Example: STI & TB - LHD may bill a T1002 to Medicaid and some third-party insurers. Some third-party insurers only accept 99211. Verify with each insurance carrier which codes they accept.

8. Standard Fee (formerly Flat Fees)- A number of factors influence whether a LHD may apply a standard to a service provided in the health department:
    - the description of the service;
    - whether the service is provided to individuals with Medicaid coverage, third party insurance and/or self-pays;
    - whether third-party payers cover the service and how it must be billed;
    - the Program in which the service is provided;
    - relevant statutes and Administrative Code; and
    - the requirements of specific types of funds

9. There should not be 3 different fees/charges for billing 340b medications or devices. You should follow the guidance below:
    - LHDs are required to bill Medicaid the acquisition cost of medication or devices purchased via the 340b drug program. Therefore, their fee/rate for Medicaid must be the purchase cost.
    - LHDs may charge insurances and self-pay clients at a different fee/rate than what they charge Medicaid for the same medications or devices purchased via the 340b drug program.
    - LHDs may choose to charge Medicaid and insurance the acquisition cost of medications or devices purchased via the 340b drug program.
    - However, LHDs (due to Title X funding) are required to slide the fee/rate of the medication or device on the SFS for all self-pay Family Planning clients.

10. As a reminder, Boards of Health, County Commissioners or other governing entities are required to approve the establishment of all fees and must approve any changes.

Authority may not be conveyed to the Health Department or Health Director to approve any fees or fee changes.

ICD Coding Resources

- NC DPH/ For Local Health Departments
  http://publichealth.nc.gov/lhd/icd10/training.htm
- 5 Steps:
  ICD-10 Quick Start Guide, which is an awesome new FREE resource from our friends at CMS. This guide can help streamline your implementation plan no matter where you are in the ICD-10 transition process. (Ctrl + left mouse click to follow hyperlink.)
  http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10QuickStartGuide20150622.pdf
- For rural and small practices:
  http://www.roadto10.org

Program Specific Guidelines

Child Health (CH)

Health Check Program Guide (HCPG) contains updated information related to Child Health Services. The guide is available at https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services

Published by the DHB (DHB), refers to the current Health Check Program Guide, Periodicity Schedule and Coding Guide as well as foot notes for guidance regarding comprehensive history, physical assessment, vision screening, hearing screening, nutrition assessment, anemia risk assessment, newborn metabolic/sickle cell screening, TB risk assessment, sexually transmitted infections/diseases, anticipatory guidance, referral/follow-up/plan of care.

Please contact your Child Health Nurse Consultant for specific questions about Child Health Services

Child Health Periodic and Inter-periodic visits (well child/preventive health care) and sick visits (primary care) are all coded to Child Health (CH) program type in Health Services Analysis (HSA) regardless of payor source.

1. Problem-focused sick visits can now be provided on the same day as a well child/preventive care.
   - A 25 modifier must be used for the sick problem focused visit to indicate it is a separate billable service on the same date of service as the well child/preventive health care visit.

   - Provider documentation must support billing of both services and providers must create separate notes for each service rendered to document medical necessity.

2. The EP modifier must be used for most components of the Periodic and Inter-periodic well visits when the payor source is Medicaid. EP modifier is an abbreviation for EPSDT, (Early Periodic Screening, Diagnosis, & Treatment) which is administered by Medicaid to provide services to beneficiaries under age 21.

3. It is allowable to append the EP modifier for all payor sources except Health Choice to be consistent and avoid confusion for staff even though it is not required for third party insurance.

4. Health Choice requires the TJ modifier to be appended for most components of the Periodic and Inter-periodic well visits.

   - Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children. This issue has now been corrected by NC Tracks and you should receive the correct reimbursement.

- The EP modifier must be included on most of the components for the periodic and inter-periodic visit types including:
    - immunization administration, (but not vaccine product codes)
    - vision,
    - hearing,
    - maternal postpartum depression screening
    - developmental screenings
    - autism screenings
    - screening for emotional/behavioral problems
    - screening for adolescent health risks
    - Other screening-related services for adolescents (i.e., smoking and tobacco cessation counseling, alcohol and/or substance abuse structured screening and brief intervention services)

- EP is a required modifier for these Health Check claim details but not to be used with laboratory services and vaccine products (except point of care lead analyzer testing). **NOTE: See the HCPG for a list of all components required in order to bill periodic or inter-periodic services. Please be sure to enter all reportable services when a Health Check visit occurs.**

5. Well child/preventive services as well as E/M problem/sick (primary care) visit codes and other related services provided at those visits. The sliding fee schedule must be applied to any services coded to CH Program Type.

Please be sure to enter all reportable services under program CH when a Child Health visit occurs. The HC Program Type was retired on April 1, 2016 due to the HC Program Type only recognizing ICD-10 Codes.

6. Completion of Forms:
    - The CPT code 99080 may be able to be reimbursed when Physicians or Advanced Practice Practitioners complete a form for administrative purposes such as for sports physical or a school health assessment.

    - If a form is presented during the visit for completion, it should be considered a part of the visit and the client would not be charged for completion of the form. In this case, the CPT code 99080 would be "reported" and the client would not be charged.

    - If the form is brought in later for completion, agencies could charge for the service using the CPT code 99080. Since most insurance companies will not pay this code, agencies need to inform clients that this is a non-covered service, and they may be responsible for the charge. This code is not reimbursable by Medicaid.

7. Laboratory services:
   - Medicaid will not reimburse separately for routine laboratory tests (Hemoglobin/Hematocrit and TB skin test) when performed during a Health Check early periodic screening visit.

   - Other laboratory tests, including, but not limited to, blood lead screening, dyslipidemia screening, pregnancy testing, urinalysis, and sexually transmitted disease screening for sexually active youth, may be performed and billed when medically necessary. http://DHB.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt. There must be documented symptoms or identified risks (based on history or physical exam) to bill for any additional labs (as part of a Periodic or Inter-periodic well child/preventive visit or as part of a sick/problem visit that may be provided on the same day as a preventive service).

   - It must be supported with an appropriate ICD-10 code to explain why the service is being provided/requested, and the appropriate CPT code for the laboratory service must also be included.

8. Same Day Health Check Wellness Visits and Sick Child (E/M) Encounters:
   - When Medicaid beneficiaries under 21 years of age receiving a Periodic or Inter-periodic visit also *require* evaluation and management of a problem focused complaint, the Physician or Advanced Practice Practitioner may deliver all medically necessary care and submit a claim for both the preventive service (CPT 9938x / 9939x) and the appropriate level of E/M service (CPT 9920x/9921x).

   - However, another option is to have the CHERRN document and bill for the well child/preventive visit if the CHERRN can complete the full well visit with all components and the Physician or APP complete a separate note for the sick visit and bill for that sick visit.
   - Beginning with services rendered after July 1, 2016, the Physician or Advanced Practice Practitioner need not submit additional documentation of medical necessity to the fiscal agent to reprocess a claim for the service rendered to treat the focused problem.

   - All requirements in this section regarding documentation of the additional, focused service must be adhered to by the Physician or Advanced Practice Practitioner.

     - *The E/M service must report only the additional time required above and beyond the completion of the Periodic or Inter-periodic well visit to address the focused complaint*.

     - The Physician or Advanced Practice Practitioner's electronic signature on the claim is the attestation of the medical necessity of both services if the Physician or AAP provides both services.

- However, if the CHERRN can complete the well child visit the Physician or APP needs to just sign for the sick visit completed on that same day.

9. Requirements for providing Preventive and Problem-Focused E/M Visits on the same day
   - Provider documentation **must** support billing of both services. CHERRN and/or Physician or Advanced Practice Practitioners **must** create separate notes for each service rendered to document medical necessity.

   - In deciding on appropriate E/M level of service rendered, only activity performed "above and beyond" that already performed during the ***Health Check*** wellness visit is to be used to calculate the additional level of E/M service. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.

   - All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.

   - The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph and additional review of systems paragraph that clearly describes the specific condition requiring evaluation and management.

   - The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.

   - 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.
   - **Modifier 25** must be appended to the appropriate E/M code. Modifier 25 indicates that the client's condition required *a significant, separately identifiable E/M service* above and beyond the other service provided.

10. Screenings
    - Developmental screening:
      - In NC, developmental screenings are to be done at 6 month, 12 month, 18 month or 24 months and ages 3, 4, and 5 years visits using the ASQ-3,PEDS or other AAP recommended developmental screening tool which can be found at: Bright Futures Developmental Screening Tools

      - Physician, CHEERN or Advanced Practice Practitioners should bill and report CPT code 96110 and EP modifier;

      - CPT code 96110 can now be billed up to a maximum of two units per visit for children 5 years of age and younger; aadditional revenue is generated when completed, documented appropriately in the medical record and billed.

- Screening for Autism Spectrum Disorders:
    - Screening for autism spectrum disorders is required at 18 and 24 months of age using a validated screening tool,

    - AAP recommended tools for screening for autism can be found at: Bright Futures Developmental Screening Tools

    - M-CHAT and M-CHAT Revised with Follow-Up (M-CHAT R/F is preferred) are the most commonly used validated screening tools used to identify children who are at risk for autism spectrum disorders and can be used for children between 16 and 30 months of age (which allows for catch up of screening if the 18 or 24-month visit is missed)

    - 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).

    - Physician, CHEERN or Advanced Practice Practitioners will bill CPT code 96110 and EP modifier; additional revenue is generated when completed documented appropriately in the medical record and billed;

- Screening for Caregivers for Maternal Postpartum Depression During a Child Health Visit:
    - 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.

    - Examples of brief screening tools include the Edinburgh Postnatal Depression Scale, Patient Health Questionnaire 2 (PHQ-2), or Patient Health Questionnaire 9 (PHQ-9). More information can be found at: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx

    - Billing providers should use CPT code 96161: administration of caregiver-focused health risk assessment instrument (e.g., 'health hazard appraisal'), for benefit of the patient, with scoring and documentation per standardized instrument. 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.

- In addition, when CPT 96161 is billed with CPT code 96127, modifier 59 must be added to the EP modifier combination table, and the EP modifier to the modifier 59 combination table.
- North Carolina Medicaid will reimburse providers for up to 4 maternal depression risk screens administered to mothers during the infant's first year postpartum.
- Resources for providers include:
    - CCNC guidance document about maternal depression screening available at: https://www.communitycarenc.org/pediatric-essentials/
    - There is also great information and resources from the AAP at the Screening Technical Assistance and Resource (STAR) Center about maternal depression screening as well as around screening for social determinants of health and social emotional and developmental screening at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/default.aspx
- More detailed information can be found at the most current Health Check Program Guide on the Wellness Visits, and Diagnostic and Treatment Services at: https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services

- Screening for Emotional/Behavioral Health Risks:
    - CPT code 96127 should be used to report the administration of a structured screen for emotional and behavioral health risks on the client, including ADHD (i.e., Vanderbilt), depression (i.e., PHQ-2, PHQ-9, Client Health Questionnaire Modified for Adolescents), suicidal risk, anxiety (i.e., SCARED), substance abuse (brief screen only), and eating disorders when their use is indicated by guidelines of clinical best practice and surveillance.
    - 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.
    - The ASQ:SE-2 can be used to screen for emotional/behavioral risks for infants and young children and must be billed using CPT code 96127.

- The Pediatric Symptom Checklist (PSC) or Pediatric Symptom Checklist for Youth (PSC-Y) can be used to screen for emotional/behavioral risks for school age children and adolescents. A Physician, CHEERN or Advanced Practice Practitioner can decide that using a PSC or Y-PSC would be beneficial to further assess positive risk factors that were identified in the HEEADSSS. CPT code 96127 must be used to bill for the PSC or PSC-Y.

- If the PHQ-2 or PHQ-9 is used to screen the client for an emotional/behavioral health risk (not the caregiver) then the 96127 CPT code should be used

- Physician or Advanced Practice Practitioners will bill CPT code 96127 and EP modifier to a maximum of two units per visit; if completed and billed this can generate additional revenue;

- When CPT 96161 is billed with CPT code 96127, modifier 59 must be added to the EP modifier combination table, and the EP modifier to the 59 modifier combination table.

- Brief screens should be used only to identify risk for presence of an emotional/behavioral problem. The use of a brief screen to assess or change an already diagnosed mental health condition or illness is not supported or recommended by CPT, AAP or CMS.

- The AAP recommends the following table with examples of validated emotional/behavioral risk tools: https://www.aap.org/en-use/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

- Q&A from March Coding & Billing Guidance Document update:
  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 DHB, 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 DHB, 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.

- Screening for Adolescent Health Risks:
  - <u>HEEADSSS Adolescent Health Risk Assessment:</u>
    - The HEEADSSS is part of the Bright Futures tools and must be used for adolescents starting at age 11 years and up to age 21 years of age

    - The pre-visit questionnaire is not the HEEADSSS but should be reviewed to identify risks and determine clarifying questions to be asked as part of the HEEADSSS

    - Providers administering the HEEADSSSS must use CPT code 96160 which is administration of client-focused health risk assessment instrument (e.g., 'health hazard appraisal'), with scoring and documentation per standardized instrument

    - 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.

    - When 96160 is billed with CPT code 96127: modifier 59 must be added to the EP modifier combination table, and the EP modifier to the 59-modifier combination table

  - <u>Alcohol and Substance Abuse Screening and Brief Intervention (i.e., CRAFFT):</u>
    - The CRAFFT is a validated screening tool and is part of the Bright Futures tools.

    - Physician, CHEERN or Advanced Practice Practitioners would use the CRAFFT screening tool if any positive risk factors for alcohol/substance abuse were identified in the HEEADSSS screening tool or in any other way during the visit.

- CHERRN's can also bill this code but ideally should have received training in brief intervention and counseling related to alcohol and substance use.

- 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.

- The Physician, CHEERN or Advanced Practice Practitioner should not bill for the CRAFFT using the CPT code 99408 if there is less than a score of 2 (i.e. Score of 0 or 1) which would require minimal or no counseling.
    - In this case, the CPT code 96127 would be used.

- Providers may bill 99408 or 99409 codes (with 25 and EP modifiers) only when alcohol and/or substance abuse screening is done, AND counseling is provided directly to the beneficiary

- As with any screen, the provider must document the screening tool used (i.e., CRAFFT), the results of the screening tool (score), the discussion with parents, and any referrals made.

11. Immunizations
    - 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 <u>not</u> appropriate for a Well Child Care Visit to be provided in one location, and child referred to another location for immunizations.**

        - In addition, other pediatric practices who are providing well child visits to Medicaid clients should not be deferring immunizations during well visits in their practice and referring these children to local health departments for their immunizations.
    - The most current *Recommended Immunization Schedules for Persons Aged 0 through 18: United States,* approved by the **Advisory Committee on Immunization Practices** (ACIP),

American Academy of Pediatrics (AAP), and the **American Academy of Family Physicians** (AAFP) may be found at: http://www.cdc.gov/vaccines/schedules/index.html

- Documentation for immunizations in the record may include:
  - 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
  - If required immunizations are not given, the reason must be documented and a plan to administer vaccines as soon as possible must be noted in the record.
  - Children with medical and religious exemptions should have documentation in the chart
  - When an immunization administration accompanies a preventive service visit, the preventive service CPT (9938x / 9939x) must appear with a '25' modifier on the claim form. Without modifier '25', these coding combinations will cause the claim to deny per CCI edit;
  - Must use ICD 10 CPT code Z.23 as one of the diagnosis codes.

12. Smoking and Tobacco Use Cessation and Counseling:

- Physicians, Advanced Practice Practitioners, and CHERRNs in Health Departments can bill DHB for services using the following:
  - Intermediate visit (3-10 minutes) - CPT code 99406
    - EP and 25 modifier must be included when provided in CH
  - Intensive visit (over 10 minutes) - CPT code 99407
    - EP and 25 modifier must be included when provided in CH
  - Counseling cannot be billed if provided to a parent/guardian
- Physicians, Advanced Practice Practitioners and Physician Assistants can bill under respective NPI number
- These CPT codes can be billed "incident to" the physician by the following professional specialties:
  - Certified clinical supervisor
  - Clinical addiction specialist
  - Clinical nurse specialist
  - Clinical social worker
  - Licensed psychologist
  - Marriage/family counselor
  - Professional counselor

- Psychological associate
- Registered Nurse
  - Must have a standing order to provide and bill for these services
  - They must have attended a certified smoking cessation counseling training

- ERRNs must document receipt of training using the 5A's or CEASE.
- Providers should always include documentation in the beneficiary's medical record noting the intervention (i.e., 5A's), client response (i.e., contemplating quitting) and status, follow up plan and referrals (i.e., referral to NC Quit Line)
- The Tobacco Cessation Counseling Standing Orders and Billing documents are posted and can be found here: https://www.quitlinenc.com/health-professionals/lhd.html

13. Dental Screenings:

- 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.

- LHDs use Bright Futures questions that ask about presence of a dental home and oral health risk factors earlier than age 3 years.

- When any screening indicates a need for dental services, referrals must be made (are required) for needed dental services and documented in the child's medical record OR an explanation for why a referral to a dentist is not able to be made and a plan of care to address any acute issues.
  - For example, when a family of a child at 1 year of age is asked about the presence of a dental home, and the family responds that the child does not have a dental home, the provider must make a referral or indicate why a referral cannot be made to a dental home (i.e., no dental providers in the area will see the client).

- The initial dental referral must be provided unless it is known that the child already has a dental home. An oral health risk assessment is recommended for all young children at well visits until age 3 ½ years.

- Oral risk screening tools include either the NC *Priority Oral Risk and Referral Tool* (PORRT) or the *Bright Futures Oral Health Risk Tool***.** When any screening indicates a need for dental services at an early age, referrals must be made for needed dental services and documented in the child's medical record.

- The NC Oral Health periodicity schedule for dental examinations *is a separate and independent schedule* for regular *dental care for children*.

Note: Physician or Advanced Practice Practitioners who perform a Health Check screening assessment and dental varnishing may bill for both services.

Application of dental varnishing is not a required Health Check Well Child visit component.

For billing codes and guidelines, refer to Clinical Coverage Policy # 1A-23, Physician Fluoride Varnish Services**,** on DHB's website at: https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/1A23.pdf

14. Additional Billing Guidelines:

    - Providers must indicate referrals using Z00.121 "Encounter for routine child health examination with abnormal findings," along with the diagnosis code attributed to the finding to ensure proper tracking of referrals.

    - Capillary blood draws are considered incidental to *Health Check* Early Periodic Screening and should not be billed.

    - CPT Code for Venous Blood Draws: Report 36415 for *Venous* blood draw when an external laboratory analysis is required. Capillary blood draws are considered incidental to the Health Check well child visit.

    - Report CPT 96161 for Maternal Depression Screens/First Year of Life administered to caregiver for benefit of infant and CPG 96160 for Adolescent Risk Screens. When billing CPT code 96160 and/or CPT code 96161 with CPT 96127, please add modifier 59 to the EP modifier combination table and the EP modifier to the 59 modifier combination table.

    - Refer to the current Health Check Program Guide Periodicity Schedule and Coding Guide and foot notes for additional guidance

15. How to bill when Child Health and Family Planning services interface:

If the reason for visit is for a well child exam but the client presents also wanting FP services, the visit is billed as follows:

- Bill the Well Child Exam along with all required components under the CH program type. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.

- REPORT all the FP portions of the visit, assuring that all required FP components have been completed. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.
- To offer 340B medications, the visit must be documented separately so that it is clear a FP visit has been made therefore establishing the client in FP.

- Document using a separate encounter form.

If the reason for visit is for FP services but the client is also in need of their CH visit, the visit is billed as follows:

- REPORT the Well Child Exam along with all required components under the CH program type. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.

- Bill all the FP portions of the visit, assuring that all required FP components have been completed.
    - The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.

- To offer 340B medications, the visit must be documented separately so that it is clear a FP visit has been made therefore establishing the client in FP.

- Document using a separate encounter form.

16. General Reminders

- 340B drug eligibility requires that the client be a registered FP client.

- If a client is seen for FP services, all the assessments and education are completed and separately documented (separate from the CH documentation) and an encounter reflects that the client received FP services, then the client should be able to receive 340B drugs, even if the encounter is entered as "report only."

- Assure all CH service components are provided.

- DO NOT try to document both visits on the same program template. Neither the CH or FP templates are structured to comply with both program requirements.

- The following information must be shared related to the provision of family planning services during a Health Check or Child Health visit:
    - General information that includes the health benefits of abstinence, and the risks and benefits of all contraceptive options;

    - Specific information related to the adolescent's contraceptive choice including effective use, benefits, and efficacy of the method, and possible side effects or complications;

    - Benefits of dual-method use (for example, condoms for STI prevention and a second method of contraception);

    - How to discontinue the method selected and information on backup methods and emergency contraception;

    - Emergency 24-hour number and location where emergency services can be obtained;

    - At subsequent visits, review this information with the recipient.

16. HMHC/Title V (Child Health funding)

- Title V policy on applying sliding fee scale:
    - Any client whose income is at or less than 100% of the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds.

    - For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service.

- This means that all services for children MUST slide using the appropriate SFS.

- 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.

17. Guidance Related to NC Administrative Code: 10A NCAC 43B .0109 CLIENT AND THIRD-PARTY FEES

1. If a local provider imposes any charges on clients for maternal and child health services, such charges:
    a. Will be applied according to a public schedule of charges;
    b. Will not be imposed on low-income individuals or their families;
    c. Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
2. If client fees are charged, providers must make reasonable efforts to collect from third party payors.
3. Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.
4. For more information: http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2043%20-%20personal%20health/subchapter%20b/10a%20ncac%2043b%20.0109.pdf

18. ~~Billing Sports Physicals-Please see Memo from Phyllis Rocco (4/19/17) on NC DPH website~~ Waiting on memo for new guidance for Billing Sports Physicals. This is being handled by the Child Health Branch.

For additional program guidance, please contact your Regional Child Health Consultant or visit the program website at http://www2.ncdhhs.gov/dph/wch/aboutus/childrenyouth.htm

19. Health Choice:
    - The North Carolina Health Choice (NCHC) Health Insurance Program for Children is a comprehensive health coverage program for low-income children.

- It is not Medicaid. The goal of the NCHC Program is to reduce the number of uninsured children in the State.

- If a family makes too much money to qualify for Medicaid, but too little to afford third party or employer-sponsored health insurance, they may qualify for NCHC.

- When billing NCHC, you should follow your procedures for billing third-party insurance programs. Health Choice claims must be billed using the **TJ** modifier.

- NC Tracks has indicated that they will no longer require the TJ modifier for NC Health Choice Family Planning clients. **The claims should only require an FP modifier and should pay at the usual rate** instead of $90.

Immunization Program

It is very important to check the Health Check Program Guide published by NC DHB. https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services

1. Services to clients seen only for immunizations services should be coded to Immunization Program

2. If a client presents for services in a program other than immunizations (e.g. CH, FP, MH, etc.) and receives immunizations (required as per Agreement Addenda or recommended), the immunizations should be coded to the program which brought them in that day. Remember that immunizations coded to CH, FP and MH programs are subject to sliding fee scale.

3. Use of NDC identifiers when billing/reporting 340b drugs/devices and Immunizations:

All providers are required to submit the appropriate NDC that corresponds to the physician administered LARCs and Vaccines used for administration and corresponding procedure code as the new pricing is based on a procedure code/NDC match. If the procedure code/NDC combination is not found, the claim line will deny and post EOB 02047: "RATE NOT FOUND. CONTACT THE M&S HELPDESK AT (1-800-591-1183) or email at ncpharmacy@mslc.com

Myers and Stauffer (M&S) is the current actuary who maintains these drug prices for Pharmacy and Professional claims. Please contact Myers and Stauffer with any questions or concerns; NCTracks will not be able to assist with these issues." (NC Tracks Bulletin March 29, 2018)

4. Immunization Administration (for Child Health/Health Check)
   - Administration Codes
     - Effective with date of service July 1, 2011, the ONLY immunization administration codes covered for Medicaid recipients in the Health Check age range, 0 through 20 years of age, are CPT codes 90471 through 90474.

     - Append modifier EP (Health Check) to all CPT immunization administration codes billed for Medicaid recipients in the Health Check age range, 0 through 20 years of age.

     - Append the TJ modifier to all CPT immunization administration codes billed for Health Choice recipients in the Health Check range, 0 through 20 years of age.

     - Do NOT append the EP or TJ modifier to the CPT vaccine product codes.

     - ALL providers are required to submit the proper NDC that corresponds to the physician administered LARCs and Vaccines used for administration and

corresponding procedure code as the new pricing is based on a procedure code/NDC match.

- If the procedure code/NDC combination is not found, the claim line will deny and post EOB 02047: "RATE NOT FOUND. All the units billed for CPT codes 90471EP/TJ, 90472EP/TJ, 90473EP/TJ and 90474EP/TJ must be billed on ONE detail to avoid duplicate audit denials.

- Administration of one injectable vaccine is billed with CPT code 90471 (one unit) with the **EP** modifier.

- Additional injectable immunization administrations are billed with CPT code 90472 with the **EP** modifier.
  - The appropriate number of units must be billed for each additional immunization administration CPT procedure code, with the total charge for all units reflected on the detail.

- Currently, 90474EP cannot be billed with 90473EP because there are no two oral/intranasal vaccines that would be given to a recipient.
  - Only one unit of either 90473EP/TJ or 90474EP/TJ is allowed.

- CPT vaccine codes for the vaccines administered **must** be reported or billed, as appropriate, even if administration codes are not being billed.
  - Remember to use the SL modifier when reporting state vaccines.

- For Medicaid recipients 21 years of age and older (above the Health Check age range), the immunization administration codes have not changed. Bill the series of CPT codes 90471 through 90474 without the EP or TJ modifier.

- Refer to individual bulletin articles on specific vaccines for additional billing guidelines.

- Physician or Advanced Practice Practitioners must use purchased vaccines for Health Check beneficiaries ages 19 and 20, who (because of their age) are not routinely eligible for NCIP/VFC vaccines.
  - When purchased vaccine is administered to this age group, Medicaid will reimburse Physician or Advanced Practice Practitioners for the vaccine product and the administration fee.

- Note that some NCIP vaccines may be administered to recipients ages 19 and older, in which case Medicaid will cover the administration fee.
  - Any time an NCIP vaccine is provided, the CPT vaccine code must be reported with $0.00.
- Medicaid clients 21 years of age and over are responsible for the $3.00 copay when they receive immunizations.

- Immunization billing guidelines are located in the Health Check Program Guide: https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services

- Denials for Preventive Medicine Codes Billed with Immunization Administration Services: (NCTracks Newsletter March 17, 2016)

  Recent system updates resulted in NCCI edit denials (EOB 49270 - NCCI EDIT) of preventive medicine service codes submitted with EP modifier only and reported in conjunction with immunization administration service(s). These are accurate NCCI edit denials.
  - CMS billing guidelines indicate Physician or Advanced Practice Practitioners may use modifier 25 with modifier EP or modifier TJ for preventive medicine service codes (99381 - 99397 and additional screening codes 99406-99409 and 96160) when reported in conjunction with immunization administrative services (90460-99474).

  - Physician or Advanced Practice Practitioners may submit corrected replacement claims if appropriate.

  - Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children.

- Please remember there is not a copay for flu vaccine or the administration fee.

- Modifier 25 can be used with other non-preventive medicine E/M services when reported in conjunction with immunization administration when the E/M service is significant and separately identifiable.
  - Exception: If a vaccine is billed with the same date of service as code 99211, NCCI edits do not permit the E/M code to be reimbursed.

  - CMS has stated that an E/M code should not be billed in addition to the administration code(s) when the beneficiary presents for vaccine(s) only.

  - Add “SL” modifier to the Vaccine Product Code for all state supplied vaccines billed or reported.

5. Vaccines for Children (VFC) Program

- The North Carolina Immunization Program works in conjunction with the federal vaccine supply program, called the VFC program, to provide vaccines free of cost to health care Physician or Advanced Practice Practitioners across the state.

- Participating health care Physician or Advanced Practice Practitioners must administer these vaccines according to NC Immunization Program (NCIP guidelines).

- Physician or Advanced Practice Practitioners may not charge clients for the cost of the vaccines, but they can charge an administration fee for each state-supplied vaccine given in an encounter.
    - The administration fee may not exceed the rate established by the state's Medicaid program.

- As of October 1, 2012, all state supplied vaccines appropriate for adults are to be used only for the uninsured adult.
    - An adult is anyone 19 or older.
    - Medicaid clients 21 years of age and older are responsible for the $3.00 copay when they receive immunizations.
    - There is never a co-pay for a Medicaid beneficiary under 21 years of age who are Medicaid or Medicare recipients are considered covered, or insured, for this purpose.)
    - Details on which clients are currently covered by NCIP vaccine may be found at:

  http://www.immunize.nc.gov/providers/coveragecriteria.htm

- Health Departments must have a mechanism in place so that clinical staff can make the correct decision regarding VFC and Non-VFC eligible clients – who should receive state vaccine and who should receive purchased vaccine.
- Medicaid beneficiaries who are VFC age (0 through 18) are automatically eligible for VFC vaccine; regardless as to whether they are dually covered by Medicaid and another insurance plan.
    - However, CDC recommends that Physician or Advanced Practice Practitioners ask the family their preference; if they want their insurance billed; privately purchased vaccine must be used. The decision should be whatever is least costly to the client.

- An administration fee can be billed for Immunizations provided by VFC but you must follow the eligibility guidelines sent out by the Immunization program, including the rule that no one under 200% of the Federal Poverty Level may be charged. This would require financial eligibility be performed each time the client

presents for immunizations in order to appropriately apply this rule. The vaccine code must be reported in order to get paid for the administration fee.

- NOTE: Clients may not be charged a fee higher than the Medicaid reimbursement rate for the administration fee, and the fee must be waived if the client expresses an inability to pay the administration fee.
- Health Choice* beneficiaries are considered *insured*; therefore, they are not eligible for VFC vaccines, with one exception.
    - Health Choice beneficiaries who are American Indian or Alaska Native are entitled to VFC vaccines—Health Choice will only reimburse an administration fee for these beneficiaries.

    - Refer to individual Health Choice articles in the general Medicaid Bulletin and the Health Check Program Guide, for details regarding the NCHC eligibility groups and the billing and claims processing of Health Choice claims.

6. Purchased Vaccines

- Health Check beneficiaries that are 19 & 20 years of age are **not** eligible for VFC vaccines, so the physician or advanced practice practitioner must use purchased vaccines for this age group.

- Per the 2016 Health Check Billing Guide the physician or advanced practice practitioners must use purchased vaccines for this age group and bill Medicaid for the cost of the vaccine and the vaccine administration fee.

- Once a Medicaid recipient reaches the age of 21 years or older, they are no longer eligible for any VFC vaccine doses. They would need to receive purchased doses and they would responsible for the $3.00 copay when they receive immunizations.

- Adults that are 19 years of age and older that are **Uninsured** are eligible for certain NCIP vaccines.
    - Please refer to the most up to date edition of the NCIP Vaccine Coverage Criteria located on the NCIP website at http://www.immunize.nc.gov/providers/coveragecriteria.htm

- Purchased vaccines (not required by Agreement Addenda) may be coded to Immunization program so that you can recoup your cost. Vaccine inventory and purchasing policies should describe the process as to what program type to code the services. LHDs must inform the client of any charges before the service. Immunizations, and their administration, in this category may be charged to insurance or the client and are not subject to any SFS.

7. Travel Immunizations

At this time, Health Departments are restricted from billing Medicaid for counseling CPT codes 99401-99403, but you may be able to bill self-pay clients and third-party payors.

Please check with other third-party payors regarding their policy on reimbursement for this series of codes.

Regardless of which payor type you are billing; your documentation must support the service as well as the time spent.

8. Billing for multi-series vaccines-
   Scenario/Question:
   Question: If client presents in FP and receives first dose of Twinrix®, when they return for doses 2 & 3 do they go to STI or IMM?? The problem presents with the admin fee.
   - If they receive in FP then it must slide, if they receive subsequent doses in IMM they do not slide. Is this OK?
     - The short answer depends on the funding source (public or private vaccine).
     - For state supplied vaccine (including Twinrix®) the NCIP Coverage Criteria must be followed (see attached pg. 1 & 4)).
     - Only uninsured adults can receive state Twinrix®. Also, the maximum charge for the vaccine administration fee is $20.45 (current fee cap), which must be waived if the client states an inability to pay regardless of the clinic in which the client is seen, according to the billing brief and LHD Immunization Agreement signed by the Health Director (see below).
     - Most LHD's do not charge a vaccine administration fee for state supplied vaccine.
   - The Long answer and resources:
     - Only those 18 years and older that are **Un**insured are eligible for the VFC Doses of Twinrix.
     - There is no 3rd party payor to bill. If they have Medicaid or Insurance, they would need to receive private stock of Twinrix and follow your normal billing procedures.
     - If these persons are covered by the ****FP Medicaid Family Planning Program—they are considered Uninsured for our purposes and would be eligible for the VFC Twinrix.

- VFC Eligibility must take place at each visit so if they were on Medicaid for dose #1 they were not eligible for a VFC dose on that date of service.
    - When they return for dose #2—they have lost their Medicaid and are now Uninsured—on that date of service they are VFC eligible and would get a VFC dose. (see excerpts from the Coverage Criteria below)

VACCINE	AGES COVERED	Cohort	ELIGIBITY CRITERIA FOR NCIP VACCINE USAGE
HepA/HepB Combination (Twinrix)	≥ 18 years	UNINSURED ADULT USE	**LHD/FQHC/RHC Only**: Any uninsured adult who meets one or more of the ACIP recommended coverage groups can receive a three-dose series of the combination Hep A/Hep B vaccine at the local health department or at Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). State-supplied Hep A/Hep B vaccine cannot be used for the accelerated schedule, four dose series **or** for persons with a documented history of a completed hepatitis A or B series.

- **** **LHD/FQHC/RHC only:** Persons covered by the FP Medicaid Family Planning Program are considered uninsured and may receive certain state-supplied vaccines as noted in this coverage criteria for uninsured adults if receiving services at a Local Health Department, Federally Qualified Health Center, or Rural Health Clinic.
- And this is the guidance from 2009 about LHD's being able to charge out of pocket admin. fees (see attached Billing Brief for the full document)
- A change in state law allows local health departments (LHDs) to charge the client an out-of-pocket administration fee for state-supplied vaccine **unless:**
    - the client is uninsured or underinsured, **and**
    - the family income is below 200% of the federal poverty level.

- If these two conditions apply, the client's administration fee must be waived.

- If the LHD chooses to charge an out-of-pocket administration fee for state-supplied vaccine, the **maximum** amount is based on the state Medicaid rate on the date of service. LHDs should check the LHD rate table provided annually by the DPH. Clients who state an inability to pay should have the administration fee waived.

- If the LHD's do charge out of pocket fee to those that are not excluded by the criteria above—they can charge it for each vaccine at each visit. (please contact your immunization nurse consultant for more information).

Excerpts from LHD Agreement:

6. I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $20.45 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
7. I will not deny administration of a publicly purchased vaccine to an established client because the child's parent/guardian/individual of record is unable to pay the administration fee.

    - As far as the criteria for who can receive the vaccine in clinical terms—refer to the Hepatitis A and Hepatitis B Chapters in the Pink Book—which ever adults that ACIP states needs Hep A/Hep B vaccines are eligible for the VFC doses if they are uninsured.

    - https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/hepa.pdf Hep A Chapter page 144

Twinrix

- Combination hepatitis A vaccine (pediatric dose) and hepatitis B (adult dose)
- Schedules
  - 0, 1, 6 months, or
  - 0, 7, 21to 30 days and a booster dose 12 months after first dose
- Approved for persons 18 years of age and older

Persons at Increased Risk for Hepatitis A or Severe Outcomes of Infection

- International travelers
- Close contact with an international adoptee from a country of high or intermediate endemicity
- Men who have sex with men
- Persons who use illegal drugs
- Persons who have a clotting factor disorder
- Persons with occupational risk
- Persons with chronic liver disease
- Healthcare workers: not routinely recommended
- Child care centers: not routinely recommended
- Sewer workers or plumbers: not routinely recommended
- Food handlers: may be considered based on local epidemiology

https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/hepb.pdf Hep B Chapter page 164

Adults at Risk for HBV Infection

- Sexual exposure
  - sex partners of HBsAg-positive persons
  - sexually active persons not in a long-term, mutually monogamous relationship*
  - persons seeking evaluation or treatment for a sexually transmitted disease
  - men who have sex with men
- Percutaneous or mucosal exposure to blood
  - current or recent IDU
  - household contacts of HBsAg-positive persons
  - residents and staff of facilities for developmentally disabled persons
  - healthcare and public safety workers with risk for exposure to blood or blood-contaminated body fluids
  - persons with end-stage renal disease
  - persons with diabetes mellitus
- Other groups
  - international travelers to regions with high or intermediate levels (HBsAg prevalence of 2% or higher) of endemic HBV infection
  - persons with HIV infection

*persons with more than one sex partner during the previous 6 months

For information regarding consent/authorization for immunizing minors, please refer to: http://www.sog.unc.edu/publications/bulletins/immunizations-children-and-adolescents-frequently-asked-questions-about-north-carolinas-laws

For additional program guidance, please contact your Regional Immunization Consultant or visit the program website at http://www.immunize.nc.gov/providers/index.htm

Sexually Transmitted Infections

STI Clinical Coverage Policy- Treatment in Local Health Department

1. The following Physician or Advanced Practice Practitioners in a LHD setting are eligible to provide STI services:
    - Physician (billed by E/M code
    - Nurse Practitioner* (billed by E/M codes)
    - Physician Assistant* (billed by E/M codes)
    - Enhanced Role Public Health Nurse (billed by T1002 to Medicaid; 99211 or T1002 to third party insurance).

***Advanced Practice Practitioner**
Every Physician or Advanced Practice Practitioner should receive an orientation to the STI Program and agree to provide services according to DPH STI Program guidelines.

2. Currently Rostered STI Enhanced Role Registered Nurses (STI ERRN) who have completed the STI Enhanced Role training course, may provide services to clients seeking STI evaluation and can bill Medicaid for these services if the STI ERRN conducts the interview, performs the physical examination, orders the appropriate testing and provides appropriate treatment and counseling.
    a. The STI ERRN uses the T1002 for Medicaid covered clients or may bill third party insurance if allowed by the client's plan using 99211 or T1002 with the client's permission.
    T1002 is billed to Medicaid in units. 1-15 minutes = 1 unit; 16-30 minutes = 2 units; 31-45 minutes = 3 units; 46-60 minutes = 4 units.
    b. The T1002 is billable when all the service components are provided, even if the treatment component is completed on a different day while waiting for the results of a lab test or if no treatment is necessary.

    Essential STI service components include the following:
        - medical history
        - sexual risk assessment
        - a physical examination inclusive of the upper and lower body,
        - laboratory testing
        - treatment (as needed) *
        - education & counseling
        - referral necessary for evaluation beyond the Registered Nurse Scope of practice
        *including treatment on a subsequent day

    c. A maximum of 4 units per day may be billed. If, due to delayed test results, the recipient must return for treatment, the 4 units may be split between 2 separate days. If T1002 is billed on separate days, between the 2 days all service components must be provided. Reimbursement for additional units is

considered when documentation support medical necessity. The time spent for each visit must be documented in the medical record.

d. You can bill beyond the 4 units if the following are met:
    1. Document the total time of the visit – Ex: 75 minutes = 5 units
    2. Documentation needs to describe the services provided in sufficient detail in order to support the time spent conducting the visit.
    3. Follow the billing instructions on page 8 of the STD Clinical Coverage policy: https://files.nc.gov/ncdma/documents/files/1D-2_0.pdf
e. Billing STI services provided by the STI ERRN-The four (4) components of the STI exam do not have to be provided by the same STI ERRN in order to bill Medicaid for the provision of the STI service. The service can still be split across two different days and can be provided by a different STI ERRN on each day, billing T1002 per unit (equals up to 15 mins.) of care provided.

3. If during a Child Health, Family Planning/FP Medicaid, Maternity or other program visit the Physician or Advanced Practice Practitioner needs to rule out STIs to meet standards of care, the client cannot be charged for the STI testing and treatment services.
    a. The client should be evaluated using the same standard of care and medical record documentation as if they were being evaluated in the STI clinic.
    b. Even in these clinics **within the Health Department**, the 340B STI drugs may be given to the client for treatment; however, all follow-up on the STI must be done in the program in which they were evaluated and/or treated (per CD Branch).
4. At the current time, most STI services cannot be charged to the client but can be charged to Medicaid and other third-party payers with the client's permission.
    a. If you bill insurance for an STI ERRN, you must use 99211 or T1002 for a nurse visit or a higher E/M code for Physician or Advanced Practice Practitioners.
        i. Remember that if the client presents as being concerned about having a reportable STI or presents in an STI Clinic, nothing related or required for STI evaluation is billable to the client.
        ii. Exceptions to this rule apply only for tests and procedures not offered by the NC SLPH or not required by the DPH STI Program.

Exceptions include:

- You may charge a client for any STI lab the client requests that is not offered through NC SLPH. For example, the SLPH does not offer Chlamydia testing for males. Therefore if the client requests the testing through a private lab, they can be charged.
- Past legal guidance has stated that "screening and diagnostic testing still falls within the guidelines of services provided at no charge to the client " but that "once a STI that is not specified in the rule [15A NCAC 19A.0204(a)], such as venereal warts, has been diagnosed; treatment and follow-up services may be charged to the client." If you have additional questions, please contact your PHNPDU Consultant.

- Asymptomatic clients who request screening for non-reportable STIs (e.g., herpes serology)
- Clients who receive follow-up treatment of warts after the diagnosis is established.
- The non- STI ERRN may bill insurance using 99211 for STI treatment only visits. 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.

5. By Agreement Addenda it is preferred that STI ERRN provide services to STI clients, but a registered nurse having demonstrated competency can administer treatment per standing order, obtain client history and provide client-centered counseling).

6. Physicians or Advanced Practice Practitioners should bill Medicaid and may bill third party payers (with the client's permission) using the appropriate E/M codes for the level of service provided. Third party payers (Medicaid and third party insurance) can be charged for STI services. *NOTE that in this case billing third party insurance will result in an EOB to the home address; therefore, the* client *should be informed of that and have the opportunity to say they do not want insurance to be billed*.

7. Billing when two different Physician or Advanced Practice Practitioners (different NPI numbers) see client same day:
    - When a client receives STI services billed with E/M or T1002 code and is also seen by another health department Physician or Advanced Practice Practitioner on the same date of service for a separately identifiable medical condition, the health department may bill both visits. There must be a separate diagnosis code and E/M code for the second procedure. No modifier is required in this circumstance since there are two separate Physician or Advanced Practice Practitioners involved (with two NPI numbers).
8. Billing Preventive and E/M visits to Medicaid on the same day
    - Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (see exception). The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology. You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to* Health Check Program Guide for changes related to CH.
    - If a client is seen by a Physician or Advanced Practice Practitioner for STI services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day,** and it is not a duplicate billing

- Billing STI services provided by the STI ERRN-The four (4) components of the STI exam do not have to be provided by the same STI ERRN in order to bill Medicaid for the provision of the STI service. *This is a clarification in the Medicaid STI Clinical Service Policy, effective 3/30/2016.* The service can still be split across two different days and can be provided by a different STI ERRN on each day, billing T1002 per unit (~~up to~~ 1- 15 mins equals 1 unit) of care provided.
- STI ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.
- The non- STI ERRN may bill insurance using 99211 for STI treatment only visits. 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.
- TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.

9. Additional Billing Scenario:
    - When a "FP Medicaid" client is scheduled for the STI ERRN visit and upon interview thinks the client has "BV again", can the client be switched to Physician or Advanced Practice Practitioner schedule and charged for the clinic visit? We do not recommend switching the client to the Physician or Advanced Practice Practitioner. You should:
        - See the client in STI clinic but do not bill "FP Medicaid".
        - If you switch a "FP Medicaid" client to a Physician or Advanced Practice Practitioner schedule, it will count towards the 6-visit limit for the year.
        - ***Keep in mind that if you use 340B drugs to treat non-reportable STIs this may significantly reduce your supply of 340B drugs available to treat clients that the health department is mandated to treat.***

10. Human Papilloma Virus (HPV):
    - Once HPV is diagnosed (in any clinic), the health department can see the client and treat them in any appropriate clinic, and you can charge at that point for the treatment of HPV.
    - If the only reason you are seeing the client for is the treatment of HPV, you can either bill the HPV treatment CPT or an E/M code, but not both.
    - If you are providing additional services that are unrelated to HPV treatment that would warrant an E/M code, then you could bill with the treatment CPT code and the E/M and append the -25 modifier to the E/M code. To bill for both services, the visit and documentation must meet all criteria for both CPT codes.
    - HPV treatment is billable to clients if they do not have Medicaid or prefer that their insurance not be billed. HPV is not a reportable STI and therefore does not fall under the "not billable to clients" stipulation.

- An STI ERRN can apply TCA (HPV treatment) if the lesion they are treating has been diagnosed as a genital wart by a provider in that health department AND the STI ERRN has been adequately trained, observed, and signed off by a provider in that health department AND a standing order is current, signed, dated, etc. STI ERRN do not receive training on applying TCA in the STI ERRN Course.
- The codes listed below are for the procedure for destroying lesions. Coding and billing for wart treatment depends on the location (anus or male/female genitalia) and the type of wart. This guidance is specific to: condyloma, papilloma, molluscum contagiosum, herpetic vesicle via chemical destruction.
  - Anus – 46900 for simple (chemical) and 46924 extensive (any method)
  - Male genitals – 54050 simple and 54065 extensive
  - Female genitals – 56501 simple and 56515 extensive
- The 17000 – 17250 are CPT codes for the destruction of benign or premalignant lesions and are generally used for non-genital/anal lesions.
- Coding Surgical Procedures-beyond the basics- Difference between 56501 & 56515 is based on provider interpretation and procedure performed.

11. STI Services Not Billable to Clients: please see memo from then Assistant Attorney General John Barkley, dated August 31, 2001 (Appendix C) regarding this topic.

STI LABS

If the NC SLPH does not provide a test, insurance can be billed with the client's consent and clients without insurance or who do not want to file with their insurance can choose to pay out of pocket if the LHD has policy to support it.

1. If a client comes in to have a syphilis serology done *for purposes of employment, ONLY* we have a ruling that says that client may be charged. **NOTE:** that the LHD can only charge for drawing the blood IF it sends the blood to an outside lab for testing. The State Lab is not an appropriate lab to send tests done solely for employment. Please refer to the STI Contract Addenda, which give additional circumstances for billing clients.
2. Modifiers with Labs

   Valid billing with a modifier:
   - Modifier-59: Distinct Procedural Service, different site or organ system, for example, multiple sources collected for screening culture GC (modifier -59)
   - Modifier-90: Specimen sent to a reference laboratory for processing.
   - Modifier-91: Repeat Clinical Diagnostic Lab test. **Note:** This modifier may not be used when tests are:
     - rerun to confirm initial results;
     - due to testing problems with specimens or equipment;

- for any other reason when a normal, one-time, reportable result is all that is required.

For example, when a Physician or Advanced Practice Practitioner requests a test be repeated on the same day. Modifier-91 indicates that it is not a duplicate billing.

Effective Jan. 1, 2015, four new modifiers more effectively identify **distinct services that are typically considered inclusive to another service**. Utilizing these modifiers will help with more accurate coding that better describes the procedural encounter. These modifiers are appropriate for NCCI procedure-to-procedure edits only

- **XE – Separate Encounter**: A service that is distinct because it occurred during a separate encounter.
- **XS – Separate Structure**: A service that is distinct because it was performed on a separate organ/structure.
- **XP – Separate Practitioner**: A service that is distinct because it was performed by a different practitioner.
- **XU – Unusual Non-Overlapping Service**: The use of a service that is distinct because it does not overlap usual components of the main service.

~~**If you receive denials when using these "X" modifiers, continue to rebill the claims until current issues between DHB and NCTracks and electronic health record vendors can be resolved.**~~ **We have been advised that that billing via the NCTracks portal works for these modifiers.**

Use of these modifiers vs. modifier 59:

Do not use one of these modifiers with modifier 59 on the same claim line. According to CPT guidelines, modifier 59 should be used only when no other descriptive modifier explains why distinct procedural circumstances exist. Therefore, these new modifiers should be used instead of modifier 59 to describe why a service is distinct.

Medicaid will continue to accept modifier 59 when the X {ESPU} modifiers do not accurately describe the encounter. Documentation must support the use of modifiers.

"OB" Modifier- Beginning July 1, 2016, if you report or bill with a zero $0 charge office visits that are associated with an OB package code or OB global package code, please use the "OB" non-standard modifier for these OB office visits.

Miscellaneous Billing Guidance:

1. At the current time, Medicaid only reimburses for STI services provided in the home setting when it is an extension of the clinical services. Use "71" as place of service.

a. **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?
   A: No. Any charges associated with using their third party 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.
b. **Q:** When a "FP Medicaid" client is scheduled for the STI ERRN visit and upon interview thinks the client has "BV again", can the client be switched to Physician or Advanced Practice Provider schedule and charged for the clinic visit?
   A: We do not recommend switching the client to the Physician or Advanced Practice Provider. You should:
   i) See the client in STI clinic but do not bill "FP Medicaid".
   ii) If you switch a "FP Medicaid" client to a Physician or Advanced Practice Provider schedule, it will count towards the 6-visit limit for the year.
   iii) ***Keep in mind that if you use 340B drugs to treat non-reportable STIs this may significantly reduce your supply of 340B drugs available to treat clients that the health department is mandated to treat.***

Even in these clinics **within the Health Department**, the 340B STI drugs may be given to the client for treatment. The Health Department should use staff resources to determine in which program abnormal STI results are to be managed.

For additional program guidance, please contact your Regional STI/Communicable Disease Consultant or visit the program website at http://epi.publichealth.nc.gov/cd/lhds.html

Tuberculosis Control & Treatment

Clinical Coverage Policy Tuberculosis Control and Treatment 1D-3
(guidance below as per TB Consultant 05/15/19)

1. The following Physician or Advanced Practice Practitioners in a LHD setting are eligible to provide TB service:
   - Physician (billed by E/M codes)
   - Nurse Practitioner* (billed by E/M codes)
   - Physician Assistants* (billed by E/M codes) Public Health Nurses* (billed by T1002 or reported by use of the appropriate LU code)
   - Public health nurses (RNs) supervised by the public health nurse (RN) who is responsible for the TB Control Program and shall complete the Introduction to Tuberculosis Management course.

   ***Advanced Practice Practitioner**

2. TB Disease or Contacts:

   - Per GS 130A-144 "the local health department shall provide, at no cost to the client, the examination, and treatment for tuberculosis disease and infection..."
     - As a result, TB services that deal with the examination and treatment of TB must be free or if billed to Medicaid or a third-party payer the LHD must assure that the client is not being billed for anything.

     - This becomes problematic because most insurance companies have in their contract with the health department that they must collect co-pay from the insured client. Medicaid does not require that a co-pay be collected due to this law.

     - If you bill third party insurance, then you would need to negotiate the copay issue with the insurance company.

   - The T1002 visit for TB clients is billed in units based on time recorded in client record by a Public Health (PH) Nurse under the guidance of a PH Nurse that has had the Introduction to TB course.

   - T1002 visits are for baseline monthly evaluation of clients on TB medication and not for DOT visits. (DOT is not a billable service, but DOT visits should be captured using LU121 or LU122).

   - If your IT system does not accommodate the use of the LU Codes, please consult your vendor for further guidance.

- Time spent with eligible nurse seeing the client must be documented in the medical record.

- A good practice is to document time = units.
  - Example: 30 minutes = 2 units.
  - Remember: 1 unit = up to 15 minutes.
  - Procedure code T1002 cannot be billed on the same day that a preventive medicine service is provided.
  - A maximum of 4 units per day may be billed per client.

- Clients that are contacts to TB or are symptomatic cannot be charged for a TB skin test.

- Clients who need a TB skin test for reasons of employment or school may be charged if the health department uses purchased supply. (Reading the TB SKIN TEST is included as part of the total charge)

- To be able to separate purchased vs. state supplied TB SKIN TEST, use the LU114 code for state supplied TB SKIN TEST (report only) and the CPT code 86580 for purchased TB SKIN TEST, which can have a charge attached.

- If the client has third party insurance and an RN is providing monthly assessments, you can bill third party insurance with the client's permission using 99211 or T1002.
  - Other Physician or Advanced Practice Practitioners eligible to bill third party insurance would use the appropriate E/M code for the level of service,

- When a client receives a billable TB service (billed using an E/M code) and is also seen by the **same health department Physician or Advanced Practice Practitioner** on the **same date of service** for a separately identifiable medical condition.
  - The health department may bill the appropriate E/M code, provided the diagnosis on the claim form indicates the separately identifiable medical condition and modifier 25 is appended to the E/M code that correlates to the primary reason for their visit to the health department.

- If the client is seen by a different health department Physician or Advanced Practice Practitioner on the same date of service.
  - The 25 modifier is not needed.

- It is permissible to bill for TB services rendered in the home for clients unable to come to clinic due to their disease.
  - These services would be billed using the T1002 code with the appropriate number of units and Place of Service Code-71 Public Health Clinic.

- You must use the 71 as Medicaid does not have the T1002 code identified for Place of Service Code 12- Home. (as per Julie Luffman and Phyllis Rocco 2/17)
- TB Risk Assessment form use LU code LU102 Completion of Screening Form. Please consult your TB consultant for further guidance.

- ***Clarification of the Two-Step Tuberculosis (TB) Test Process and Billing (Adult Care homes, Nursing homes, Health Departments)***

There has been much confusion regarding the two-step tuberculosis (TB) test – what is it and how can a physician's office get paid for administering both parts of the test?

Two-step testing reduces the likelihood of interpreting a "boosted" reaction as a true conversion or a new infection; it is recommended in situations where there will be repeat testing on a regular basis.

Two-step testing is required for residents of long-term care facilities upon admission. **If the resident has had a documented TB skin test (TST) within the last 12 months, that TST can be counted as the first step in twostep testing.**

1. If the reaction to the first test is positive, consider the individual infected.
2. If the reaction to the first test is negative, a second test should be given 1 to 3 weeks later.

a. If the second test is positive, consider the individual infected.

b. If the second test is negative, consider the individual not infected, record reactions, and document

dates of reading and signature(s) of person(s) reading the tests.

Source: NCTB Control Program Policy Manual (Rev 01/09 11-11) at http://www.epi.state.nc.us/epi/tb

Physicians should bill Medicaid for the two-step TB test as follows:

1. Bill the first part of the test using CPT procedure code 86580. This code can be billed only one time per day.
2. For the second part of the test that is administered 1 to 3 weeks after the first test, bill using the same CPT procedure code, 86580. No modifier is required.

Two-step testing is required for staff in long-term care facilities, as well as for staff in adult day health care centers who provide care for HIV/AIDS clients (see Chapter XI, 10A NCAC 41A.0205 (b) 4 and 5). TB skin

testing is not covered by Medicaid for job requirements. Another payment source will need to be identified when the test is administered to staff to meet these requirements.

- Billing Preventive and E/M visits to Medicaid on the same day
    - Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. This applies to all programs (see exception).
        - The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology.
        - You will need to consult with each insurance carrier for their plan specific billing rules.
        - *Exception:* Please see the Health Check Program Guide for changes related to CH.

    - If a client is seen by a Physician or Advanced Practice Practitioner for STI services and an additional problem on the same day, two E/M codes may be billed, however, the -25 modifier must be appended to the second E/M code. This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing.

    - Billing STI services provided by the STI ERRN-The four (4) components of the STI exam do not have to be provided by the same STI ERRN to bill Medicaid for the provision of the STI service.

        - The service can still be split across 2 different days and can be provided by a different STI ERRN on each day, billing T1002 per unit (up to 15 mins.) of care provided.
    - TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.

Refugee Health Initial Assessment by Nurse

- T1002 is only approved for ERRNs or TB certified RNs. Having said that, your only alternative is to use the 99211 if you plan to bill for the RN initial visit for Refugee health and refer the client out for their physical.
- You may also bill Medicaid for any labs that are performed in-house (without venipuncture). Any labs sent to a reference lab should be provided with the client's Medicaid number for them to bill. The health department may bill for the venipuncture in this case.
- You may not bill for vaccine administration along with a 99211. There is an NCCI edit that prohibits billing these two codes at the same time.

3. <u>TB Skin Test (TST) and Interferon Gamma Release Assays (IGRA's) for Employment, College or other non-mandated reasons.</u>
    - Clients who need a TST or IGRA for reasons of employment or school may be charged if the health department uses purchased supply. (Reading the TB skin test is included as part of the total charge.)

    - It is preferable to use symptom and risk screening questionnaires in lieu of placing a skin test for low risk individuals and to place the skin test or obtain an Interferon Gamma Release Assay (IGRA) if the person responds yes to any of the questions. IGRA's are preferred in this situation.

    - TB skin tests can be provided as a flat fee service if the client does not qualify as "free" per TB program guidelines because the TB program does not have a required sliding fee scale.

    - If the only service that a client comes in for is a skin test due to employment, school, etc., it should go under the TB program type.
        - However, if the client comes in for another service like MH, CH, or FP and it is determined as a part of the history that they are at high risk for TB and need a skin test, then that TB skin test should go under the program that the client is seen in.
        - The basic rule is that the TB skin test was then related to the program that brought the client in and is determined by the purpose of the visit.
    - 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

    - Billing Q&A:
      Q: I have a patient that is "Company Billing". He gets several "prepaid" private immunizations but also needs a TB skin test. A company will be invoiced for the TB test not the patient. Do we still put this TB test in TB program or in Other Services Program.
      Other services program is what brought him in? His private Immunizations were done in Other Services.
      A: You would put the TB skin test in the OS program.

Communicable Disease

1. EPI Program type is used for General Communicable Disease activities including Hepatitis A, Hepatitis B, food-borne outbreaks as well as other reportable disease investigations and follow-ups other than STI or TB.
2. Clinical visits can be reported using the appropriate CPT Ccde, and there are LU codes that can be used to report activities that don't fit into a CPT code.
3. EPI services cannot be charged to the client but if a clinical service is provided that is a billable service Medicaid may be charged. Other third-party payers may be charged with permission from the client.

For additional program guidance, please contact your Regional Communicable Disease Consultant or visit the program website at http://epi.publichealth.nc.gov/cd/lhds.html

Women's Health

Maternity/OB Billing

Maternal Health (prenatal) clients may have health department prenatal services paid for in a variety of ways. Those include NC DHB (DHB) for Pregnant Women, Presumptive Eligibility, third-party insurance, or self-pay (client pays for services). Details on how each of these is handled should be outlined in the health department Fee & Eligibility Policies & Procedures.

Forms of Payment

1. **Traditional Medicaid**

A client with traditional Medicaid continues this coverage through pregnancy. Only *Family Planning (FP)* Medicaid would be require being converted to Medicaid for Pregnant Women (MPW).

2. **DHB for Pregnant Women (MPW)**

- Clients who do not qualify for traditional Medicaid coverage (e.g., coverage that extends beyond the pregnancy period) may be eligible for MPW, which covers a broad range of healthcare services
- Covers:
  - Prenatal, antenatal, delivery, and on the last day of the month in which the 60th postpartum day occurs
  - Services to treat medical conditions that may complicate pregnancy
  - Childbirth classes
  - Family planning services
- Clients enrolled in any category of DHB, including MPW are exempt from co-pays for medical care and prescriptions

3. **Presumptive Eligibility (PE)**

Is short term, limited prenatal coverage to ensure access to care while the DHB application is being processed.

- Clients covered by third-party insurance carriers should also have PE completed since the policy may be inadequate therefore MPW could be considered as secondary coverage
- Covers the following services:
  - Ambulatory antepartum care (including ED visits)
  - Pharmacy
  - Laboratory
  - Diagnostic testing

- Agencies should complete PE at the time of the positive pregnancy test or at the first prenatal visit even if the client indicates the application for DHB/MPW has been

completed. It extends from the date of approval through the end of the following month.

- An example, a client applies and is approved on September 15th, then eligibility is through October 31st.

- Services rendered during the PE period may not be billed to the client.
  - Please see NCAPHNA WHNC Fall 2015 Report excerpt below:

PE – Email sent 9/28/15 from the Women's Health Branch to Local Health Directors
"As shared during the August Core Public Health Meeting, the FY15-16 Maternal Health Agreement Addenda includes the following language: "Completion of PE determination AND referral for DHB eligibility determination for all pregnant women, not just those who will remain in the Local Health Department for prenatal care services".

This language has been included in previous agreement addenda with the exception of OR was replaced by AND.

"The purpose of this language is to help ensure that pregnant women have access to prenatal care services as soon as possible in pregnancy. This is regardless of the payer source. Note that the state's overall first trimester entry into prenatal care numbers are moving in the negative direction; fewer women are accessing prenatal services early in pregnancy. The goal is to reduce barriers to care for all clients. Please make sure that completion of PE determination and referral for DHB eligibility determination is completed as early as possible for accessing prenatal care services. "

4. **Third-Party Insurance**
   - Health departments most often file third-party insurance for many (if not all) of services. This varies by health department and may depend on participation in a specific plan which is considered "in network" or "out of network".

   - Third-party insurance is always billed at 100% of the charge. Any remaining balance (minus copays) is billed to the client based on where they fall on Sliding Fee Scale (SFS).

   - If the LHD has a contract with the insurance carrier the remaining balance (minus copays) is to be billed to the client based on where they fall on SFS.

   - If there is no contract with the insurance carrier, then the full amount of services rendered with fall on SFS (copay deduction not required)
   - Bill using E/M or Package codes in accordance with the payors billing guidance

5. **Self-Pay Clients**

- Charges assessed based on financial eligibility
- Clients should be billed using the E/M codes & SFS

Sliding Fee Scale

- Maternal Health programs include all services funded in whole/part by maternal health dollars (from the Women's Health Branch) such as:
  - Healthy Mothers, Health Children (Title V)
  - State Funds
  - Other special grants to provide a service
- The fee for service must slide to 0%

Details on how each of these is handled should be outlined in the health department Fee & Eligibility Policies & Procedures.

Encounter Forms

- All services provided should be indicated on the Encounter Form whether reportable or billable
- Due to edits/audits related to the National Correct Coding Initiative
  - The practice of billing a 99211, "establishes" the client
  - A subsequent office visit can only be billed using an established client Evaluation/Management (E/M) code

Standing Orders

- Must follow the North Carolina Board of Nursing (NCBON) template, found at the Public Health Nursing website
  - http://www.ncpublichealthnursing.org/publications.htm
- Orders must be in place for a nurse to provide and/or order medical services
- The only level of E/M service that may be billed by an RN is 99211
- Billing third-party insurance payors, other than DHB
  - Ensure compliance is being met with the guidelines consistent with the specific insurer's supervision and "incident to" definitions

Enhanced Role Registered Nurses (ERRN)

- ERRNs must be in compliance with training & rostering

Billing for Antepartum Care

- Office/Outpatient Visit, New - CPT code(s) 99201 -> 99205
- Office/Outpatient Visit, Established (Est.) - CPT code(s) 99211 -> 99215
- Visits can be billed in the following manner:
    - Separate - Initial nurse and provider visit (only if this is the agency's routine practice):
        - Cannot code as a "new" client on the day of provider visit
        - Use 99211 to establish the client at the nurse visit if she has had 3 or fewer total visits, or
        - Use 99211 toward the total number of visits for the pkg. if the client has been seen for 4 or more total visits
    - Combined - Initial nurse and provider visit
        - Use 99211 for reporting purposes only, not billed or counted as a separate visit toward the total number of visits
        - Provider portion of the visit would be coded as "new" client visit if never having been seen in the agency for a nurse or provider E/M visit in the past 3 years
- Additionally, any in-house labs performed at the initial visit (that are not on the list of laboratory studies in 1E-5 that are considered to be included in the prenatal package codes) may be billed by the agency to DHB at the time of service.
- It may be appropriate to note that the 99211 may be billed individually if the client leaves care after 3 or fewer visits. Then the 99211 would be billed to DHB along with the one or two additional visits, rather than billing a package code.

NC DHB Clinical Coverage Policy 1E-5:

- LHDs that do not bill for delivery services, must bill for antepartum services provided to clients who are seen according to the traditional care schedule using the following guidance and CPT codes:
    - Antepartum care only, 4 - 6 visits - 59425
    - Antepartum care only, 7 + visits - 59426
- Antepartum Package Services codes are based on number of visits
- LHD that provide delivery services are eligible to bill using global codes that include delivery

An uncomplicated pregnancy follows this traditional care schedule as described in **NC DHB 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 client may be seen more frequently than the traditional care schedule if the provider determines and documents that the client and/or pregnancy warrants additional care
- http://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/1E5.pdf

NC DHB Clinical Coverage Policy 1E-5, Section 3.2.2:

- Individual Antepartum Services (use of E/M codes) are covered if:
  - 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
  - Client is seen for only (1-3) office visits
- 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 client 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
- Codes Z34.0 - Z34.9 (normal pregnancy codes) may be billed with appropriate "O" codes

Opportunities for Agency Decision/High-Risk Pregnancies

- When providing prenatal/antepartum care to clients with a high-risk diagnosis, the agency will need to determine if the client was seen more than the "routine care" for an uncomplicated pregnancy. An agency may use either of the following standards as defined:
  - **ACOG** definition: with early entry into PNC, a traditional number of visits would equal 13
  - **NC DHB Clinical Coverage Policy 1E-5, section 3.2.1**, (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/obstetrics-and-gynecology-clinical-coverage-policies) as defined as:
    - 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 agency can choose to bill the prenatal package code (59425 or 59426) even if the client is seen more than the traditional number of visits
- The agency's decision on how they bill should be reflected in policy

Submitting Billing to DHB

- Clients who complete all PNC at the LHD, bill the antepartum package using the delivery date

- Clients who are "Lost-to-follow-up", use the date of the last kept visit (it is recommended to wait until after client's due date to file)
- If it is the policy of the LHD to transfer client's care to another OB provider (at a pre-determined number of weeks gestation), use the last date of service at the LHD for package billing
- If client transfers care to another provider for the remainder of the pregnancy, use the date of transfer
- Laboratory studies
    - If the labs are included in the package billing code, then "yes" they need an OB modifier
    - If the labs are not included in the package billing code and DHB pays for them separately, then "no" they do not need an OB modifier
    - If your agency keys PNC as reportable services and uses the OB modifier (so they can be pulled out of the DHB Cost Study), the OB modifier goes on all services including labs that are included in the package billing
- Agencies must bill under the facility's NPI, as well as the rendering NPI listed on the PMH contract
- When determining which rendering NPI number to use with a package or global code, Health Departments should use the following:
    - Package code
        - NPI of the last provider that saw the client in the office
    - Global billing
        - NPI of the provider that delivered the client
    - CPT codes are as follows:
    - Venipuncture - 36415 <u>and</u>
    - Serum specimen
        - Pregnancy - 84703
        - Hematocrit - 85013
        - Hemoglobin – 85018
        - Genetic quad
            - UNC Healthcare recommends ordering/reporting all four tests below:
            - -90 Modifier must be used to indicate that the specimens were processed elsewhere on each individual test
                - Alpha-Fetoprotein (AFP) - 82105
                - Estriol - 82677
                - Human chorionic gonadotropin (HCG) - 84702
                - Inhibin A – 86336

- HD will report the CPT code with the -90 modifier to third-party insurance payors or DHB
- UNC Healthcare (or another outside laboratory) will bill the test(s) without the -90 Modifier to third-party insurance payors or DHB
- Providers can choose to solely perform the AFP using its code
- Further guidance - http://www.uncmedicalcenter.org/mclendon-clinical-laboratories/available-tests/alpha-fetoprotein-maternal-serum-quad-screen-2nd-trimester

- Glucose; quantitative – 82947
- 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

Billing Scenarios for Glucose Tolerance Testing:

- 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. 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
- 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.

- Specific CPT Codes may be billed in addition to the prenatal clinical services as identified in the **NC DHB Clinical Coverage Policy 1E-5.** For further guidance see Section 3.2, page 26, Attachment B.

  These codes cannot be billed separately when using prenatal package codes 36415, 81000, 81001, 81002, 81003, 82731.
  However, these codes may be used when coding/billing as an E/M visit for clients seen less than 4 visits.

- Amniotic, Cervical, Fecal, Rectal and Urine specimens
  - Pregnancy/urine - 81025
  - Colposcopy of the cervix - 57452
  - Group Beta Strep culture, aerobic & anaerobic - 87070
  - Group Beta Strep bacterial identification & susceptibility, aerobic - 87077
  - Urinalysis (by dipstick or tablet reagent) non-automated w/ microscopy 81000
  - Urinalysis (by dipstick or tablet reagent) automated w/ microscopy - 81001
  - Urinalysis (by dipstick or tablet reagent) non-automated w/o microscopy - 81002
  - Urinalysis (by dipstick or tablet reagent) automated w/o microscopy - 81003
  - Wet mount (analysis of microorganisms) - 87210
  - Culture, Urine, routine - 87086
  - Chlamydia trachomatis - 87491
  - Neisseria gonorrhoeae - 87591
  - Fecal occult blood - 82270
  - Assay of fluid acidity - 83986
  - Fetal fibronectin immunoassay - 82731

Antenatal Fetal Surveillance

- Fetal Surveillance Clinical Coverage Policy E4
  https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/1E4_1.pdf
- **Non-Stress Test (NST)**
  - Complete -HD bills for completing both aspects of testing
  - 59025
  - Technical Component- HD bills when solely performing the test.
  - 59025TC
  - Professional Component -HD bills when provider solely interprets results
  - 59025-26

- **Ultrasound (U/S)**
  - CPT codes are as follows:
    - Limited, fetal size, heartrate, position - 76815TC
    - Limited, fetal size, heartrate, position (includes interpretation) – 76815
    - 14 weeks, 0 days gestation, single or first gestation, fetal & maternal evaluation - 76805TC
    - 14 weeks, 0 days gestation, single or first gestation, fetal & maternal evaluation (includes interpretation) – 76805

        - 14 weeks, 0 days gestation, additional gestation, fetal & maternal evaluation (includes interpretation) – 76802
        - Amniotic Fluid Index (AFI), limited study – 76815
        - Biophysical Profile (BPP) – 76819
        - BPP with an AFI level – 76816

- **Tuberculosis Screening (TB)**
    - There is a greater risk to clients and the fetus if TB disease is not diagnosed and treated
    - ~~TB skin testing is considered both valid and safe throughout pregnancy~~
    - ~~CPT code 86580~~
- Examination and treatment are at no cost to the client
- Testing is considered both valid and safe throughout pregnancy
- Types:
    - Interferon-gamma release assay (IGRA) is the preferred method
    - Skin testing
        - Reading of a skin test is not billable
- Providers able to bill
    - Physicians and APPs - use E/M coding
    - RN (under the guidance of a PH RN that has completed the *Introduction to TB* course)
        - T1002, use unit based for time or the appropriate LU code
- Testing for reasons of employment or educational institutions may be charged if the HD uses purchased supply.
    - CPT code 86580
- Testing is reserved for clients with high-risk factors that include the following but are not limited to:
    - Documented HIV infection; close contact with individuals known/suspect to have TB; medical risk factors known to increase risk of disease if infected (e.g., DM, chronic renal failure, malabsorption syndrome, silicosis, weight loss greater than 10% of ideal body weight, gastrectomy, intestinal by-pass, current or planned use of immunosuppressive medication, lupus, cancer, alcoholism, and substance use); birth in or emigration from high-prevalent countries; being medically underserved; homelessness; living or working in long-term care facilities, such as correctional/mental health institutions, and nursing homes.
    - Client returning for a skin test is prohibitive in a case investigation
        - LU114 - State supplied
- For further guidance consult Tuberculosis Control & Treatment portion of this document

- **Lead Screening**

- If the client agrees to testing, staff will facilitate the following steps for collecting a venous blood lead specimen for analysis at the NC State Laboratory of Public Health (NCSLPH).
- This is a cost-free service for only those clients who seek prenatal care through the health department. The specimen will be drawn at HD and analyzed at the NCSLPH.
- Health department billing/finance should only file for potential reimbursement on clients covered by DHB funding. NCSLPH does not maintain the capability to bill third-party insurance; therefore, does not request third-party insurance data from health departments.
    - CPT code 83655
- Currently, the cost of uninsured client testing is covered by the revenues generated. The NCSLPH will continue to assess cost recovery on an annual basis.

Pregnancy Medical Home (PMH) Program: Clinical Coverage Policy IE-6
https://files.nc.gov/ncDHB/documents/files/1E6_1.pdf

PMH providers are obstetric specialty providers who offer managed care services that to DHB beneficiaries with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care.

The PMH seeks to engage the participation of any provider that is eligible to bill DHB for obstetric services. Case Management services are provided for all pregnant DHB beneficiaries who are determined to be high-risk and qualify for services.

To allow the PMH to stay abreast of PMH beneficiary medical needs, DHB's designated vendor shall provide the PMH alerts, including: emergency department (ED) visits, visits to a specialist, missed appointments, and etc. For more information,
http://files.nc.gov/ncDHB/documents/files/1E6_1.pdf

- **Billing for PMH Incentives:**
    - Risk screening:
        - Bill incentive code S0280 – use after pregnancy screening tool has been completed
            - Will only pay once per gestational period
            - Complete the risk screening form at the first PNC visit when OB history and exam are completed and reviewed by the provider
            - Must be completed and signed by an RN or licensed provider including advanced practice practitioners
    - Services must be billed to DHB in the following manner:

    - Rendering provider National Provider Identifier (NPI) number identified on the Community Care of North Carolina (CCNC) contract and
    - Health Department's billing NPI number

- **Postpartum**
  - Bill incentive code S0281 once the comprehensive postpartum visit has been completed
    - Date of service must be within 60 days of delivery or termination of the pregnancy
      - Exceptions
        - Relocates to another state with the intent to live there permanently
        - An undocumented citizen and eligible only for emergency services
        - Found eligible only for PE
        - Applies after the termination and documented income
          - Exceeds the MPW Poverty Level and MAF-M
    - Cannot be billed for a pregnancy that terminates by a spontaneous or therapeutic abortion
    - Will only pay once per gestational period

Maternity/Obstetrical Billing

- Preventative visit codes should never be billed for the 1st prenatal exam
- DHB will not reimburse for same day preventive and/or E/M visits
  - Exception
    - Child Health Section, item F
      - https://DHB.ncdhhs.gov/medicaid/get-started/find-programs-and-services/health-check-and-epsdt
- All PNC visits that will be billed using a package or global code should be coded in the following manner:
  - An E/M CPT code and
  - Reported with an OB modifier
  - Or utilize a separate tracking system for OB package or global services
- All PNC visits should be billed or reported
- When a pregnancy is billed to NC Medicaid with a prenatal package or global fee code, individual prenatal visits should be:
  - Entered into billing system (EHR) and
  - Accompanied by an appropriate E/M code as "0" charge and
  - Accompanied by an OB modifier (as report status only)
  - Or reported in a separate tracking system
- This is important to assure appropriate NC DHB Cost Settlement

Postpartum

- Postpartum care should be billed using an OB package code or global OB code, not an office visit (E/M) CPT code for Traditional Medicaid Coverage or MPW
- OB package codes that include postpartum care include the following:
  - **59400 – Global fee**; Routine Obstetrical care including antepartum care, vaginal delivery (with or without episiotomy, &/or forceps) and postpartum care
  - **59510 – Global fee**; Routine Obstetrical care including antepartum, cesarean delivery, and postpartum care (including incision check visit(s)
  - **59410 – Postpartum package**; Vaginal delivery only (with or without episiotomy &/or forceps) and postpartum care
  - **59515 – Postpartum package**; Cesarean delivery only, including postpartum care (including incision check visit(s) <u>or</u>
  - **59430 – Postpartum care only** (separate procedure, typically used when an agency does not bill for delivery)

Postpartum Care Services

- Visit occurs within 60th day following delivery
  - Bill using CPT code 59430 (or an appropriate global code if the agency provides delivery services)
  - PMH incentive code S0281
- Visit occurs after 60th day following delivery
  - PMH incentive code S0281 will <u>not</u> be reimbursed if the visit occurs more than 60 days after delivery.
  - The postpartum package CPT code 59430 will be reimbursed by MPW until the coverage expires
  - For clients who transition to Family Planning (*FP Medicaid*) program, the postpartum clinic visit date is recognized as the Annual Exam Date (AED)

Home Visit for Postnatal Assessment

- Follow requirements in NC DHB Clinical Coverage Policy 1M-5
- Rendered by an RN
  - CPT code 99501

Family Planning Methods Postpartum

- Bilateral Tubal Ligation
  - Return within 60 days of delivery for postpartum visit in <u>Maternal Health Clinic</u>
  - LHD uses CPT code 59430 (package code) <u>and</u>
    - Incentive code S0281 (if LHD is a PMH) <u>and</u>
    - Diagnostic ICD-10 code, Z39.2

- Depo-Provera® injection (J1050 FP UD)
    - Administered in Family Planning Clinic, not Maternal Health Clinic
    - Initial injection, Diagnostic ICD-10 code, Z30.013
    - Surveillance injection if provided at the hospital post-delivery, Diagnostic ICD-10 code, Z30.42
    - Postpartum package
        - CPT code 59430 and
        - Incentive code S0281 (if LHD is a PMH) and
        - Diagnostic ICD-10 code, Z39.2
- Intra-Uterine Device (IUD)
    - Return within 60 days of delivery for postpartum visit in Family Planning Clinic
        - LHD uses CPT code 59430 (package code) and
        - Incentive code S0281 (if LHD is a PMH) and
        - Diagnostic ICD-10 code, Z39.2
            - Insertion CPT code 58300 FP and
            - Diagnostic ICD-10 code, Z30.430 and
            - Contraception HCPCS code:
                - ParaGard® J7300 FP UD
                - Skyla® J7301 FP UD
                - Liletta® J7297 FP UD
                - Mirena® J7298 FP UD
                - Kyleena® ~~Q9984~~ J7296 FP UD
                - Not covered by *FP Medicaid/BeSmart*
- Nexplanon® implant
    - Return within 60 days of delivery for postpartum visit in Family Planning Clinic
        - LHD uses CPT code 59430 (package code) not an E&M code and
        - Incentive code S0281 (if LHD is a PMH) and
        - Diagnostic ICD-10 code, Z39.2
            - Insertion CPT code 11981 FP plus modifier 59 and
            - Diagnostic ICD-10 code, Z30.017 ~~Z30.018~~ and
            - Contraception HCPCS code:
                - Nexplanon® J7307 FP UD

Modifier 59

- Package code not considered and E/M
- Use with 58300 IUD insertion

Billing guidance

- 25 Modifier cannot be used with the insertion CPT code 58300 when CPT code 59430 (package code is being used)
- The FP Modifier must be used on the IUD insertion code 58300.
- The FP and UD modifiers must be used when billing the IUD HCPCS code or anytime the contraceptive method was purchased utilizing 340B stock
- 340B stock may only be used in the LHD Family Planning Clinic, not the Maternal Health Clinic
- The provider must include the appropriate diagnostic code for the contraceptive method and counseling

Billing Scenarios for Postpartum Care & PMH:

1. Client who received a bilateral tubal ligation at the time of delivery and/or within the 60 days postpartum. Returns to the LHD within 60 days of delivery for the postpartum visit in the Maternal Health clinic. There is no contractual arrangement for the LHD to bill for the delivery.
   - Therefore, the LHD bills **59430** for the postpartum package and **S0281** for the PMH postpartum incentive, along with diagnosis code **Z39.2**. (AF modifier no longer required – do not use or you will not be paid).
   - Service must be billed under the rendering physician name on the PMH contract with CCNC.
     - If after 60 days postpartum, HCPCS code **S0281** will not be reimbursed but the client may return for the postpartum visit using CPT code **59430** under MPW until the end of the month that the 60th postpartum day falls.

2. Client returns to LHD within 60 days of delivery for the postpartum visit. The client needs to begin a contraceptive method and is seen in the Family Planning Clinic. Client receives a Depo-Provera® injection.
   - LHD bills **59430** for the postpartum package, **S0281** for the PMH postpartum incentive with diagnosis code **Z39.2**.
   - The injection **J1050** FP UD billed with diagnosis **Z30.013** (initial injection) or **Z30.42** (surveillance of injection if provided at the hospital post-delivery).

3. Client returns to LHD within 60 days of delivery for the postpartum visit. Client has an IUD inserted at the postpartum visit in the Family Planning Clinic.
   - The LHD can bill **59430**, **S0281** and **codes for the contraceptive device and insertion**. Billing is as follows:

        - The FP modifier must be used on the contraceptive device and insertion code 58300, if the LHD is using 340 B stock.
        - The physician or advanced practice practitioner must include an appropriate diagnosis code for the contraceptive method and method counseling.

4. Client delivers on May 15, 2017. 60th postpartum day is July 14, 2017. MPW coverage extends through July 31, 2017. A postpartum exam that occurs on or before July 31, 2017 will be covered by MPW.
    - Client is seen for the postpartum care on July 10th, the PMH participating practice can bill for the 59430 postpartum package AND the S0281 incentive code.
    - If the client is not seen for the postpartum care until July 20th, the 59430-postpartum package would be covered because the MPW extends through to the last day of the month. The S0281 would not be covered because the client was more than 60 days postpartum.

5. Incision checks or any other routine postpartum care provided.
    - Since the 59430, billed with S0281 at the time of the comprehensive postpartum visit, represents a "package" of postpartum services and not a single visit. An incision check would be included in the 59430 package

6. Client comes in for an incision check and then a BP check and then an MMR or Varicella vaccination before the "comprehensive postpartum visit"
    - All those visits are covered by the 59430
    - Only the vaccinations/administration codes would be billed separately

Modifier 24 Issues Unrelated to Pregnancy

- If the provider treats a client for a problem unrelated to the pregnancy, these visits are excluded from the maternity package and can be billed separately
- Append Modifier 24 Unrelated E/M service by the same provider during the prenatal period to all E/M services that address unrelated issues as to alert the payor
- The order of diagnostic codes for billing is as follows:
    - First -> Unrelated pregnancy ICD-10 Diagnostic code
    - Second -> Z33.1 Pregnancy state, incidental
- Dependent upon the payor, services billed using this modifier + unrelated diagnostic codes may only be paid after the global, package, and/or delivery has been billed
    - Consult specific payors for guidance
    - An Example: A maternal health client presents to the LHD clinic with an Upper Respiratory Infection. The client is seen by a provider and treated.

- The visit may be billed outside the prenatal package using an appropriate E/M code with the -24
- Modifier and the following diagnostic codes:
    - First -> Unrelated pregnancy ICD-10 Diagnostic code (code to describe the URI)
    - Second -> Z33.1 Pregnancy state, incidental

Sexually Transmitted Infections (STI)

- Please refer to the STI section.

HMHC/Title V (Well Child funding)

Title V policy on applying SFS: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds.

For clients having income above the federal poverty level, the SFS of the LHD will be used to determine the percent of client participation in the cost of the service.

Maternal Care Skilled Nurse Home Visit

- Follow requirements in NC DHB Clinical Coverage Policy 1M-6
- Rendered by an RN skilled in Maternity Care
    - HCPCS Code T1001

Health & Behavior Intervention (HBI)

- Only provided by Licensed Clinical Social Worker (LCSW)
- Per unit/15 minutes
- Maximum of 44 units/pregnancy and postpartum
    - Additional units will be considered for coverage with documentation of medical necessity
- DHB funding
    - CPT code 96152, no cost to client
- Third-Party insurance funding
    - Consult specific payors for guidance
    - CPT code 96152
- https://files.nc.gov/ncDHB/documents/files/1m3.pdf

Medical Lactation Services

- Only provided by physician, advanced practice practitioner and physician assistant
- The following must apply:

    - A medical condition (e.g., feeding problem or low weight gain) diagnosed by the above-mentioned provider
    - If the client is seen by the physician and the International Board-Certified Lactation Consultant (IBCLC) on the same date of service, the physician must include the services provided by the IBCLC by billing the appropriate E/M code
    - Health and behavior visits using codes 96150, 96151, 96152 may not be reported on the same date of service as an E/M service
    - The visit is not for generalized preventive counseling or risk factor reduction
    - When more than four CPT codes 96150 are submitted by a provider/group the additional services will be denied. If a redetermination is requested, documentation showing the medical necessity of the additional time must be submitted.
- Component of the office visit code
    - Per unit/15 minutes, based on the IBCLCs time (they are not for use by physicians or other billable licensed health care provider), when performed
    - Health Departments use the following CPT codes:
    - 96150 - Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 mins. face-to-face with the client; initial assessment
    - 96151 - Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 mins. face-to-face with the client; re-assessment
    - 96152 - Health and behavior intervention, each 15 mins., face-to-face; individual

These codes may only be used for self-pay and third-party insurance clients:

- 96153 – Health and behavior intervention, each 15 mins., face-to-face; group (2 or more clients) This code is not reimbursed by Medicaid.
- 96154 - Health and behavior intervention, each 15 mins., face-to-face; family (with the client present) This code is not reimbursed by Medicaid

Medical Nutrition Therapy (MNT)

- Only provided by physician, advanced practice practitioner and physician assistant
- The following must apply:
    - A medical condition (e.g., feeding problem or low weight gain) diagnosed by the above-mentioned provider

    - If the client is seen by the physician and the IBCLC on the same date of service, the physician must include the services provided by the IBCLC by billing the appropriate E/M code
    - The visit is not for generalized preventive counseling or risk factor reduction
- Health Departments use the following CPT codes:
- Per unit/15 minutes
    - Initial – 97802
        - Service limited to a maximum of 4 units/date of service
        - Service cannot exceed 4 units/270 calendar days
    - Reassessment – 97803
        - Service limited to a maximum of 4 units/date of service
        - Service cannot exceed a maximum of 20 units/365 calendar days
    - Reassessment & subsequent intervention(s) for change in diagnosis – HCPCS code G0270

- Per unit/30 minutes
    - Group (2 + or more individuals) - CPT code 97804
    - Reassessment and subsequent intervention(s) for change in diagnosis (group) – HCPCS code G0271

Please refer to MNT Section for additional guidance

Group Prenatal Care (e.g., CenteringPregnancy®)

- Currently does not have specific coding distinguishing that it is "group"
- Proceed with using the traditional care schedule of coding for individual clients' provider visits
- Bill for childbirth education in addition to PNC if group PNC session meets the NC DHB requirements for Childbirth Education

Childbirth Education

- Refer to Birthing Classes-Clinical Coverage Policy 1M-2
    - https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/1m2.pdf
- May not be billed as Telehealth (virtual participation)
- Provider must be a certified childbirth educator by a nationally recognized organization for childbirth education or meet State-approved childbirth education program requirements; and
- Licensed practitioner operating within the scope of practice defined under State law; or
- Under the personal supervision of an individual licensed under State law to practice medicine.
    - One unit/one hour

- Childbirth education is reimbursed per class. Each class can be either one hour or two hours.
- The childbirth education provider may submit claims for reimbursement only for classes that the client attends
- Maximum of 4 hours per day (four 1-hour classes or two 2-hour classes) may be provided per day
- A maximum of 10 hours of instruction (ten 1-hour classes or five 2-hour classes) may be billed for reimbursement per client/pregnancy
- A complete childbirth education series consists of ten hours of instruction
    - Use CPT or HCPCS code S9442

Tobacco Cessation and Counseling

- Physicians, Advanced Practice Practitioners, ERRNs in the Health Departments can bill DHB for services using the following:
    - Intermediate visit (3-10 minutes) - CPT code 99406
    - Intensive visit (over 10 minutes) - CPT code 99407
    - Counseling <u>cannot</u> be billed if provided to a parent/guardian
- Physicians, Advanced Practice Practitioners and Physician Assistants can bill under respective NPI number
- These CPT codes can be billed "incident to" the physician by the following professional specialties:
    - Certified clinical supervisor
    - Clinical addiction specialist
    - Clinical nurse specialist
    - Clinical social worker
    - Licensed psychologist
    - Marriage/family counselor
    - Professional counselor
    - Psychological associate
    - Registered Nurse
        - <u>Must</u> have a standing order to provide and bill for these services
        - They <u>must</u> have attended a certified smoking cessation counseling training
- Tobacco cessation counseling may be billed in addition to the package or global fee for PNC except in the Family Planning (*FP Medicaid*) program.
- The tobacco cessation counseling standing orders and billing documents are posted and found here: https://www.quitlinenc.com/health-professionals/lhd.html

Oral Health Screening

- Dental care is included for clients with:
    - Traditional Medicaid

    - MPW (only up to time of delivery)
- Providers should be screening clients
    - At every visit throughout care
- Referrals should be facilitated for the following:
    - Clients without a dental home or regular/routine care
        - Comprehensive exam
        - Preventative services, such as cleanings
        - Problems identified
    - Clients with dental home that are currently under regular/routine care
        Continued care throughout pregnancy
- Regional Dental Hygienists have a current resource list of dental providers that accept DHB and pregnant women

Depression Screening During Maternal Health Visit

- Screenings should be performed with an approved tool/instrument 1x each trimester and postpartum
- Effective July 1, 2019, the PHQ-9 must be used during the antenatal period of pregnancy
- Effective July 1, 2019, the PHQ-9 or the EPDS may be used during the postpartum period of pregnancy
- Agency must have a policy on screening, follow-up and referral (if applicable) for abnormal results
- Postpartum agency visit can occur in either
    - Maternal Health
    - Family Planning
- Depression screening may be billed in addition to the postpartum package, global and incentive codes
- **Obstetric providers** may be reimbursed for three (3) units of CPT code 96127 (depression screening) during the first year after the delivery date or until the recipient's eligibility ends (MPW the last date of the month in which the 60th post-delivery day occurs) in addition to global obstetrics and postpartum package services." The intent is that depression screening (CPT code 96127) is to be performed in an office setting.
- Pregnancy Medical Home providers may bill CPT code 96127 in addition to S0281.

- Depression screening is only reimbursable if completed in an agency setting

During the prenatal course of pregnancy, a provider ~~may choose~~ must complete from the following:

- Screening Questions

    - Maternal Health History - Part C-2 *DHHS 4160*
        - Questions #1, #2 and #3
    - Agency cannot bill for completion of the screening questions on this form
    - If screening questions are positive, then a PHQ-9 or Edinburgh Postnatal Depression Scale (EPDS) is completed and may be billed
    - Effective July 1, 2019 the PHQ-9 must be completed during the antenatal period of pregnancy.
    - Effective July 1, 2019, the PHQ-9 or the EPDS may be used during the postpartum period of pregnancy
- PHQ-9
    - Bill on the date of service using CPT code 96127
        - ICD 10 code Z13.89
- EPDS
    - Bill on the date of service using CPT code 96127
        - ICD 10 code Z13.89

Vaccines

- If the client is self-pay or services are billed using individual E/M codes, the agency can bill in the following manner:
    - The provider E/M office visit CPT code (99212 - 99215)
    - Vaccine CPT code and
    - A vaccine administration CPT code 90471 or 90472
- Vaccines administered in Maternal Health Clinic
    - Self-pay clients will be billed on the SFS
- Vaccines administered in Immunization Clinic
    - HD would not bill according to Maternal Health SFS and follow Immunization Clinic guidance
- Measles, Mumps, and Rubella (MMR) and Varicella-Zoster Immune Globulin (VZIG) are only administered postpartum. If the client is seen in Family Planning or Maternal Health Clinics, healthcare providers must assess for immunization compliance and refer to immunization clinic as required.
    - MMR - CPT code 90707
    - VZIG, human - CPT code 90396
- If a client comes to clinic only to receive an immunization, (not during routine PNC), then the agency is to bill in the following manner:
    - A vaccine code and
    - Administration fee
- The only vaccines that are recommended to be routinely administered during pregnancy are:
    - Influenza
        - Preservative free, CPT code 90686

        - With preservative, CPT code 90688
    - Tetanus, Diphtheria, and Pertussis (Tdap)
        - CPT code 90715
- These vaccines may be billed during routine PNC visits as follows:
    - Bill administration CPT code 90471 or 90472 and
    - Bill vaccine CPT code per immunization program rules and
    - Bill or report the office visit E/M CPT as appropriate
    - No copay during prenatal period
- Vaccine administration and the vaccine specific CPT codes should be billed on the date the vaccine is administered

Billing for Antepartum Care – Therapeutic Injections

RhoGam or 17 Alpha-Hydroxyprogesterone caproate (17P) provided during PNC

- If the agency plans to bill PNC using a package or global code for OB services and a provider E/M office visit is conducted the same day as a therapeutic injection administration, then the office visit should be billed as follows:
    - Report the office visit (CPT codes 99212 - 99215) with an OB modifier
    - Bill the therapeutic injection CPT code 96372
    - Bill the specific medication HCPCS code:
        - RhoGam, Full dose - J2790
        - RhoGam, Partial dose - J2788 and
            - NC DHB approved NDC
        - 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.)
        - Makena®
            - HCPCS code J1726 and
            - NDC
        - Delalutin®
            - HCPCS code J3490
            - 17-P is only for the treatment of advanced adenocarcinoma of the uterine corpus (Stage III or IV); in the management of amenorrhea

(primary and secondary) and abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology, such as submucous fibroids or uterine cancer; as a test for endogenous estrogen production and for the production of secretory endometrium and desquamation.

- https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_Bulletin_2016_09.pdf (begins p. 35)

Injections provided outside of a prenatal visit

- Regardless of the payor, a therapeutic injection administration and a Nurse E/M office visit may not be billed on the same day of service
- If a package or global code will be billed for OB services and the therapeutic injection was the only reason for the visit, the following are billing options:
  - #1 - Report the nurse office visit - CPT code 99211 with the OB modifier as part of the total number of visits in the package and bill the HCPCS code for the specific medication
    - Do not bill the therapeutic injection CPT code 96372
    - Documentation must be present to support billing for a Nurse office visit OR
  - #2 - Bill the therapeutic injection - CPT 96372 with the HCPCS code for the specific medication
    - Do not report the office visit CPT code 99211
- Self-pay clients should be billed on SFS

Injections for agencies that are not the PNC provider

- When an RN provides multiple visits for a client not receiving prenatal services at that particular agency, these visits may be billed in one of two manners:
  - Utilize CPT code 99211 (supportive documentation is present) and
    - HCPCS J1726 (Makena®) and
    - NDC
    - HCPCS J3490 (Compound 17P)
      - NDCs for all compounds and
      - Invoice from compounding pharmacy
  - Utilize CPT code 96372 and
    - HCPCS J1726 (Makena®) and
    - NDC
    - HCPCS J3490 (Compound 17P)
      - NDCs for all compounds and
      - Invoice from compounding pharmacy

- Regardless of the number of visits for 17P administration, an agency that is not providing PNC services may not bill a package code 59425

For additional program guidance please contact the Regional Nurse Consultant (RNC) or visit the program website at http://whb.ncpublichealth.com.

Family Planning

Clinical Coverage Policy, Family Planning, 1-E7
https://files.nc.gov/ncDHB/documents/files/1E-7_3.pdf

1. General Tips regarding Family Planning Billing

- Specific Criteria Covered by Traditional Medicaid, NCHC and FP Medicaid:
  Traditional Medicaid, NCHC and FP Medicaid (also known as MAFDN, and Be Smart) shall cover family planning services, nurse midwife, or nurse practitioner, or furnished by or under the physician's supervision. Family planning services include laboratory tests, and FDA-approved methods, supplies, and devices to prevent conception, as follows:
  - The "fitting" of diaphragms;
  - Birth control pills;
  - Intrauterine Devices (IUD's) (including Mirena, Paragard, Liletta® and Skyla);
  - Contraceptive injections (including Depo-Provera®);
  - Implantable contraceptive devices;
  - Contraceptive patch (including Xulane transdermal system);
  - Contraceptive ring (Nuva Ring);
  - Emergency Contraception (including Plan B and Ella);
  - Screening, early detection and education for Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS);
  - Treatment for STIs; and
  - Lab services (refer to **Attachment A, Section C, Item 1 of the Clinical Coverage Policy)**
- Sliding fees apply to all FP services according to Family Planning Program guidelines.
  - 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.
  - Revisions to the Clinical Coverage Policy effective 11/1/2018 added the following Diagnostic and Procedural codes to the covered code lists:
    - new ICD-10 diagnosis codes as covered:
      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
    - new CPT codes as covered:
      36415, 87660, 76830, 76856, 78657, 87480, 87510
  - From November 2018 DHB Bulletin (https://files.nc.gov/ncDHB/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
    1. 87480 – Candida species, direct probe technique
    2. 87510 – Gardnerella vaginalis, direct probe technique
    3. 87660 – Trichomonas vaginalis, amplified probe technique
- Diagnosis codes
    1. N76.0 – acute vaginitis
    2. N76.1 – subacute and chronic vaginitis
    3. N76.2 – acute vulvitis
    4. N76.3 – subacute and chronic vulvitis
- Medications
    1. Metronidazole 250mg, 500mg
    2. Metronidazole gel 0.75%
    3. Clindamycin cream 2%
    4. Clindamycin oral 150mg
    5. 300mg, Clindamycin ovules100mg
    6. Tinidazole 2gm, 1 gm, 500mg, 250mg

- Medicaid covered pharmaceutical supplies and devices, including oral contraceptive pills, intrauterine devices, implantable contraceptive devices, contraceptive patch, contraceptive ring, emergency contraception and contraceptive injections are covered under the FP Medicaid program if provided for family planning purposes. There is no co-payment for beneficiaries in the Family Planning program for Medicaid covered contraceptive supplies and devices.
  All eligible drugs for Family Planning will have a family planning indicator on the drug file (including birth control pills, Depo-Provera, Ortho Evra contraceptive patch, Nuva Ring). The dispensing fee is based on traditional Medicaid rules. There is a six-prescription limit per month with no override capability. Providers are not allowed to distribute "brand medically necessary" (DAW1 (dispense as written)) drugs, if a generic is available. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-10-CM code. Post-operative medications are covered for sterilizations procedures. All approved post-operative medications must have the appropriate ICD-10-CM Diagnosis for sterilization on the prescription.
  The AED is not required on FP Medicaid program prescriptions
- New ICD-10 Codes effective 10/1/18 that may be used in the FP setting are:
    - F12.23 Cannabis dependence with withdrawal
    - F12.93 Cannabis use, unspecified with withdrawal
    - F53.0 Postpartum depression
    - F53.1 Puerperal psychosis
    - Z13.31 Encounter for screening for depression
    - Z13.32 Encounter for screening for postpartum depression
    - N35.82 Other urethral stricture, female

- N35.92 Unspecified urethral stricture, female
- P35.4 Congenital Zika Virus disease
- Z20.821 Contact with and suspected exposure to Zika Virus
- T74.51 Adult forced sexual exploitation, confirmed
- T74.52 Child sexual exploitation, confirmed
- T76.51 Adult forced sexual exploitation suspected
- T76.52 Child sexual exploitation suspected
- Z04.81 Encounter for examination and observation of victim following forced labor exploitation (not related to sex work)
- Z62.813 Personal history of forced labor or sexual exploitation

More information related to human trafficking can be found at www.aha.org/icd-10-cm-coding-human-trafficking-resources

- New CPT Codes effective 1/1/19 which may be used in the FP setting are:
  - G2012 Brief communication technology-based service such as virtual check-in. This allows the provider to get paid via a virtual communication that does not result in a subsequent E&M visit. This is not the same as telemedicine.
  - G2010 Remote evaluation of recorded video and/or images submitted by an established patient commonly called a “store and forward”, such as a patient sending the provider a picture of a rash. This allows the provider to get paid if the communication does not result in a subsequent E&M visit.
  - G0071 Rural Health Center/Federally Qualified Health Center virtual communication service (generally 5-10 minutes long) which does not result in a subsequent E&M visit and which is not conducted as follow-up to an E&M visit which occurred in the last 7 days.

- **Please see the following verbiage from the 4/6/2018 Women’s Health Branch Memorandum entitled “Title X - Collections and Debt Set-Off”:**

  We have received numerous questions pertaining to collections and debt set-off for clients receiving Family Planning services under Title X. Our team reached out to the Office of Population Affairs to gain further clarification. Below is the guidance that we have received.

  Q. Agencies have asked us if it's okay to send clients ' information to collection agencies and/or debt set-off, and how to handle confidential clients.

  A. Yes, it is generally permissible for an agency to refer clients to collection agencies and/or debt set-off

  However, "confidential " clients/clients should only be referred to Debt Collections and/or Debt Set-off, if the Grantee, and/or it's subrecipients (including service sites) can ensure that the client's "confidential" status will NOT be compromised by going through

[he Debt Collection or Debt Set-off process. If "confidentiality" cannot be guaranteed, a "confidential " client should NOT be referred to Debt Collections and/or Debt Set-off.

Q: May a county provide free pregnancy tests and still bill Medicaid?

A: A county may decide to offer pregnancy test at no cost to a certain subpopulation of clients and still bill Medicaid. The process to carry out this is through a manual discounting of the service to zero on the sliding fee scale. I've offered an example of acceptable wording for a policy. There are 2 options:

Policy:

In order to identify teens in need of family planning services and subsequently enroll them in care and/or to identify teens early in pregnancy to enroll in prenatal care the fee associated with pregnancy testing will be discounted to zero for those xx years of age and under. Local funding will be used to cover the cost of the service or discount the pregnancy test to zero for to all women without insurance or Medicaid.

Procedure:

Manually override the sliding fee scale and discount the service to zero for all clients xx and under, regardless of their insurance or Medicaid status. (do not bill third party ins. Or Medicaid)

The rule here is the county cannot charge one 18-year-old "0" and turn around and bill Medicaid for the next 18 yr. old that shows up. It will have to be consistently applied to all ages X and under, whatever they determine that age to be.

or

They could also just decide to discount the pregnancy test to zero for to all women without insurance or Medicaid.

- Family planning diagnosis (DX) codes Z30.0 –Z30.9 (except Z30.8) must be the 1st Dx for all Medicaid clients when family planning services are provided (except postpartum exams);
    - you may use Z01.41 Gynecological exam for third party insurance.

- If the client has Medicaid and is receiving postpartum clinical follow-up in the FP clinic
    - Instead of an E/M or preventive code; use the routine postpartum follow-up CPT code 59430 (postpartum exam) and S0281 (postpartum incentive code) if the is a Pregnancy Medical Home without any modifiers and pair with the Z39.2 diagnosis.

- The Family Planning diagnosis is coded second using the appropriate ICD-10 (Z30.0 – Z30.9, except Z30.8) diagnosis code along with the appropriate CPT code for the method provided, using both the FP and UD modifiers

- Providers may bill (both traditional Medicaid and Family Planning Medicaid (also known as MAFDN and BeSmart) for both insertion/removal of an intrauterine device or contraceptive implant and an E/M office visit if there is a separate, identifiable issue that would warrant an office visit.
    - The office visit is billed with a 25 modifier, and the ICD-10 diagnosis must support the reason for billing the additional office visit with an additional diagnosis other than contraceptive insertion.
    - Beneficiaries covered under FP Medicaid (also known as MAFDN and BeSmart) are only eligible for family planning services as described in NC DHB's 1E-7 Clinical Coverage policy and are not eligible for any other Medicaid program.

- Annual exam & IUD:
  If during an annual exam, the beneficiary requests an IUD insertion (CPT procedure code 58300), an IUD removal (CPT procedure code 58301), insertion, non-biodegradable drug delivery implant (CPT procedure code 11981), removal, non-biodegradable drug delivery implant (CPT procedure code 11982), removal with reinsertion, non-biodegradable drug delivery implant (CPT procedure code 11983), or diaphragm or cervical cap fitting with instructions (CPT procedure code 57170) or during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and CPT procedure code 58300, 58301, 57170, 11981, 11982 or 11983. An appropriate modifier must be submitted with the annual exam procedure NC Medicaid and Health Choice Family Planning Services Clinical Coverage Policy No: 1E-7 Amended Date: March 15, 2019 19B27 19 code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service. The providers documentation must support that the service rendered was a separately identifiable service provided by the same provider on the same day of service. If the only reason that the beneficiary is seen in the office is to request an IUD insertion, an IUD removal), insertion, non-biodegradable drug delivery implant removal, non-biodegradable drug delivery implant removal with reinsertion, non-biodegradable drug delivery implant or diaphragm or cervical cap fitting with instructions providers shall not bill a separate inter-periodic office visit. An office visit component is contained in the reimbursement for CPT procedure codes 58300, 58301, 57170, 11981, 11982 and 11983. However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the inter-periodic visit and CPT procedure code 58300, 58301, 57170, 11981, 11982 or 11983. The providers documentation must support that the service rendered was a separately identifiable service.
    - An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

- The provider's documentation should support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

- Inter-Periodic Visit & IUD:
  - If the only reason that the beneficiary is seen in the office is to request an IUD insertion (CPT procedure code 58300) or an IUD removal (CPT procedure code 58301)
    - providers should not bill a separate inter-periodic office visit.
    - An office visit component is included in the reimbursement for CPT procedure codes 58300 and 58301.
    - However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the inter-periodic visit and the IUD insertion or IUD removal.
    - The provider's documentation should support that the service rendered was a separately identifiable service.

- The list of procedure codes that meet the comprehensive annual or physical exam requirement under the FP Medicaid (also known as MAFDN and BeSmart) program now contains procedure codes that include the postpartum exam
  - CPT 59400, 59410, 59430, 59510, and 59515
  - in addition to the comprehensive annual or physical exam codes:
    - 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, and 99397.

Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information. https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_Bulletin_2016_02.pdf

Effective October 1, 2015, (per WH RNCs) DHB will now allow the CPT code 59430 (postpartum package code) to meet the annual exam date (AED) requirement for the FP Medicaid (also known as MAFDN and BeSmart) program. Physician or Advanced Practice Practitioners can list the date from the postpartum visit as the AED on FP Medicaid (also known as MAFDN and BeSmart) claims. DHB included this change in their revised Family Planning Services (1E-7) policy released 11/1/2018.

- The annual preventive exam should be age appropriate and services provided as medically necessary. Only one preventive exam is billable per 365 days.

- If the client is being seen for a Preventive visit during her menses and a Pap smear is required, the complete exam with the exception of the pelvic exam should be performed.
  - It is preferred that you do everything possible at the Preventive visit.
  - You should charge for the Preventive visit and lab work done on that day.

- If the client returns for a Pap smear and/or labs, you can then charge for the labs and a handling fee (99000) that are done to complete the visit.
- No visit code or pelvic exam should be billed since this is considered the completion of the Preventive visit you have already billed.
- If the Pap smear is not completed with the preventive visit, it must be completed within 30 days of the preventive visit to be covered.

- When a client presents for a service which is usually performed by a nurse such as a "pill pick up" or a "Depo only" visit but is instead performed by a Physician or Advanced Practice Practitioner or a physician because the nurse is unavailable
  - The visit should still be coded as a CPT code 99211 since that is the usual level of service.
  - Coding the visit to a higher level without provision of higher level services penalizes the client based only on having been seen by a higher-level Physician or Advanced Practice Practitioner.
  - When a client presents for that same type visit and sees a Physician or Advanced Practice Practitioner, and it is noted in the history that the client is having severe headaches or other problems requiring the judgment of the Physician or Advanced Practice Practitioner, then the visit should be billed at the appropriate higher level.

- Contraceptive Injection/Depo-Provera
  - For nurse-only visits at which clients receive Depo injections, agencies may opt to bill in one of the following two ways for traditional Medicaid, FP Medicaid (also known as MAFDN and BeSmart), self-pay and commercial insurance:
    - Bill a 99211 FP and a J1050 FP UD
    - Note: the FP modifier is not needed with 99211 for self-pay clients. Or Bill a 96372 FP and a J1050 FP UD

  - For clients with FP Medicaid (also known as MAFDN and BeSmart):
    - Billing with 96372 does not count toward the client's annual limit of six inter-periodic office visits, while 99211 does count toward this limit.
  - In deciding how your agency will bill, please be aware of the different reimbursement rates for 99211 and 96372.
    - 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 FP Medicaid use many or all of their six, allotted inter-periodic visits per year.

- It is permissible to bill 96372 (injection fee) for contraceptive injections (Depo) with an E&M visit code (99212-99215) or with a preventive visit code when:
    - 1) a provider or an RN is onsite, and 2) the RN clearly documents that he/she administered the injection.
    - A -25 modifier is required and should be appended to the office visit code.

- Nurses providing follow-up care to Family Planning clients for birth control methods (including Depo) should always bill or report these services under the prescribing Physician or Advanced Practice Practitioner.
    - For example, Sue comes for her annual FP exam and the Physician or Advanced Practice Practitioner writes a new prescription for Depo for the next 12 months.

    - Each time Sue returns during those 12 months, the Depo should be billed under the Physician or Advanced Practice Practitioner who prescribed it and not the Physician or Advanced Practice Practitioner/nurse who gives it.

    - This should remain constant until a new prescription is written (whether it is for Depo or a different method.)

    - If the originating physician or APP has left the practice, a new prescription would need to be written and billing would then be under the new prescribing physician or APP's NPI number.

- National Drug Codes (NDCs):
    - Effective January 1, 2007
    - Must be used when billing/reporting HCPCS codes (drugs/medications i.e. Depo, Implantable Device, etc.) to Medicaid.
    - **Note:** National Drug Codes are a universal drug identification number. They identify the manufacturer of the drug and are assigned by the FDA.
    - It is recommended that the nurse/Physician or Advanced Practice Practitioner administering the drug be responsible for documentation of the NDC number required for billing purposes.
    - LHDs should follow the guidance below in billing Medicaid for methods/devices

DHB ICD-10 update

The Division of Public Health has confirmed that all the following ICD-10 codes are active/paying in NCTracks:

- Z30.015 Encounter for initial prescription of vaginal ring hormonal contraceptive
- Z30.016 Encounter for initial prescription of transdermal patch hormonal contraceptive device
- Z30.017 Encounter for initial prescription of implantable subdermal contraceptive
- Z30.44 Encounter for surveillance of vaginal ring hormonal contraceptive device
- Z30.45 Encounter for surveillance of transdermal patch hormonal contraceptive device
- Z30.46 Encounter for surveillance of implantable subdermal contraceptive

Additional Guidance

Previous guidance was to see a Family Planning client requesting STD services in STD/Adult Health instead of in Family Planning, especially if the client was using the Depo injection for contraception.

However, since updated FP Medicaid Family Planning Medicaid guidance states that agencies may opt to bill 96372 instead of 99211 for Depo injections without depleting one of the six inter-periodic visits, there is no longer significant concern about depleting inter-periodic visits by seeing these clients in Family Planning for STI testing/treatment.

- Agencies shall incorporate the CD/STD program's STD screening questions at the annual/preventive visit via the Family Planning Health History Form (DHHS 4060F and DHHS 4060M).

- At a problem/inter-periodic visit, agencies only need to ask the CD/STD program's screening questions as indicated.
    - For example, if a client presents with a vaginal discharge at a problem/inter-periodic visit, the provider may ask screening questions as indicated, and does not necessarily need to ask all STD screening questions on the DHHS 4060F/4060M forms.

- No STD services covered under 10A NCAC 41A.0204(a) provided to a FP client should be billed to that client. Medicaid and third-party payers (with client's permission) may be billed, but not the client.

10A NCAC 41A .0204 CONTROL MEASURES - SEXUALLY TRANSMITTED DISEASES:
Local health departments shall provide diagnosis, testing, treatment, follow-up, and preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale. These services shall be provided upon request and at no charge to the client.

a) One exception is diagnosis of and treatment for genital warts, which may be billed either to traditional Medicaid, third party insurance, or to the client via the Sliding Fee Scale.

- LHDs that operate and dispense through an outpatient pharmacy (either a contract pharmacy or a LHD operated pharmacy that fills contraceptive prescriptions written by any community Physician or Advanced Practice Practitioner, not just LHD Physician or Advanced Practice Practitioners):
    - Can either bill using the Medicaid Outpatient Pharmacy Rules or can use the Physician Drug Program (PDP) process.

    - If the Pharmacy is a Medicaid Pharmacy provider (outpatient pharmacy), then standard dispensing fees (as established by Medicaid) can be billed to Medicaid along with the cost of the method/device.

    - LHDs that bill for IUDs, Implantable Devices, and Depo through the Family Planning Clinic/PDP process must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.

    - LHDs that dispense and bill for other Family Planning contraceptives through the Family Planning Clinic/PDP process (LHDs that fill contraceptive prescriptions only for clients seen in the LHD Family Planning Clinic) must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.
    - 340B stock Emergency Contraception may only be prescribed/dispensed/ administered via the Family Planning clinic.
        - Therefore, if pregnancy testing is done in NON-Family Planning clinics (i.e. in General Clinic), and if it is appropriate to offer Emergency Contraception with a negative pregnancy test, then a Family Planning encounter must be opened before prescribing/ dispensing/administering the Emergency Contraception from 340B stock.

    - The FY 18-19 Family Planning Agreement Addendum, Attachment B, lists J3490 ("unclassified drugs") as a HCPCS code that may be used for Emergency Contraception (EC), based on the Family Planning National Training Center's recommendation.
        - Because J3490 is used in other programs for other drugs, we suggest that agencies consider using HCPCS code S5001 ("prescription drug, brand name") for Ella and Plan B for internal reporting or billing self-pay clients.
        - If your agency uses generic EC drugs, HCPCS code S5000 ("prescription drug, generic") may be used for internal reporting or billing self-pay clients
        - If your Electronic Health Record (EHR) system permits multiple modifiers to be added to the HCPCS code to distinguish between Ella and Plan B,

then your agency can use modifiers to distinguish the fees for each of these drugs.

- If your EHR does not permit the addition of multiple modifiers to the HCPCS code to distinguish between Ella and Plan B, then you may set one fee for HCPCS code S5001, based on a weighted average cost for Ella and Plan B.
    - When calculating a combined fee for Ella and Plan B, please use the same methodology that you use when calculating your agency's fee for all types of Oral Contraceptive Pills under HCPCS code S4993.
    - Because the NC DHB will not reimburse Local Health Departments for EC, we recommend that clients with Medicaid be provided a prescription for EC and sent to the pharmacy whenever possible.
    - However, assigning a HCPCS to EC will allow you to count the number of doses of EC dispensed and provide a mechanism for charging insured clients and self-pay clients (on the Sliding Fee Scale) for EC.
    - Alternatively, if your EHR permits the use of LU codes, you may wish to track EC use and set fees for EC using LU codes.
    - Billing Scenarios:
        - A visit for ECP may be billed using the appropriate CPT code if it meets the criteria (i.e. 99211). Otherwise there may not be a charge for the visit portion.
        - If the client has Medicaid or insurance, they may be given a script to take to the pharmacy to be filled. If there are barriers to the client using their Medicaid or Insurance, 340B stock from the HD may be used, but there is no mechanism for the LHD to bill Medicaid for ECP at this time.
        - If the client does not have Medicaid…agency can set fees using HCPCS codes S5000, S5001.

- Since 340b prices change regularly, we suggest that you determine your average cost for a year for each 340b method or device.
    - This amount can then be used for billing using the UD-modifier and FP-modifier.
    - As this methodology is updated annually, this should provide the least amount of risk as it will be the closest to your actual cost.
    - Your purchase cost for each device should be reviewed and updated at least annually.

- There should not be 3 different fees/charges for billing 340b medications or devices. You should follow the guidance below:

- LHDs are required to bill Medicaid the acquisition cost of medication or devices purchased via the 340b drug program. Therefore, their fee/rate for Medicaid must be the purchase cost.
- LHDs may charge insurances and self-pay clients at a different fee/rate than what they charge Medicaid for the same medications or devices purchased via the 340b drug program.
- LHDs may choose to charge all payors the acquisition cost of medication or devices purchased via the 340b drug program.
- However, LHDs (due to Title X funding) are required to slide the fee/rate of the medication or device on the SFS for all self-pay Family Planning clients.

IUD CPT Code Changes

The following HCPCS codes may be used to bill for IUDs and implants as of 1/1/2018:

- J7297 - Liletta®, 52 mg levonorgestrel-releasing IUD
- J7298 - Mirena®, 52 mg levonorgestrel-releasing IUD
- J7296 - Kyleena®, 19.5 mg levonorgestrel-releasing
- J7301 - Skyla®, 13.5mg levonorgestrel-releasing IUD
- J7300 - ParaGard®, the copper IUD
- ~~J7306~~ J7307 - Nexplanon®, etonogestrel implant system

- For Medicaid and NCHC Billing
  - The NDC units for Kyleena® should be reported as "UN1".

  - DHB and NC Health Choice cover the Kyleena® IUD as of October 2016.
    - Please see page 17 of the January 2017 DHB Bulletin for more detailed information on this coverage: https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/medicaid_bulletin_2017_01.pdf

  - While Kyleena® is covered by regular DHB and NC Health Choice, DHB has informed us that **Kyleena® is <u>not</u> covered by FP Medicaid Family Planning Medicaid** (also known as MAFDN and BeSmart).
    - Because there are other similar, less expensive devices available, Kyleena® has not been included on the current FP Medicaid formulary.

  - For additional information on NDC, refer to the January 2012, Special Bulletin, National Drug Code Implementation Update.

  - For additional information regarding NDC claim requirements related to the PDP, refer to the PDP Clinical Coverage Policy No. 1B, Attachment A, H.7 on DHB's website.

- Providers shall bill their usual and customary charge for non-340-B drugs. Medicaid Bulletin January 2017

- PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA).
    - Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost.
    - Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.

- The fee schedule for the PDP is available on DHB's PDP web page

- Physician or Advanced Practice Practitioner(s) shall follow applicable modifier guidelines.
    - Family planning services billed to Medicaid must be billed with the appropriate code using the FP modifier (not just method related services).
    - If you bill insurance, it is recommended that you contact each carrier to find out what the procedure is for using program related modifiers.
    - For guidance on billing Health Choice for Family Planning services please see below.

- *NOTE: 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). [According to the 2016 LARC Quick Coding Guide Supplement at http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement.pdf]
- Agencies are encouraged to provide prescriptions for clients with Medicaid or insurance prescription coverage for oral contraceptives, Xulane patch, NuvaRing and Plan B or other emergency contraception to be taken and filled at a private pharmacy of the client's choice.
    - The pharmacy will use their own stock and bill DHB directly. **See decision-making flow charts at the end of this document for additional guidance (Appendixes A and B).**

340B Guidance

Billing scenario for client with insurance and Medicaid with device purchased with 340b funds:

Jane has both BCBS and Medicaid. Her family planning appointment includes an IUD that costs $300 at 340B/acquisition cost. That same IUD costs $600 at the usual and customary cost. The agency bills BCBS $600, and BCBS reimburses the agency $200. The agency then bills Medicaid $100 in the hopes of being reimbursed for $300 total – the 340B acquisition cost.

> So, our (WHB) advice is that it's okay to bill Medicaid the remainder of the 340B/acquisition cost if third party insurance reimburses an amount that's less than the 340B/acquisition cost.
>
> If, however, the device was **purchased privately (NOT via 340B pricing),** you would bill Medicaid the $400.00 difference between the billed price **($600)** and what BCBS paid **($200)**.

- For sliding fee scale clients
    - Use HCPCS code S4993 with the modifiers FP and UD to bill for oral contraceptives and include the number of packs.
    - Refer to the joint memo from Dr. Holliday and Dr. Joy Reed, 6-18-08, which gives recommendations for determining a fee based on the agencies average cost for oral contraceptives.

- If a billable visit is not provided, there are LU Codes that can be used to capture related services provided
    - LU235 Pill Replacement (REPORT ONLY) and/or LU236 Pill Pick-up (REPORT ONLY)
- The UD modifier indicates that the contraceptive was purchased through the 340B Drug Pricing Program.
    - The fee for Medicaid-insured clients must be set at the acquisition cost.
    - The fee for uninsured, self-pay clients may be set EITHER at the acquisition cost **OR** at the usual and customary fee.
    - The fee for commercially-insured clients may be set at EITHER the acquisition cost **OR** at the usual and customary fee.
    - Agencies may opt to either charge all commercially-insured clients the 340B/acquisition fee, or to charge all commercially-insured clients the usual and customary fee. Any charges that are not fully reimbursed by the commercial insurance carrier must be charged to the client on the SFS.
- If the agency opts to charge all commercially-insured clients the usual and customary fee, and if the agency is not contracted with clients' insurance carrier
    - Then the agency should inform clients prior to rendering services that they may be charged less at a facility that is in-network with their commercial insurance carrier.
    - If clients make an informed decision to be seen at the agency's family planning clinic, the agency should bill clients on the SFS for any amount not reimbursed by their commercial insurance carrier.

Example 1: The agency decides to set the two fees for Family Planning devices/medications as above, and to charge commercially-insured clients the usual and customary fees.

Client Beth has BCBS and comes to the agency's family planning clinic requesting an IUD. Beth is informed that her visit may cost less with an in-network provider, since the agency is not contracted with BCBS.

Beth makes an informed decision to be seen at the agency. The provider inserts a Liletta® IUD. The agency purchased the Liletta® IUD at the $50 340B/acquisition fee. The agency bills BCBS their usual and customary Liletta® IUD fee of $600. BCBS reimburses the agency $300. The agency then bills Beth the remaining $300 on the SFS. Since Beth falls at 20% on the SFS, her charge for the Liletta® device is $60.

- Pro = Agency receives higher reimbursement from commercial insurance

- Con = Client is charged higher fee

Example 2: The agency decides to only set one fee for Family Planning devices/medications – the 340B/acquisition fee.

Client Beth has BCBS and comes to the agency's family planning clinic requesting an IUD. The provider inserts a Liletta® IUD. The agency bills BCBS the $50 340B/acquisition fee for Liletta®. BCBS reimburses the agency $25. The agency then bills Beth the remaining $25 on the SFS. Since Beth falls at 20% on the SFS, her charge for the Liletta® device is $5.

- Pro = Client is charged lower fee
- Con = Agency receives lower reimbursement from commercial insurance

Example 3:
Question: When a FP Medicaid 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 DHB 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/ncDHB/documents/files/Medicaid-Bulletin-2018-11.pdf)

How to bill when Child Health and Family Planning services interface
If the reason for visit is for a well child exam but the client presents also wanting FP services, the visit is billed as follows:

- Bill the Well Child Exam along with all required components under the CH program type.
    i. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.

- REPORT all the FP portions of the visit, assuring that all required FP components have been completed.
    i. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.

- In order to offer 340B medications, the visit must be documented separately so that it is clear a FP visit has been made therefore establishing the client in FP.

- Document using a separate encounter form.

- If the reason for visit is for FP services but the client is also in need of their CH visit, the visit is billed as follows:
    i. REPORT the Well Child Exam along with all required components under the CH program type.
    ii. The CH portion of the visit would be documented using the CH templates whether in EHR or paper format.

- Bill all the FP portions of the visit, assuring that all required FP components have been completed.
    i. The FP portion of the visit would be documented using the FP templates whether in EHR or paper format.
- NCTracks has indicated that they will no longer require the TJ modifier for NC Health Choice Family Planning clients.
    i. **The claims should only require an FP modifier and should pay at the usual rate** instead of $90. ~~We have not been able to verify that this fix is working properly.~~

- General Reminders
    - 340B drug eligibility requires that the client be a registered FP client.

    - If a client is seen for FP services, all the assessments and education are completed and separately documented (separate from the CH documentation) and an encounter reflects that the client received FP services, then the client should be able to receive 340B drugs, even if the encounter is entered as "report only."

    - Assure all CH service components are provided.

    - DO NOT try to document both visits on the same program template. Neither the CH or FP templates are structured to comply with both program requirements.

Additional guidance can also be found in the following Physician's Drug Program Clinical Coverage Policy under the reimbursement section: https://files.nc.gov/ncDHB/documents/files/1B_0.pdf

- If a Health Check exam is provided in FP and a method is provided
    - LHDs will need to add the FP modifier in the first modifier field (to match the FP CPT and diagnosis codes) AND the EP modifier in the second modifier field (to match the Health Check CPT and diagnosis codes)

    - Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

- If you bill other third-party payers, it is recommended that you contact them individually for guidance on use of the FP modifier.

- Clarification from Title X has greatly expanded the services that should be included under the FP Program.
  - The revised guidance clearly indicates that services to promote the reproductive and general health of the clients are an expected part of FP services.
    - Example One: Client has a Pap test done in Family Planning; the follow-up, re-test, etc. must be done in the FP program.

    - Example Two: FP Annual Exam is done, and client needs a thyroid screen that has nothing to do with FP or method the client is receiving;
      i. In this case, the client should be referred for the thyroid screen to another clinic or health department, and the client would be responsible for the cost of that screen.

      ii. When a FP client calls in to make an appointment for a problem (discharge, headaches, breakthrough bleeding, etc.) the client should be seen initially in the FP Clinic for a determination of whether this is related to or has an impact on the method of contraception being used.

      iii. If the problem requires follow-up with another Physician or Advanced Practice Practitioner or a specialist, the referral can be made after that evaluation. If you have questions, please contact your Women's Health Nursing Consultant.

- Billing Preventive and E/M visits to Medicaid on the same day
  - Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit. UPDATE AFTER CODING COUNCIL ON 9/16/19

  - This applies to all programs (see exception).

  - The only additional CPT codes that can be included in the service are CPT codes for injectable medications or ancillary studies for laboratory or radiology.

  - You will need to consult with each insurance carrier for their plan specific billing rules. *Exception: Please refer to* the Health Check Program Guide for changes related to CH.

- If a client is seen by a Physician or Advanced Practice Practitioner for STI services and an additional problem on the same day
    - Two E/M codes may be billed,
    - However, the -25 modifier must be appended to the second E/M code.
    - This will identify that two "separately identifiable services" were provided by the **same Physician or Advanced Practice Practitioner** on the **same day** and it is not a duplicate billing

- HMHC/Title V (Well Child funding):

  Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the LHD will be used to determine the percent of client participation in the cost of the service.

  10A NCAC 43B .0109 Client and Third-Party Fees
    - If a local provider imposes any charges on clients for maternal and child health services, such charges:
        - Will be applied according to a public schedule of charges;
        - Will not be imposed on low-income individuals or their families;
        - Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
    - If client fees are charged, providers must make reasonable efforts to collect from third-party payors.
    - Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.
        - All maternal and child health services, whether sick or well, no matter where delivered, must be billed on the SFS that slides to zero.

  History Note: Authority G.S. 130A-124; Eff. April 1, 1985; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017.

Smoking and Tobacco Use Cessation and Counseling

- Physicians, Advanced Practice Practitioners, ERRNs in the Health Departments can bill DHB for services using the following:
    - Intermediate visit (3-10 minutes) - CPT code 99406
    - Intensive visit (over 10 minutes) - CPT code 99407
    - Counseling <u>cannot</u> be billed if provided to a parent/guardian
- Physicians, Advanced Practice Practitioners and Physician Assistants can bill under respective NPI number

- These CPT codes can be billed "incident to" the physician by the following professional specialties:
    - Certified clinical supervisor
    - Clinical addiction specialist
    - Clinical nurse specialist
    - Clinical social worker
    - Licensed psychologist
    - Marriage/family counselor
    - Professional counselor
    - Psychological associate
    - Registered Nurse
        - Must have a standing order to provide and bill for these services
        - They must have attended a certified smoking cessation counseling training
- Tobacco cessation counseling may be billed in addition to the package or global fee for PNC except in the Family Planning (*FP Medicaid*) program.
- The Tobacco Cessation Counseling Standing Orders and Billing documents are posted and can be found here: https://www.quitlinenc.com/health-professionals/lhd.html

- Pap Test Fee
    - If the client is self-pay, the reference lab bills the health department (based on negotiated rate) and the health department bills the client using the appropriate CPT code and 90 modifier based on SFS. The reference lab could file a claim with the insurance company.
    - **Do Not** charge clients with Medicaid for Pap test processing. The lab that performs & interprets the test is responsible for billing Medicaid directly.
    - Health Departments should negotiate rates with their reference lab.

- **Title X Rule Change Coding and Billing Pregnancy test visits in FP clinic**

Q: How should the PHN bill for the Pregnancy test visit? If the client sees a provider that day, then how would the visit be billed when turned over to an APP or MD?

A: If the visit is a "Pregnancy Test" only visit, then the agency should still bill for the visit with a 99211. Even if an APP or MD is called in to the room to provide counseling, since this service is within a Registered Nurse's scope of practice, it should still be billed with a 99211. It cannot be billed with a higher CPT (99212-99215) simply because Title X requires an APP or MD to provide the counseling. Alternatively, if the client is brought back on a different date for counseling, the APP or MD could bill for that visit with a 99211 or with an appropriate counseling code (99401-99404 for individual counseling). Please note that Medicaid does not reimburse Local Health Departments

for the 99401-99404 codes, though private insurance may do so. However, the agency should determine with which code providers will bill these visits, and all clients should be billed with the same CPT code, regardless of payor source.

Q: Is billing a straight 99211 when an advanced practitioner is called in to see the patient not considered under-coding?

***A:* No**, this is not considered under-coding. The level of counseling provided by the APP or MD is within the scope of practice of an RN. Although the new Title X rule prohibits an RN from providing the counseling, it does not change the CPT code level of the visit. The CPT code level of the visit is determined by the level of service provided, not the licensure of the individual providing the service.

Family Planning Medicaid (FP Medicaid also known as MAFDN and Be Smart)

Physician Advanced Practice Practitioners can bill FP Medicaid Family Planning Medicaid for a limited set of CPT codes. The complete list of these codes may be found in Attachment A, C1 of the Clinical Coverage Policy.
https://files.nc.gov/ncDHB/documents/files/1E-7_1.pdf

FP Medicaid and Retroactive Coverage

- FP Medicaid coverage is retroactive for 90 days.
- If a client has a Family Planning preventive visit within the 90 days preceding her receipt of FP Medicaid coverage, the service should be reimbursed by FP Medicaid, provided that the client notifies her Department of Social Services (DSS) case worker of the date of the visit and the need for retroactive coverage.
- Once a local health department confirms that the client has FP Medicaid, the health department may bill for a Family Planning preventive visit that occurred within the 90 days before the FP Medicaid coverage was issued.
- That visit date would then be listed as the Annual Exam Date (AED) in NC Tracks.
- If more than 90 days have passed between the Family Planning preventive visit date and the patient's receipt of FP Medicaid, then the local health department would not be able to bill retroactively for the visit.

1. Annual Examination
    - An annual examination must be completed on all FP Medicaid (also known as MAFDN or BeSmart) program beneficiaries.
    - **The annual examination must be performed for all beneficiaries prior to the rendering of any other family planning services.**
    - However, for established clients, if emergent or urgent contraceptive services are needed, beneficiaries are allowed limited office visits prior to their annual examination.

- **FP Medicaid allows for one (1) annual exam/preventive visit per 365 days.**

- Postpartum visit now = AED for FP Medicaid (also known as MAFDN or BeSmart)
    - Clients who have their postpartum visit while insured under Medicaid for Pregnant Women (MPW) sometimes enroll in FP Medicaid when their MPW expires.
    - In the past, these clients needed an annual exam appointment after their postpartum visit to meet FP Medicaid billing requirements.
    - "FP Medicaid" claims require that the annual exam date (AED) be documented to be reimbursed for contraceptive and other services provided under this coverage.

2. Six medically necessary inter-periodic visits are allowed per 365 calendar days under the "FP Medicaid" option.

a. The purpose of the medically necessary inter-periodic visits is to evaluate the beneficiary's contraceptive program, renew or change the contraceptive prescription and to provide additional opportunities for counseling as follow-up to the annual exam.

b. The AED is required on all claims for inter-periodic visits with the exception of pregnancy tests.

c. For a list of components that should be included during the inter-periodic visit with pelvic exam refer to **Clinical Coverage Policy- Attachment B, section B** https://files.nc.gov/ncDHB/documents/files/1E-7_1.pdf

- The primary purpose of the 6 inter-periodic visits is to provide contraceptive services
    - It is recommended that the health department prioritize method-related concerns for the six inter-periodic visits.

- The contraceptive method may necessitate an evaluation in FP clinic
    - The health department policy may specify methods like IUD or vaginal rings are automatically brought back into the FP clinic for any complaints of discharge and clients on pills, patches and Depo may be sent to the STI clinic for complaints of discharge.
    - If the six inter-periodic visits have been exhausted, and the client returns to the FP clinic for a method related concern (not caused by an STI), then the health department can bill the client on the SFS for those services.

- Physician or Advanced Practice Practitioners may bill an E/M visit code when administering Depo-Provera®.

- However, the use of this visit code is subject to the 6-visit per year limit for FP Medicaid.
- Do not charge both an administration fee and an office visit for Depo-Provera®.

3. Contraceptive Services, Supplies and Devices
   - **Emergency Contraceptives**

     Emergency contraceptives are a covered service. The appropriate office visit code may be billed but there is no mechanism to bill Medicaid, FP Medicaid/MAFDN/BeSmart) for ECP at this time (Plan B or Ella)
   - **Pharmaceutical Supplies**
     a. All eligible drugs for FP Medicaid (also known as MAFDN or BeSmart) will have a family planning indicator (modifier) on the drug file (including birth control pills, Depo-Provera®, Xulane, Nuva Ring).

     b. Even though most local health departments provide prescriptions to clients with insurance and Medicaid for pills, patch, ring and emergency contraceptives to take their pharmacy of choice, there are rare circumstances (e.g., issues of confidentiality) where LHDs may provide these drugs in house and bill Medicaid using the appropriate UD and FP modifiers. Health Departments cannot bill Medicaid for the patch, ring, or ECP because these CPT codes are not on the Medicaid Reimbursement fee schedule for health departments.

     c. The dispensing fee is based on traditional Medicaid rules. **There is a 6 (six) prescription limit per month with no override capability.**

     d. Physician or Advanced Practice Practitioners are not allowed to distribute "brand medically necessary" (DAW1) drugs, if a generic is available.

     e. All claims must be submitted via Point of Sale (POS) and must have the approved ICD-10-CM code.

     f. **Note:** The AED is not required on FP Medicaid (also known as MAFDN or BeSmart) program prescriptions.

   - **Birth Control Pills**
     a. Birth control pills may be dispensed through a pharmacy.

     b. A beneficiary may receive up to a 3-month supply.

     c. When provided in a health department FP clinic, the clinic Physician or Advanced Practice Practitioner may bill **S4993**.

- **Diaphragms**
    a. FP Medicaid (also known as MAFDN or BeSmart) beneficiaries can choose a diaphragm as a birth control method.

    b. A Physician or Advanced Practice Practitioner can fit the client and bill using the appropriate CPT code for diaphragm fitting.

    c. However, the program does not cover the actual diaphragm

- **Injectable Drugs**
    a. Depo-Provera® contraceptive injection is a covered service.

    b. Use the diagnosis code for contraceptive management.

    c. The appropriate office visit code may be billed separately.

- **Intrauterine Devices (IUDs) and Implantable Devices**
    a. The FP Medicaid (also known as MAFDN or BeSmart) program covers only the removal of Norplant.

    b. The global period for 11976 is one (1) pre-care day and ninety (90) post-operative days.

- Physician or Advanced Practice Practitioners **should not** bill a separate inter-periodic office visit code for CPT codes 57170 (Diaphragm), 58300 (Insertion IUD), 58301 (Removal of IUD) except ~~in the circumstances~~ when there is a separate, identifiable issue that would warrant and office visit (see below)
    - an office visit component is included in the reimbursement. CPT codes 57170, 58300, 58301 are included in the six inter-periodic visit limitations.
- ***NOTE: 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). [According to the 2016 LARC Quick Coding Guide Supplement at http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement.pdf

- Providers may bill {(both traditional Medicaid and FP Medicaid (also known as MAFDN or BeSmart)} for both insertion/removal of an intrauterine device or

contraceptive implant and an E/M office visit if there is a separate, identifiable issue that would warrant an office visit.

- The office visit is billed with a 25 modifier, and the ICD-10 diagnosis must support the reason for billing the additional office visit with an additional diagnosis other than contraceptive insertion.

- Beneficiaries covered under FP Medicaid (also known as MAFDN or BeSmart) are only eligible for family planning services as described in DHB's 1E-7 Clinical Coverage policy and are not eligible for any other Medicaid program.

- When diaphragm fitting, intrauterine device insertion, or removal of an intrauterine device occurs during an annual examination, Physician or Advanced Practice Practitioners must only bill the appropriate annual examination procedure code.

- **Annual Examination DATE(AED**)

  An annual examination must be completed on all FP Medicaid (also known as MAFDN or BeSmart) program beneficiaries. The annual examination must be performed for all beneficiaries prior to the rendering of any other family planning services. One annual examination is allowed per 365 calendar days. Six medically necessary inter-periodic visits are allowed per 365 calendar days under the "Be Smart" option. The AED is required on all claims for inter-periodic visits with the exception of pregnancy tests.

  Providers who bill on the CMS-1500 must enter the AED in the appropriate location on the claim form.

  Providers who bill on the UB-04 must use the occurrence form locators 32, 33, 34, or 35. Enter an "11" in the occurrence code field and then enter the AED in the corresponding "date" field.

Annual Examination Codes	
99383	99394
99384	99395
99385	99396
99386	99397
99387	RC0510
99393	RC0519

Laboratory Procedures

The following laboratory procedures are only allowable for the FP Medicaid (also known as MAFDN or BeSmart) program when performed "in conjunction with" or pursuant to an annual examination. For the purpose of "Be Smart," "in conjunction with" has been defined as the day of the procedure or 30 days after the procedure. Testing performed after 30 days will not be reimbursed by FP Medicaid (also known

as MAFDN or BeSmart). LHD must enter the AED in their claims and submit the claims in timely fashion for NCSLPH to submit its claims and get paid.

1. Urinalysis
2. Blood count; and
3. Pap test

HIV and Sexually Transmitted Diseases

Providers are allowed to screen a total of any combination of six (6) HIV or sexually transmitted infections per beneficiary per 365 days. Screening for HIV and sexually transmitted infections can be performed during the annual examination or during any of the six (6) inter-periodic visits allowed under the program, when an annual exam has been in paid history. (CPT Codes in red font are used by NCSLPH for FP Medicaid (also known as MAFDN or BeSmart)

HIV Screening	
Miscellaneous	
87789	87391
86701	87534
86702	87535
86703	87536
87389	87537
87390	87538
87539	

Syphilis
86592
86593

General STI Screening
87081
87210

Herpes	
86694	87274
86695	87528
86696	87529
87207	87530
87273	
Treponema	
86780	87285

Chlamydia	
86631	87490
86632	87491
87110	87492
87270	87810
87320	

Gonorrhea	
87590	87592
87591	87850

Papillomavirus
87623
87624
87625

ICD-10 Diagnosis Codes for Clinical Laboratory Submission forms for BeSmart Program

TESTS	ICD-10
STD	**Z11.3** Encounter for screening for infections with a predominantly sexual mode of transmission (excludes HPV and HIV) **Z30.09** Encounter for other general counseling and advice on contraception
HIV	**Z11.4** Encounter for screening HIV **Z30.09** Encounter for other general counseling and advice on contraception

Pap Test

- Physician or Advanced Practice Practitioners are allowed one Pap test procedure per 365 calendar days in conjunction with an annual examination.

- **The Annual Exam Date is required on all claims for Pap tests.**

- If you are unable to obtain a Pap specimen at the time of the preventive visit (i.e. client is on menses), and they return within the allowable 30-day timeframe, you may bill for the Pap (with the appropriate code) and the handling fee (99000).
- If they return for the Pap after 30 days has passed, you may bill the handling fee 99000 only (FP Medicaid will not cover the Pap test after 30 days)

Collection of Pap Test

- Pap test CPT codes should not be used to bill collection of a specimen.

- Collection of the Pap test is included in the reimbursement for office visits, and no separate fee is allowed.

- Physician or Advanced Practice Practitioners who do not perform the lab test should not bill the Pap tests.

- Only the Physician or Advanced Practice Practitioner who performs the lab test should bill the Pap test codes.

- Repeat Pap Test for Insufficient Cells

- **One repeat Pap test is allowed due to insufficient cells.**
    a. Physician or Advanced Practice Practitioners shall perform the repeat Pap test within 180 calendar days of the first Pap test.

    b. **Physician or Advanced Practice Practitioners shall include the ICD-10-CM diagnosis R87.615 as the secondary diagnosis on the appropriate claim.**

4. HIV and Sexually Transmitted Infections Screenings
    - Physician or Advanced Practice Practitioners can screen a total of any combination of six (6) HIV or sexually transmitted infections per beneficiary per 365 days.

    - Screening for HIV and sexually transmitted infections can be performed during the annual examination or during any of the six (6) inter-periodic visits allowed under the program, when an annual exam has been in paid history.

    HIV Screening

    - The “FP Medicaid” Family Planning program allows screening for HIV during the annual examination or the six inter-periodic visits allowed under the “FP Medicaid” program.

    - This is a recommended screening and should be completed as necessary and appropriate.

- Physician or Advanced Practice Practitioners must include the **ICD-10-CM Diagnosis Z11.4** as the secondary diagnosis on the appropriate claim.

- Physician or Advanced Practice Practitioners must include the Annual Exam Date on all claims submitted for FP Medicaid (also known as MAFDN or BeSmart) services.
    - The AED is the date of the annual examination.

STI Screening

- A total of no more than six (6) STI screenings per 365 days are also covered under the FP Medicaid (also known as MAFDN or BeSmart) program performed in conjunction with an annual examination or after an annual exam has been in paid history.

- Physician or Advanced Practice Practitioners must include the AED on all claims submitted for FP Medicaid (also known as MAFDN or BeSmart) services. The AED is the date of the annual examination

5. Previous guidance was to see a Family Planning client requesting STD services in STD/Adult Health instead of in Family Planning, especially if the client was using the Depo injection for contraception.
    a. However, since updated FP Medicaid (also known as MAFDN or BeSmart) guidance states that agencies may opt to bill 96372 instead of 99211 for Depo injections without depleting one of the six inter-periodic visits, there is no longer significant concern about depleting inter-periodic visits by seeing these clients in Family Planning for STI testing/treatment.

6. Agencies shall incorporate the CD/STD program's STD screening questions at the annual/preventive visit via the Family Planning Health History Form (DHHS 4060F and DHHS 4060M).
    a. At a problem/inter-periodic visit, agencies only need to ask the CD/STD program's screening questions as indicated.
        i. For example, if a client presents with a vaginal discharge at a problem/inter-periodic visit,
        ii. the provider may ask screening questions as indicated, and does not necessarily need to ask all STD screening questions on the DHHS 4060F/4060M forms.
7. No STI services covered under 10A NCAC 41A.0204(a) provided to a FP client should be billed to that client. Medicaid and third-party payers (with client's permission) may be billed, but not the client.

    10A NCAC 41A .0204 CONTROL MEASURES - SEXUALLY TRANSMITTED DISEASES: (a) Local health departments shall provide diagnosis, testing, treatment, follow-up, and

preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale. These services shall be provided upon request and at no charge to the client.

a) One exception is diagnosis of and treatment for genital warts, which may be billed either to traditional Medicaid, third party insurance, or to the client via the Sliding Fee Scale.

8. Consultation for Sterilization
   ~~a. The "FP Medicaid" Family Planning program will cover consultation for a sterilization procedure.~~

   ~~b. When a Physician or Advanced Practice Practitioner refers a beneficiary to **another Physician or Advanced Practice Practitioner** for a sterilization procedure, then the Physician or Advanced Practice Practitioner performing the sterilization procedure must select one of the following codes when providing consultation to the beneficiary.~~

   ~~c. **Beneficiaries are allowed two consultations for sterilization per lifetime**.~~
   a. Male and female beneficiaries with FP Medicaid are eligible for sterilization procedures. Refer to Clinical Policy 1E-3, Sterilization Procedures on the NC Medicaid website at https://medicaid.ncdhhs.gov/ for requirements related to sterilization procedures.
   b. Once a beneficiary with FP Medicaid has had a permanent sterilization procedure and the necessary post-surgical follow-up has occurred, the beneficiary is no longer eligible for FP Medicaid program services. If the beneficiary has no need for family planning services, but requires further medical care, the provider shall refer the beneficiary to the local department of social services, health department, federally qualified health center (community health center), or rural health clinic in their county. If one of the above primary care providers is not available in the county where the beneficiary resides, they may seek services in nearby or surrounding counties.
   c. NCHC shall not cover sterilization procedures.

9. Miscellaneous Billing Instructions
   a. Inter-periodic & Non-biodegradable drug delivery Implant (i.e. Implantable Devices):
      i. Physician or Advanced Practice Practitioner shall not bill a separate inter-periodic office visit code when billing for CPT codes 11981 (Insertion), 11982 (removal), 11983 (insertion & removal);
      ii. an office visit component is included in the reimbursement for FP Medicaid (also known as MAFDN or BeSmart) beneficiaries.
      iii. You may also be reimbursed for the device using the appropriate HCPCS code.
   b. Interperiodic & Diaphragm fitting:

i. Physician or Advanced Practice Practitioner shall not bill a separate inter-periodic office visit code when billing for CPT code 57170 (Diaphragm fitting); an office visit component is included in the reimbursement for FP Medicaid (also known as MAFDN or BeSmart) beneficiaries.

c. Providers may bill (both traditional Medicaid and "FP Medicaid" Family Planning Medicaid) for both insertion/removal of an intrauterine device or contraceptive implant and an E/M office visit if there is a separate, identifiable issue that would warrant an office visit.
    i. The office visit is billed with a 25 modifier, and the ICD-10 diagnosis must support the reason for billing the additional office visit with an additional diagnosis other than contraceptive insertion.
    ii. Beneficiaries covered under "FP Medicaid" are only eligible for family planning services as described in DHB's 1E-7 Clinical Coverage policy and are not eligible for any other Medicaid program.

d. Annual exam & Non-biodegradable drug delivery Implant (i.e. Implantable Devices):
    i. Physician or Advanced Practice Practitioners can be reimbursed for insertion, removal, and removal with reinsertion of implantable device in addition to the annual exam.
    ii. You may also be reimbursed for the device using the appropriate HCPCS code.

e. Annual exam & Diaphragm: Physician or Advanced Practice Practitioners must only bill the appropriate annual examination procedure code.

f. Annual exam & IUD: Physician or Advanced Practice Practitioners must only bill the appropriate annual examination procedure code.
    i. You may also be reimbursed for the device using the appropriate HCPCS code.

g. If a Physician or Advanced Practice Practitioner discovers that a beneficiary is pregnant, a referral to the local Department of Social Services (DSS) for enrollment in the Medicaid for Pregnant Women (MPW) program should be made for **FP Medicaid** (also known as MAFDN or BeSmart) **program beneficiaries.**

h. To ease the transition to the FP Medicaid (also known as MAFDN or BeSmart) program, prevent duplication of services and minimize the burden for Medicaid beneficiaries, NC DHB is now allowing beneficiaries transitioning to the "FP Medicaid" program from other Medicaid programs to use the comprehensive annual, physical or postpartum exams received under these programs to meet the FP Medicaid (also known as MAFDN or BeSmart) annual exam requirement.

i. To meet the comprehensive annual or physical exam requirement, the beneficiary is allowed one of the three options below:

ii. Receive the MPW postpartum exam in the 365 days prior to enrollment as the required comprehensive annual or physical exam; **or**,
    i. Receive the traditional Medicaid comprehensive annual or physical exam in the 365 days prior to enrollment; **or,**
    ii. Receive the comprehensive annual or physical exam under the FP Medicaid(also known as MAFDN or BeSmart) program prior to receiving other FP Medicaid services.

- The list of procedure codes that meet the comprehensive annual or physical exam requirement under the FP Medicaid (also known as MAFDN or BeSmart) program now contains procedure codes that include the postpartum exam
    - 59400, 59410, 59430, 59510, and 59515
    - in addition to the comprehensive annual or physical exam codes: 99383, 99384, 99385, 99386, 99387, 99393, 99394, 99395, 99396, and 99397.

- Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information.
    https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_Bulletin_2016_02.pdf

i. An ICD-10-CM diagnosis related to family planning services must be the primary diagnosis on the claim form. The Division of Public Health has confirmed that all of the following ICD-10 codes are active/paying in NCTracks:
    i. Z30.015 Encounter for initial prescription of vaginal ring hormonal contraceptive
    ii. Z30.016 Encounter for initial prescription of transdermal patch hormonal contraceptive device
    iii. Z30.017 Encounter for initial prescription of implantable subdermal contraceptive
    iv. Z30.44 Encounter for surveillance of vaginal ring hormonal contraceptive device
    v. Z30.45 Encounter for surveillance of transdermal patch hormonal contraceptive device
    vi. Z30.46 Encounter for surveillance of implantable subdermal contraceptive
    vii. Z01.411 – encounter for gynecological examination (general) (routing) with abnormal findings

viii. Z01.419 – encounter for gynecological examination (general) (routing) without abnormal findings

11. Local Health Departments (excerpt from Clinical Coverage Policy)
    a. All services must be billed with the appropriate CPT or HCPCS code, ICD-10-CM diagnosis, and FP modifier.
        i. N.C. Medicaid **requires** the UD modifier to be billed on the CMS-1500/837P and the UB04/837I claims forms, with applicable HCPCS code and National Drug Code (NDCs) to properly identify 340B drugs.

        ii. All non-340B drugs are billed using the associated HCPCS and NDC pair without the UD modifier.

    b. The AED must be entered as the "initial treatment date" on the CMS-1500. The AED is required on all claims.

    c. Indicate "Yes" on the HIS Service Screen data field for FP Medicaid (also known as MAFDN or BeSmart) Program Services.

    d. All approved antibiotic treatment and pain medications must have the appropriate ICD-10-CM diagnosis written on the prescription.

    e. No "brand medically necessary" (DAW1) medications are allowed, if a generic is available.

    f. All Local Health Departments must adhere to all applicable North Carolina Medicaid policies and procedures for the FP Medicaid (also known as MAFDN or BeSmart) program.

12. North Carolina Health Choice & Family Planning Programs
    a. If a Health Choice exam is provided in FP and a method is provided, LHDs will need to add the FP modifier in the first modifier field (to match the FP CPT and diagnosis codes)
        i. Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

    b. If a Health Check exam is provided in FP and a method is provided, LHDs will need to add the FP modifier in the first modifier field (to match the FP CPT and diagnosis codes) AND the EP modifier in the second modifier field (to match the Health Check CPT and diagnosis codes).
        i. Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

c. If you bill other third-party payers, it is recommended that you contact them individually for guidance on use of the FP modifier.

d. [MAFDN = FP Medicaid Family Planning Medicaid]
   i. Effective April 1, 2018,

   ii. When performing a wet mount screening, providers serving Family Planning Medicaid (MAFDN) beneficiaries shall bill procedure code 87210 (smear, primary source with interpretation; wet mount for infectious agents [e.g., saline, India ink, KOH preps]).

   iii. If both saline and potassium hydroxide (KOH) methods are needed, two units may be billed.

   iv. Wet mount screenings may be performed during the annual exam or during any of the six inter-periodic visits allowed per 365 days under Family Planning Medicaid, when a sexually transmitted screening is required.

   v. Line items submitted with a service date on or after April 1, 2018, for MAFDN eligible beneficiaries, with Procedure code Q0111 (wet mounts, including preparations of vaginal, cervical or skin specimens) will be denied.

   vi. The above guidance is from p. 4 of the February 2018 Medicaid Bulletin: https://files.nc.gov/ncDHB/documents/Providers/Bulletins/Medicaid_Bulletin_2018_01.pdf?uigTXM_bpAJA7pZqK6P8oSYeQUS0qD8M

FP Medicaid and Sterilization

- Providers have been seeking clarification from N.C. Medicaid about sterilization and MAFDN eligibility under the FP Medicaid (also known as MAFDN or BeSmart) 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 FP Medicaid (also known as MAFDN or BeSmart) 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 FP Medicaid (also known as MAFDN or BeSmart) for a beneficiary who does not have family planning needs.

- Claims may be subject to audit to ensure proper billing.

- For additional program guidance, please contact your Women's Health RNC or visit the program website at *Family Planning Clinical Coverage Policy 1E-7*
  FP Medicaid Q&A from June 20, 2018 (see appendix D)

- If a patient with FP Medicaid (also known as MAFDN or BeSmart) does not have or no longer has a need for family planning services (whether because he/she is sterilized or for another reason), the provider should refer the patient to an appropriate safety net provider, and should not bill FP Medicaid for services.

Pharmacy (related to Family Planning)

1. **340b Drugs**
    a. Although the following section is specific to FP and birth control methods, the same methodology should be followed for all 340b drugs.

    b. LHDs should follow the guidance below in billing Medicaid for methods/devices.

    c. LHDs that operate and dispense through an outpatient pharmacy (either a contract pharmacy or a LHD operated pharmacy that fills contraceptive prescriptions written by any community Physician or Advanced Practice Practitioner, not just LHD Physician or Advanced Practice Practitioners) can either bill using the Medicaid Outclient Pharmacy Rules or can use the Physician Drug Program (PDP) process.
        i. If the Pharmacy is a Medicaid Pharmacy Physician or Advanced Practice Practitioner (outpatient pharmacy), then standard dispensing fees (as established by Medicaid) can be billed to Medicaid along with the cost of the method/device.

    d. LHDs that bill for IUDs, Implantable Devices, and Depo through the Family Planning Clinic/PDP process must bill Medicaid the actual (or acquisition) cost which they paid for the method/device, and no dispensing fee is allowed.

    e. LHDs that dispense and bill for other Family Planning contraceptives through the Family Planning Clinic/PDP process (LHDs that fill contraceptive prescriptions only for clients seen in the health department Family Planning Clinic) must bill Medicaid the actual (or acquisition) cost which they paid for the method/device and no dispensing fee is allowed.

    f. N.C. Medicaid requires the UD modifier to be billed with the applicable HCPCS code and NDC to properly identify 340B drugs.
        i. All non-340-B drugs are billed using the associated HCPC and NDC pair without the UD modifier.

    g. 340B stock Emergency Contraception may only be prescribed/dispensed/ administered via the Family Planning clinic.
        i. Therefore, if pregnancy testing is done in NON-Family Planning clinics (i.e. in General Clinic), and if it is appropriate to offer Emergency Contraception with a negative pregnancy test, then a Family Planning encounter must be opened before prescribing/ dispensing/administering the Emergency Contraception from 340B stock.

h. Since 340b prices change regularly, we suggest that you determine your average cost for a year for each 340b method or device.
   i. This amount can then be used for billing using the UD-modifier and FP-modifier.
   ii. As this methodology is updated annually, this should provide the least amount of risk as it will be the closest to your actual cost.
   iii. Your purchase cost for each device should be reviewed and updated at least annually.

2. **Administering medication from an outside source**
   a. is a practice we do not support based on being able to assure medication integrity.

   b. If the health department chooses to engage in this practice, they should have policy and procedures in place and record the lot number and prescription information from the bottle/syringe.

   c. The above guidance is from p. 8 of the January 2018 Medicaid Bulletin - https://files.nc.gov/ncDHB/Medicaid_Bulletin_2018_01.pdf

For additional program guidance, please contact your Women's Health RNC or visit the program website at *Family Planning Clinical Coverage Policy 1E-7*

Questions & Answers: Clarification from WHB regarding billing 340b for clients with commercial insurance:

Q**:** If an agency has a client with commercial insurance, and the agency is not contracted with that commercial insurance but bills for a device, and the reimbursement is less than the fee, what happens to the rest of the charge?

A: The agency may set two fees for Family Planning devices/medications:

1. The 340B/acquisition fee, which is also the fee billed to Medicaid. This is the lower of the two allowable fees.
2. The usual and customary fee. This is the higher of the two allowable fees.

FAQs related to above FP Billing Guidance 5/18/17:

1. Does this guidance only apply to local health departments, or does it also apply to private providers and other clinics?
   · The guidance applies to **all Medicaid billers**, not just to local health departments.

2. Does this guidance also apply to contraceptive implants?
   - Yes, the guidance sent on 5/18/17 pertains to how to bill for both IUD **and implant** procedures associated with annual exams and inter-periodic visits.

- Please read the sentences below to see how the first part of the guidance **(annual exams)** applies to implants:
    - An appropriate modifier must be submitted with the annual exam procedure code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

    - The provider's documentation should support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

    - If during an annual exam, the beneficiary requests an IUD insertion (CPT procedure code 58300), an IUD removal (CPT procedure code 58301), insertion, non-biodegradable drug delivery implant (CPT procedure code 11981), removal, non-biodegradable drug delivery implant (CPT procedure code 11982), removal with reinsertion, non-biodegradable drug delivery implant (CPT procedure code 11983), or diaphragm or cervical cap fitting with instructions (CPT procedure code 57170) or during the annual visit the beneficiary decides to switch from birth control pills to an IUD, the provider may bill for the annual exam and CPT procedure code 58300, 58301, 57170, 11981, 11982 or 11983.

      An appropriate modifier must be submitted with the annual exam procedure NC Medicaid and Health Choice Family Planning Services Clinical Coverage Policy No: 1E-7 Amended Date: March 15, 2019 19B27 19 code, indicating that the service rendered was a separately identifiable service provided by the same provider on the same day of service. The providers documentation must support that the service rendered was a separately identifiable service provided by the same provider on the same day of service.

      If the only reason that the beneficiary is seen in the office is to request an IUD insertion, an IUD removal), insertion, non-biodegradable drug delivery implant removal, non-biodegradable drug delivery implant removal with reinsertion, non-biodegradable drug delivery implant or diaphragm or cervical cap fitting with instructions providers shall not bill a separate inter-periodic office visit. An office visit component is contained in the reimbursement for CPT procedure codes 58300, 58301, 57170, 11981, 11982 and 11983. However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the inter-periodic visit and CPT procedure code 58300, 58301, 57170, 11981, 11982 or 11983. The providers documentation

must support that the service rendered was a separately identifiable service.

- Please see below to see how the second part of the guidance **(inter-periodic visits)** applies to implants:
  - If the only reason that the beneficiary is seen in the office is to request an IUD/implant insertion (CPT procedure code 58300 or 11981) or an IUD/implant removal (CPT procedure code 58301or 11982 or 11983),
    - providers should not bill a separate inter-periodic office visit.
    - An office visit component is included in the reimbursement for CPT procedure codes 58300 and 58301, as well as procedure codes 11981, 11982 and 11983).
    - However, if during the same visit, services are rendered for a separately identifiable service provided by the same provider on the same day of service, the provider may bill for the inter-periodic visit and the IUD/implant insertion or IUD/implant removal.
      - The provider's documentation should support that the service rendered was a separately identifiable service.

3. Does this guidance mean that Medicaid no longer pays for IUD and implant devices?
   - Medicaid will continue to pay for IUD and implant devices at both preventive and inter-periodic visits.

4. When will DHB change their Clinical Coverage Policy 1E-7 (Family Planning Services) to reflect this new guidance?
   - **Updated Answer:** This guidance is found in DHB's revised Family Planning Services (1E-7) Clinical Coverage policy dated 11/1/2018: https://files.nc.gov/ncDHB/documents/files/1E-7_1.pdf

5. Can agencies back bill based on this guidance?
   - No, agencies may not back bill. The guidance takes effect on 5/18/2017.

6. When our agency has tried to bill as per the guidance related to inter-periodic visits, the claim has either denied, or the claim has gone through only to be recouped within a few weeks.
   - Please contact your Regional Women's Health Nurse Consultant with examples.

- They can assist you with sending them TCNs via password-protected documents, so that the Division of Public Health and DHB can further evaluate the issue.

7. Can a Positive pregnancy test be billed in the maternal health clinic?
    - If the pregnancy test was performed in the FP clinic, but the result is positive, then the visit may be converted to a Maternal Health visit for billing purposes, provided agency policy/procedure/protocol supports this practice

    - Although FPW/FP Medicaid will not pay for pregnancy testing services provided in the MH clinic, all payor sources must be billed in the MH clinic when the pregnancy test result is positive, if this is the agency's practice.
        - In other words, an agency may not bill some positive pregnancy tests under the FP program and others under the MH program based on the client's payor source.
        - For self-pay clients, positive pregnancy test visits billed in the MH clinic must slide based on where the client falls on SFS

8. Family Planning & STI services:
   Question:
   If a client comes in for STI treatment (to STI) and then is seen for depo shot and client is FP Medicaid (also known as MAFDN or BeSmart) how should that be billed since you must use the 99211?

   Answer #1
   - The agency renders and documents the STI treatment within the STI program. There is no charge to the client. FP Medicaid cannot be billed for STI program encounters rendered by RNs (including ERRNs) as 99211 cannot be billed by an RN and T1002 is not a billable CPT code under FP Medicaid.

   - FP Medicaid may be billed for STI program encounters rendered by advanced practice practitioners.

   - The agency renders and documents the contraceptive injection (Depo) services within the Family Planning program.

   - The agency bills FP Medicaid for these Family Planning program services, including a 99211, if applicable for the administration of the Depo

   Answer #2
   - The agency renders and documents both the STI treatment by an APP or Physician and the contraceptive injection (Depo) services within the Family Planning program.

- The agency bills FP Medicaid for these Family Planning services including an appropriate E&M code for the provider service and therapeutic injection code for the Depo, if applicable.

Question: Can LHDs bill FP Medicaid from the STD clinic?
Answer:

- LHD providers may bill FP Medicaid from the STD program. LHD nurses (included ERRNs) cannot bill FP Medicaid from the STD program, since they are not allowed to bill 99211 or T1002 to FP Medicaid.

- The contraceptive method related diagnosis code should be listed first, whether the agency bills FP Medicaid through Family Planning or through STD clinic. As per page 19 of the current policy (https://files.nc.gov/ncDHB/documents/files/1E-7_2.pdf), "The purpose of the inter-periodic visits is to evaluate the beneficiary's contraceptive needs, renew or change the contraceptive prescription, STI screening and treatment, HIV screening and to provide additional opportunities for counseling as follow up to the annual exam." Providers who see patients in the STD clinic and bill the visit to FP Medicaid should therefore render services as above.

- Example: Patient with FP Medicaid is seen in STD clinic by mid-level provider for an inter-periodic visit. In addition to rendering the appropriate STD clinic services, the mid-level provider also asks the patient if she is happy with her Depo Provera contraception, if she has any questions about the method, and/or if she desires to change methods. If the patient is happy with her method and wants to continue it, the provider bills all covered and appropriate services to FP Medicaid, with Z30.42 (encounter for surveillance of injectable contraceptive) as the primary diagnosis code. If the patient prefers to change methods, she may need a visit/encounter in the Family Planning clinic, depending upon agency policy/protocol/capacity. If the client was due for her administration of Depo during the visit, 340b stock cannot be administered in the STD clinic. Agency may use non-340b stock or refer the client to the FP clinic for her Depo.

Question: If a client comes in for a FP service and receives immunizations, do you put a FP modifier on immunizations if the client has Health Choice?
Answer:

- No, you would not put the FP modifier on the immunization codes. S
  - See DHB Clinical Coverage Policy 1E-7, page 16.

- Recommended billing guidance for NCHC visits in FP:

i. Bill the preventive or E&M visit code with the FP modifier.
    a. If immunizations are provided during the visit use the 25 modifier as the second modifier on the office visit.

ii. On the immunization administration code, 90471 or 90472, use the TJ modifier but do not use a modifier on the actual immunization.

iii. If a contraceptive is provided use the FP and UD modifiers.

iv. Labs are being paid with and without the FP modifier.

Laboratory

- An on-site or in-house laboratory is one where the LHD is the owner/responsible party for the CLIA certificate. The LHD may employ testers or contract them from some other entity.
- A reference lab is one where someone other than the LHD is the owner/responsible party for the CLIA certificate.
- A collection-only site does not require a CLIA certificate.
- Tests are categorized into *waived* and *non-waived*. Non-waived includes Physician or Advanced Practice Practitioner performed microscopy procedure (PPMP), moderate & high complexity designations.
- QW is used for waived tests, and you only must use it if you have more than one way of doing a test. If the only way to perform it is WAIVED, then do not put the QW.

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.

iii. Modifiers with Labs

- Valid billing with a modifier:
  - Modifier-59: Distinct Procedural Service, different site or organ system, for example, multiple sources collected for screening culture GC (modifier -59)
  - Modifier 90: Specimen sent to a reference laboratory for processing.
  - Modifier-91: Repeat Clinical Diagnostic Lab test. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, on-time, reportable result is all that is required. -e.g. Physician or Advanced Practice Practitioner requests test be repeated on the same day. Modifier required do indicate that it is not a duplicate billing (modifier -91)

Effective Jan. 1, 2015, four new modifiers more effectively identify distinct services that are typically considered inclusive to another service. Utilizing these modifiers will help with more accurate coding that better describes the procedural encounter. These modifiers are appropriate for NCCI procedure-to-procedure edits only

- XE – Separate Encounter: A service that is distinct because it occurred during a separate encounter.
- XS – Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
- XP – Separate Practitioner: A service that is distinct because it was performed by a different practitioner.
- XU – Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

Use of these modifiers vs. modifier 59:

- Do not use one of these modifiers with modifier 59 on the same claim line.

- According to CPT guidelines, modifier 59 should be used only when no other descriptive modifier explains why distinct procedural circumstances exist.

- Therefore, these new modifiers should be used instead of modifier 59 to describe why a service is distinct.

- Medicaid will continue to accept modifier 59 when the X {ESPU} modifiers do not accurately describe the encounter. Documentation must support use of modifiers.

Venipuncture/Specimen Collection

- The physician or lab shall bill directly for lab fees.

- The physician may bill, if the physician sends the lab work to an independent lab, it's for venipuncture collection.

- One collection fee is allowed for each beneficiary, regardless of the number of specimens drawn.

- When a series of specimens is required to complete a single test, the series is treated as a single encounter.

- CPT code 36416 may be used to bill for capillary blood collection.
    - However, it is not payable by Medicaid.
    - You should include in your fee/billing policy that you do not have to continue to bill services that you know are "not a covered service," this will limit unnecessary denials.
    - Since it is not a covered service for Medicaid, it could and should (if you are billing to other insurers) be billed to the client

- The amount you bill the client for a CPT code for lab work done <u>in your LHD</u> should include everything it takes to provide that service: supplies, collection, processing, and interpretation of results.
    - Therefore, you would not charge an additional fee for a venipuncture if done since that cost should be included in the total fee for the CPT code for the test.

Handling Fee

- Use CPT code 99000 for Handling, transfer and/or conveyance of specimen from the physican's office (LHD) to another laboratory.

- Medicaid does not reimburse for handling and/or conveyance of specimen.
    - You may bill this code but remember that if you bill, you must bill everyone for the handling fee, but you will get denials from Medicaid.
    - You should include in your fee/billing policy that you do not have to continue to bill services that you know are "not a covered service", this will limit unnecessary denials.
    - Since it is not a covered service for Medicaid, it could and should (if you are billing to other insurers) be billed to the client.

Pap Test Fee

- If the client is self-pay

- The reference lab bills the health department (based on negotiated rate) and the health department bills the client using the appropriate CPT code and 90 modifier based on SFS.
- The reference lab could file a claim with the insurance company (if appropriate)

Fern Test

- The fern test is used for PROM (premature rupture of membranes) in a prenatal client by applying vaginal fluid to a slide and allowing it to dry.
  - If placental fluid is present, then the fluid will dry in a pattern that looks like a fern branch when examined under the microscope.

- Currently, counties that participate in the state lab's CLIA contract program should NOT be performing the fern test because it is not on the test menu.

- CMS categorizes the fern test as a Physician or Advanced Practice Practitioner performed microscopy procedure (PPMP) that can be performed if the lab has a CLIA PPMP certificate, a certificate of Accreditation (CoA), or certificate of compliance (CoC) but cannot be performed if the lab has a CLIA certificate of waiver.
  - If the lab has a PPMP certificate only a Physician or Advanced Practice Practitioner can perform the test, not a lab tech or nurse.

- CMS lists Q0114 as the only CPT code for the fern test in the list of approved PPMPs.

- To bill or report for the fern test it is necessary to use HCPCS Q0114.
  - Although Medicaid does not reimburse this code you would still bill Medicaid and receive a denial and can then bill the client if they are aware that they may be responsible for payment because it is a non-covered service.

Update- NCSLPH Requisition Forms

- NPI numbers are now required on all NCSLPH requisition forms. Please see full memo at the link below.
- http://slph.ncpublichealth.com/doc/NPI-SubmissionForms-08-18-16.pdf

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.

- For additional program guidance, please contact your Regional NC State Lab for Public Health Consultant or visit the program website at https://slph.ncpublichealth.com/

Medical Nutrition Therapy (MNT)

Clinical Coverage Policy- Dietary Evaluation & Counseling (MNT)
https://ncDHB.s3.amazonaws.com/s3fs-public/documents/files/1-I.pdf

1. Dietary evaluation and counseling provided in public agencies, private agencies, clinics, physician or medical diagnostic clinics, and physician offices shall be performed by:
   - Dietitian/Nutritionist currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable); OR
   - a registered dietitian currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).
   - It is the responsibility of the Dietician's/Nutritionist's agency to verify in writing all staff qualifications for their staff's provision of service.
   - A copy of this verification (current licensure or registration) shall be maintained by the Dietician's/Nurtritionist's agency.
     a. (NOTE: Additional credentialing information to be included in June 2018)

2. Dietary Evaluation and Counseling (Medical Nutrition Therapy)
   - offers direction and guidance for specific nutrient needs related to a beneficiary's diagnosis and protocol.
     - Individualized care plans provide for disease-related nutritional therapy and counseling.
     - Refer to Clinical Coverage Policy for specific diagnoses that are covered.

   a. Children through 20 Years of Age
      Dietary evaluation and counseling is covered for children through 20 years of age receiving Medicaid and for children receiving NCHC ages 6 through 18 years when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management.

   b. Pregnant and Postpartum Women
      Medicaid covers dietary evaluation and counseling for pregnant women when the pregnancy is threatened by chronic, episodic, or acute conditions for which nutrition therapy is a critical component of medical management, and for postpartum women who need follow-up for these conditions or who develop such conditions early in the postpartum period.

   c. Service Setting
      Dietary evaluation and counseling shall be provided as an individual, face-to-face encounter with the beneficiary or the beneficiary's caretaker.

d. Service Limitations
    a. The initial assessment and intervention is limited to four units of service per date of service and cannot exceed four units per 270 calendar days by the same or a different Dietician/Nutritionist.

    b. The re-assessment and intervention is limited to four units of service per date of service and cannot exceed 20 units per 365 calendar days by the same or a different Dietician/Nutritionist.

e. Medical Record Documentation
    a. Medical record documentation shall be maintained for each beneficiary, in the medical records of the beneficiary's primary care Physician or Advanced Practice Practitioner for at least six (6) years, and shall include, at a minimum:
        i. The date of service.
        ii. The presenting problem.
        iii. A summary of the required nutrition service components.
        iv. The signature of the qualified nutritionist providing the service.
        v. The beneficiary's primary care or specialty care Physician or Advanced Practice Practitioner's order for the service.

Billing Units

a. Dietician/Nutritionist(s) shall report the appropriate code(s) used which determines the billing unit(s).
    i. CPT code 97802 MNT: initial assessment & intervention
    ii. Each 15 minutes of service equals 1 billing unit.
    iii. Service is limited to a maximum of 4 units per date of service.
    iv. Service cannot exceed 4 units per 270 calendar days.

b. CPT code 97803 MNT: reassessment & intervention
    i. Each 15 minutes of service equals 1 billing unit.
    ii. Service is limited to a maximum of 4 units per date of service.
    iii. Service cannot exceed a maximum of 20 units per 365 calendar days.

WIC Program

All individuals categorically eligible for the Women, Infants, and Children (WIC) Program shall be referred to that program for routine nutrition education and food supplements.

Note: For agencies that also administer a WIC Program, the nutrition education contacts required by that program shall be provided prior to billing Medicaid for dietary evaluation and counseling. Staff time utilized to provide a Medicaid-reimbursable nutrition service shall not be charged to WIC program funds.

Dietitians/Nutritionists providing dietary evaluation and counseling are encouraged to refer eligible clients to the Pregnancy Care Management (PCM) or CC4C programs as appropriate.

Telemedicine & Telepsychiatry

- 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 off-site providers may participate in the care. Please read the DHB Clinical Policy 1-H carefully prior to initiating this service. Special equipment and security is required.
- **Reference the Medicaid Clinical Policy at https://files.nc.gov/ncDHB/documents/files/1-H.pdf**
- The list of **codes that local** health departments may bill as of this time are as follows

99201	99241
99202	99242
99203	99243
99204	99244
99205	99245
99211	~~99251~~
99212	~~99252~~
99213	~~99253~~
99214	~~99254~~
99215	~~99255~~

Telemedicine Services provided by the local Health Department

- Distant location = where provider is located
- Originating location= where the client is located
- Service site= 71 (Public Health Clinic)
- Facility fee- may not be billed by distant location (Medicaid/NCHC)
  - May only be billed by originating site if eligible provider will be billing for an approved service from the originating location
  - Example: MESH unit is originating site. Nurse is facilitating the service with the provider but is not an eligible provider for Telemedicine so may not bill for any services provided on the same day as the Telemedicine service. No billing for facility is allowed.
  - Medicaid/NCHC does not reimburse for a facility fee at any distant location. *CCP 1-H, 4.2.1, a.*

- Eligible providers include:
- The following providers enrolled in the Medicaid or NCHC program who provide this service may bill Medicaid or NCHC: *6.1*

- *Telemedicine Professional Services*
- Nurse practitioners
- Nurse midwives; and
- Physician's Assistants

- Billable Codes:
- The following CPT procedure codes can be billed, as appropriate, by the eligible providers noted in Subsections 6.1 and 6.2 for professional service:

- E&M (New & Established): 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215
- Consultation (New or Established) 99241 99242 99243 99244 99245 ~~99251 99252 99253 99254~~

Local Use Codes

Please refer to memo and updates list regarding use of LU codes on the DPH/LHD website under the Documentation and Coding header

http://publichealth.nc.gov/lhd/docs/Discontinuation-LU-CodeSet-020118.pdf
http://publichealth.nc.gov/lhd/docs/LU-CodesRevised2016List-010518.pdf

Adult Health

1. Procedures and E/M codes
    a. When providing a procedure, you will bill the procedure code alone (i.e.colposcopy).

    b. If you are providing additional components and have the documentation to support an office visit in addition to the procedure that was performed, then you can bill an E/M code as appropriate and append the -25 modifier to the E/M code.

2. Pre-Employment Physicals
    a. LHDs may perform pre-employment physicals provided they follow appropriate clinical and billing guidelines.

    b. The CPT code selected should best align with a complete adult physical and must be provided by a Physician or Advanced Practice Practitioner.

    c. An ERRN is not qualified to perform a physical exam for a commercial driver's license or for pre-employment with The Department of Corrections (DOC).

    d. The LHD is permitted to have a "flat fee" in an agreement with an organization that is different from the fee charged to individuals.
        i. You would still follow "your charge is your charge" mantra, but you can accept different levels of reimbursement.

3. The adult annual health assessment
    a. Is not covered when the medical criteria listed in **Section 3.0 of the Clinical Coverage Policy** **https://files.nc.gov/ncDHB/documents/files/1A-2.pdf** are not met.
    b. 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** below are not met:
    c. **Limitations**
        i. Medicaid beneficiaries 21 years of age and older may receive one annual health assessment per 365 days.
        ii. The annual health assessment is not included in the legislated 22-visit limit per year.
        iii. 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.
        iv. An annual health assessment and an office visit cannot be billed on the same date of service.
        v. See page 11 for information related to more than one physical within a 365 day period.

WISEWOMAN/Breast & Cervical Cancer Control Program (BCCCP)

If you have any questions regarding BCCCP, please contact your BCCCP/ WISEWOMAN Regional Consultant**.**

Dental Services

- Guidance for Billing of Procedure Codes D0145 and D1206
    - Claims that include procedure codes D0145 (Oral evaluation for a client under three years of age and counseling with primary caregiver) and D1206 (Topical application of fluoride varnish) must be billed in a particular order for both to pay correctly.

    - Procedure code D1206 must be billed on the detail line before D0145.
        - NCTracks is designed to adjudicate one detail line at a time, beginning with the first detail line on the claim and proceeding through the last.
        - NCTracks must verify that D1206 has been paid before D0145 can be paid for the same date of service.
        - Ensuring that claims are billed with the procedure codes in this order will expedite processing and payment.
        - If the claim is originally submitted to NCTracks with the procedure codes in the wrong order and only D1206 is paid, the Physician or Advanced Practice Practitioner must submit a new claim for D0145 only.

Medicaid Specific Modifiers

Link to Modifiers:
https://publichealth.nc.gov/lhd/docs/AC-NewsNotes-Vol2-Sept2019-Modifiers.pdf

Local Health Department specific: (these are modifiers, **not** program types)

- **EP** modifiers
  - are used for immunizations, preventive visits and other services under Health Check.

- **FP** modifiers
  - are used in Family Planning program type with Family Planning related services.

- **TJ** modifiers
  - are used for immunizations, preventive visits and other services for Health Choice covered children.

  - Do not use TJ modifier when billing Medicaid for Family Planning services rendered to Health Choice covered children.

- **UD** modifiers
  - Are used to identify contraceptives purchased with 340b pricing.

  - N.C. Medicaid requires the UD modifier to be billed with the applicable HCPCS code and NDC to properly identify 340B drugs.

  - All non-340-B drugs are billed using the associated HCPC and NDC pair without the UD modifier.

Additional Modifiers that may be used

- **Modifier -24 Complications of Pregnancy, Unrelated Issues**

  - If a client develops complications of pregnancy or the provider treats the client for an unrelated problem, these visits are excluded from the maternity global package and can be reported separately.

  - Append modifier 24 *Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues.

  - Modifier 24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package

Example: An established client at 22-weeks' gestation is admitted to hospital observation with pre-term labor. The client's OB/GYN visits the client in observation and performs a comprehensive history, exam, and MDM of moderate complexity. The next day, the OB/GYN returns and determines the client has improved. The client is discharged from observation care with orders to follow up in the OB/GYN's office in one week. Note: this can be a service provided in the office and is not specifically related to hospital services/care.

Remember: The global maternity package includes uncomplicated care. Because this client was diagnosed with pre-term labor and admitted to observation, this is not uncomplicated care and, thus, it is separately reportable with the observation E/M codes. Modifier 24 is needed to indicate these encounters are unrelated to the global maternity package. Note- these services must be billed after the OB package code is billed.

- **Modifier 25 - Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day of the Procedure or Other Service.**
    - Modifier 25 needs to be used if a separately identifiable E/M service by the same Physician or Advanced Practice Practitioner or other qualified health care professional is done on the same day as a procedure or other service.
    - The physician may need to indicate that the client's condition required a service above and beyond what is expected for other services provided on the same day.
    - The modifier 25 is attached to the E/M code, not the procedure code.
- **Modifier 51 - Multiple Procedures.**
    - Modifier 51 indicates several procedures were performed during the same encounter, for the same client, on the same date by the same Physician or Advanced Practice Practitioner.
    - Medicaid will not determine the major procedure for the Physician or Advanced Practice Practitioner.
    - It is the Physician or Advanced Practice Practitioner's responsibility to identify the primary and secondary procedures correctly to be reimbursed appropriately.
    - Code the primary procedure first and add 51 to the 2nd and other subsequent procedures.

- **Modifiers 52 & 53-** *NOTE: 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). [According to the 2016 LARC Quick Coding Guide Supplement at http://beyondthepill.ucsf.edu/sites/beyondthepill.ucsf.edu/files/LARC%20Quick%20Coding%20Guide%20Supplement.pdf

- **Modifier 59- Modifier 59 Guidance from Centers for Medicare and Medicaid Services (CMS)**

  - ~~**Modifier 59** is used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances.~~

  - ~~A health care Physician or Advanced Practice Practitioner may need to use modifier 59 to indicate that a procedure or service was distinct or independent from other services performed on the same day.~~

  - ~~This means a different location, different anatomical site, and/or a different session. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.~~

  - ~~However, when another already established modifier is appropriate, it should be used rather than modifier 59.~~

  Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day.

  Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or service, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

  However, when another already established modifier is available it should be used instead of modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: modifier 59 should not be appended to an E/M service. To report a separate and distinct service with a non-E/M service performed on the same day, see modifier 25.

X Series Modifiers- may be used in place of modifier 59 if appropriate.

- **Modifier 76 - Repeat Procedure by the Same Physician or other qualified health care professional on the Same Day.**
    - Modifier 76 is appended to report that a diagnostic procedure or service was repeated by the same Physician or Advanced Practice Practitioner on the same date of service.
    - Modifier 76 is used to indicate that a repeat diagnostic procedure was medically necessary and is not a duplicate billing of the original procedure done on the same date of service.

- **Modifier 90 – Reference (Outside) Laboratory.**
    - When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure should be identified by adding the modifier “90” to the CPT code for the laboratory test.
        - (e.g. LHD obtains sample but sends to outside laboratory for processing; in this case, the 90 modifier would be appended to the laboratory test)

- **Modifier 91 - Repeat Clinical Diagnostic Laboratory Tests.**
    - It may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results.
    - Under these circumstances, the laboratory test performed can be identified by its usual CPT code and the addition of modifier "91."
    - This modifier may not be used when tests are repeated to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.
    - It may not be used when other codes describe a series of test results (e.g. Fasting and 2-hour Postprandial Glucose.)

- **"OB" Modifier**-
  - If you report or bill office visits with a $0.00 charge that are associated with an OB package code or OB global package code, use the "OB" non-standard modifier for these OB office visits.

- **"SL" Modifier**
  - add "SL" modifier to all state supplied vaccines billed or reported.

- **X Modifiers**
  - Modifiers more effectively identify **distinct services that are typically considered inclusive to another service**.

  - Utilizing these modifiers will help with more accurate coding that better describes the procedural encounter.

  - These modifiers are appropriate for NCCI procedure-to-procedure edits only

  - Do not use one of these modifiers with modifier 59 on the same claim line.

  - According to CPT guidelines, modifier 59 should be used only when no other descriptive modifier explains why distinct procedural circumstances exist.
  - Therefore, these new modifiers should be used instead of modifier 59 to describe why a service is distinct.

  - Medicaid will continue to accept modifier 59 when the X {ESPU} modifiers do not accurately describe the encounter. Documentation must support use of modifiers

X series Modifiers may to be used in place of modifier 59 if appropriate.

- **XE – Separate Encounter**:
  - A service that is distinct because it occurred during a separate encounter.

- **XS – Separate Structure**:
  - A service that is distinct because it was performed on a separate organ/structure.

- **XP – Separate Practitioner**:
  - A service that is distinct because it was performed by a different practitioner.

- **XU – Unusual Non-Overlapping Service**:
  - The use of a service that is distinct because it does not overlap usual components of the main service.

Pre-Operative Services and Consultation Codes

- Consult codes currently allowed and on the LHD fee schedule are 99241-99245 and 99275.

- The consultation visit codes can be used when another "physician or appropriate source" refers a client to the LHD "to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the client's entire care or the care of a specific condition or problem."
    - For example: Under new procedures supported by AAP and CCNC, DSS requires an initial assessment (not necessarily a full PE) prior to assigning the child to foster care.
    - The assessment is meant to identify any issues that require immediate medical attention such as uncontrolled asthma or significant behavioral health issues and to link with needed resources such as CC4C or behavioral health.
    - The LHD may or may not become the medical home for the child. DSS is engaging LHDs across the state to provide these services to expedite transfer to foster care.

References:

- Current CPT, ICD and HCPCS code books, which are updated annually, should be available to the appropriate staff.

- DHB website should be reviewed regularly for monthly General Medicaid and Special Bulletins as well as Clinical Policy Manuals and Billing Guidelines: https://DHB.ncdhhs.gov/

- Contact your program consultants or PHNPDU Nursing consultant for coding questions.

Contacts:

PHNPDU Nurse Consultants:

Lynn Conner: (336) 207-3300 lynn.conner@dhhs.nc.gov
Carolynn Hemric (919)801-0727 carolynn.hemric@dhhs.nc.gov
Pamela Langdon: (919) 218-5391 pamela.langdon@dhhs.nc.gov
Rhonda Wright (828) 289-0782 rhonda.wright@dhhs.nc.gov

LTAT Administrative Consultants:

Kathy Brooks: (336) 212-1678 kathy.brooks@dhhs.nc.gov
Brook Johnson: (919) 710-0133 brook.johnson@dhhs.nc.gov

Public Health Nursing and Professional Development Unit, Local Technical Assistance & Training Branch

Phyllis Rocco, RN, BSN, MPH, Branch Head
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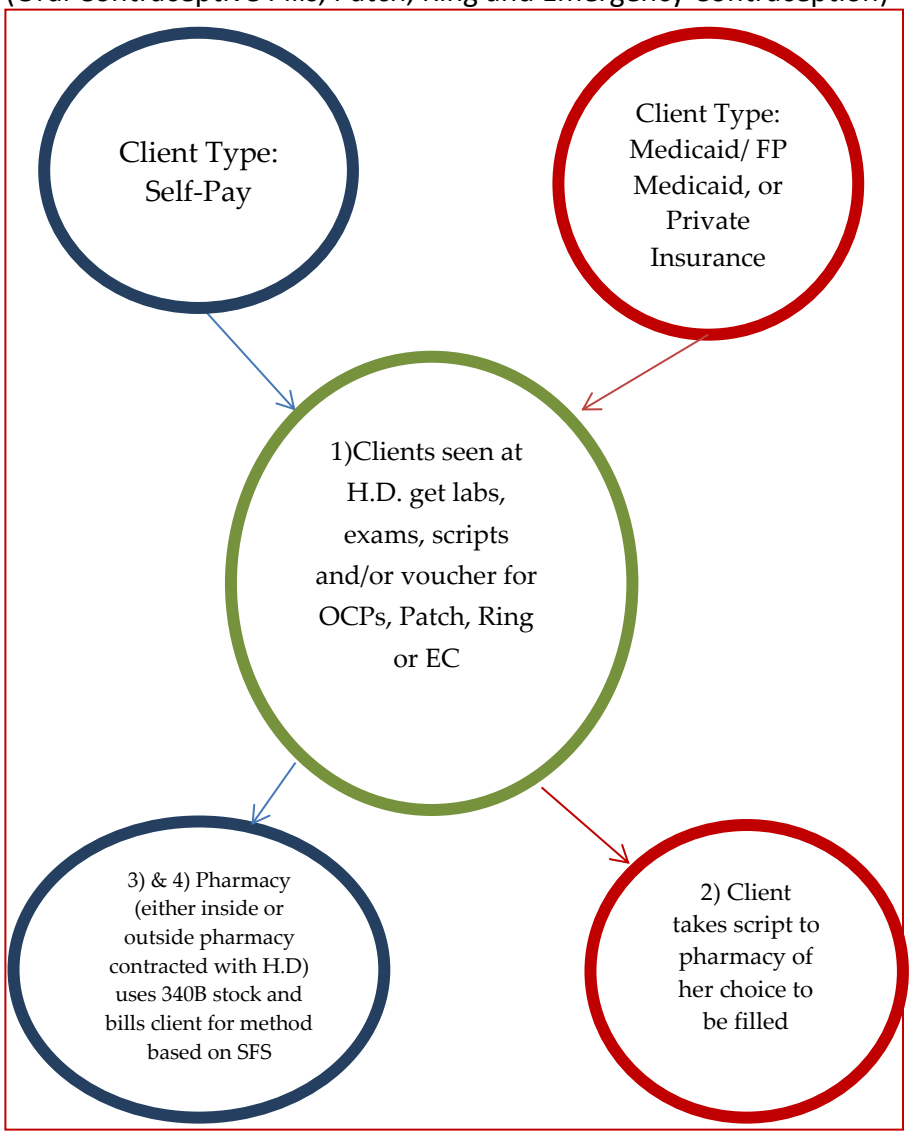
NCDPH Regional Nurse Consultant Directory http://ncpublichealthnursing.org/phn_dirc.htm

Appendices

Appendix A Flow Chart for LHD Billing by Client Types
(Oral Contraceptive Pills, Patch, Ring and Emergency Contraception)



1) H.D. bills financial source for labs, exam, visit, etc. (i.e., DHB/third party insurance or self-pay on sliding fee scale) using appropriate ICD-10 codes with FP modifier.
2) Clients who have Medicaid and/or third party insurance take prescription (not voucher) to pharmacy of their choice and that individual pharmacy will bill DHB/third party insurance directly using their **OWN** stock and **NOT the** LHD's 340B purchased inventory.
3) Self pay clients will receive their supply from the LHD's 340B purchased inventory and will pay the LHD based on their sliding fee scale (SFS) percentage (%).

Appendix B Flow Chart for LHD Billing by Client Types
(Depo, IUDs: Mirena/Paragard and Implants:)

1) H.D. bills financial source for labs, exam, visit, etc. (i.e., DHB/third party insurance or self-pay on sliding fee scale) using appropriate ICD-10 codes with FP modifier.

2) Clients who have Medicaid/FPW and/or third-party insurance receive method from H.D. 340B purchased inventory and H.D. bills using FP and UD modifiers to DHB (no UD modifier for third party insurance).

3) Self pay clients will receive their supply from the LHD's 340B purchased inventory and will pay the LHD based on their SFS category.

Appendix C: Memorandum from Evelyn Foust re: STD services not billed to client

State of North Carolina
Department of Justice
P. O. Box 629
RALEIGH
27602-0629

FOY COOPER
ATTORNEY GENERAL

Reply to:
John P. Barkley
Health & Public Assistance
Tel.: (919) 716-6864
Fax: (919) 716-6758

August 31, 2001

Ms. Evelyn Foust
HIV/STD Prevention and Care Branch
1902 Mail Service Center
Raleigh, NC 27699-1902

Re: STD Services at No Charge to Patient

Dear Evelyn:

15A NCAC 19A .0204 (a), requires that "diagnosis, testing, treatment, follow-up and preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale ... be provided upon request and at no charge to the patient." The HIV/STD Prevention and Care Branch in DHHS has prepared a guidance document on billing for STDs that states that screening or diagnostic testing services for all sexually transmitted diseases (STDs) must be provided at no charge to the patient, even for patients who do not have one of the STDs specifically identified in the Rule .0204(a). The Division of Medical Assistance (DMA) asked how services for diagnosis and testing can be provided at no charge to the patient for diseases other than those specified in Rule .0204(a)?

When screening or diagnostic testing is done, it is not known which STDS will be found. It is only after the screening or testing is done that the non-specified diseases are discovered. Therefore, the screening or diagnostic testing still falls within the rubric of services provided at no charge to the patient because they are designed to either diagnose or rule out both specified and unspecified STDs. However, once a STD that is not specified in the rule, such as venereal warts, has been diagnosed, treatment and follow-up services may be charged to the patient.

Sincerely,

John P. Barkley
Assistant Attorney General

cc: Judy Owen O'Dowd
Steve Cline
Chris Hoke

This is an advisory letter. It has not been reviewed and approved in accordance with procedures for issuing an attorney general's opinion.

“FP Medicaid” Family Planning Medicaid Program
June 20, 2018 - Webinar Questions

Contact: Shahnee Haire, Program Manager “FP Medicaid” Family Planning Medicaid Program North Carolina Division of Public Health, Women’s Health Branch 919-707-5683 // shahnee.haire@dhhs.nc.gov

Question: Can you review specific labs covered under family planning?
Answer: Laboratory services covered under the “FP Medicaid” 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 “FP Medicaid” 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 FP Medicaid 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: “FP Medicaid” 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 “FP Medicaid” Family Planning Medicaid should not be billed for any such services. However, an 80-year-old male is still eligible to receive service through “FP Medicaid”.

Question: What does a provider say if a client was given Medicaid but cannot use it?
Answer: Individuals that are eligible for FP Medicaid 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 "FP Medicaid" Medicaid is being finalized. Until our script is published, please refer to the Division of Medical Assistance January 2018 Medicaid Bulletin for provider guidance.

- DHB Sterilization and Eligibility Guidelines Bulletin Link: https://files.nc.gov/ncDHB/Medicaid_Bulletin_2018_01.

Glossary

- **AED-** Annual Exam Date
- **AH-** Adult Health- Program type typically used for adult preventive or sick care visits. An adult preventive medicine health assessment consists of a comprehensive unclothed physical examination, comprehensive health history, anticipatory guidance/risk factor reduction interventions, and the ordering of gender- and age-appropriate laboratory and diagnostic procedures. Some LHDs use this program code for BCCCP and WISEWOMAN services.
- **CH-** Child Health- Pediatric primary care at LHDs. Children may be treated for common illnesses, and their long-term health needs can be managed. Doctors will refer children as necessary to specialists.
- **CPT-** Current Procedural Terminology; codes & descriptions for reporting/billing medical services, procedures, supplies and materials. Accurate CPT coding provides an efficient method of communicating medical services and procedures among health care Physician or Advanced Practice Practitioners, health care facilities, and third-party payers and enhances the health care Physician or Advanced Practice Practitioner's control of the reimbursement process.
- **DPH-** Division of Public Health
- **DSM-** Diabetes Self-Management
- **E/M-** Evaluation & Management (CPT codes)
- **EP-** Modifier required on ~~*all*~~ *most* Medicaid claims to identify services rendered to recipients under the age of 21. It is not required for E&M visits.

  The EP modifier must be included on most of the components for the periodic and inter-periodic visit types including:
  - immunization administration, (but not vaccine product codes)
  - vision,
  - hearing,
  - maternal postpartum depression screening
  - developmental screenings
  - autism screenings
  - screening for emotional/behavioral problems
  - screening for adolescent health risks
  - Other screening-related services for adolescents (i.e., smoking and tobacco cessation counseling, alcohol and/or substance abuse structured screening and brief intervention services)

  EP is a required modifier for these Health Check claim details but not to be used with laboratory services and vaccine products. **NOTE: See the HCPG for a list of all components required in order to bill periodic or inter-periodic services. Please be sure to enter all reportable services when a Health Check visit occurs.**
- **EPI-** Communicable Disease
- **ERRN-** Enhanced Role Registered Nurse-

CHERRN: At the completion of the CHERRN program, Rregistered nurses will be able to independently:

- perform EPSDT (Health Check) screenings using AAP Bright Futures evidence-based recommendations as the clinical framework.
- Complete all components of a Health Check screening visit, focusing on the comprehensive pediatric history and the complete physical assessment.
- identification of problems, assuring appropriate consultation, referral and/or treatment of identified problems, along with documentation to support quality of care and billing requirements

STI ERRN: At the completion of the STI Nurse ERRN program, Registered Nurses will be able to independently:

- Perform and document an STI assessment.
- Identify and treat specified STIs by standardized protocols and standing orders.
- Develop a working knowledge of specimen collection and laboratory procedures as they relate to STI assessment and treatment.
- Provide STI client education, risk reduction counseling and follow-up for STIs, utilizing a client-centered approach.
- Integrate STI risk assessment into the client assessment process.

- **Flat Fee**- a charge that does not slide. Often used for services provided in Adult health and Other Services.
- **FP-** Family Planning- provision of family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the state plan and who desire such services and supplies
- **FP Medicaid-** also known as MAFDN, BeSmart
- **HC**- Health Check- The Health Check program facilitates regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. There is no separate enrollment in Health Check. If someone is eligible for Medicaid and is under the age of 21, they automatically receive Health Check services. Together, Health Check and EPSDT provide for the complete care of children and youth in Medicaid
- **Health Choice-** N.C. Health Choice for Children (NCHC) provides free or low-cost health insurance for children and teens from age 6 through the end of the month of their 19th birthday. The benefits covered by NCHC are equivalent to the benefits covered by the Medicaid program with four broad exceptions: 1) No EPSDT; 2) No long-term care; 3) No non-emergency medical transportation; and, 4) Restricted dental and orthodontic benefits.
- **HCPCS-** Healthcare Common Procedure Coding System. It was established in 1978 as a way to standardize identification of medical services, supplies and equipment.
- **ICD-** International Classification of Diseases
- **Inter-periodic/Periodic -** The **2016 HCBG** defines Periodic and Interperiodic well visits as follows:

Periodic: Encounter for routine child health exam with abnormal findings – Z00.121 Encounter for routine child health exam without abnormal findings – Z00.129
Routine Interperiodic: Encounter for other administrative exam – Z02.89

The NC *Health Check* Program recommends regular medical screening assessments (well child visits) for beneficiaries as indicated in the following table. North Carolina Medicaid's periodicity schedule is only a guideline. Should a beneficiary need to have screening or assessment visits on a different schedule, the visits are still covered. While frequency of visits is not a required element of reimbursement by NC *Health Check*, this schedule of visits for eligible infants, children and adolescents is strongly recommended to parents and health care providers.
Please Note: Completion of all elements of the *Health Check* well-child visit as indicated for each age group in the periodicity schedule is *required* for Medicaid provider reimbursement.

- **LU-** Local - (codes) LU codes may be used to **report or bill** services that are NOT billable by a CPT or HCPCS code
- **MH-** Maternal Health/Obstetrics/Prenatal Care- Obstetrics is a branch of medical science that deals with maternity care, including antepartum care, labor and delivery, and postpartum care. Standards of care are published by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and the American College of Nurse Midwifery (ACNM) for the perinatal care of the mother.
- **MNT-** Medical Nutrition Therapy
- **Modifiers- additions** to CPT codes to identify that something additional/different was performed at the same time.
- **NC DHB/DHB-** North Carolina Division of Health Benefits (formerly NC Division of Medical Assistance)
- **NCIP-** The North Carolina Immunization Program works in conjunction with the federal vaccine supply program, called the Vaccines for Children (VFC) program, to provide vaccines free of cost to health care Physician or Advanced Practice Practitioners across the state. Participating health care Physician or Advanced Practice Practitioners must administer these vaccines according to NCIP guidelines.
- **NCTracks-** Medicaid Contractor. Processes and pays Medicaid claims.
- **NDC**- National Drug Code
- **OS-** Other Services; used to record services not identified with another program type
- **PC-** Primary Care; may be used to record primary care services to Adults or Children.
- **PMH-** Pregnancy Medical Home
- **SFS-** Sliding Fee Scale; required by most programs
- **STI-** Sexually Transmitted Infections - diagnosis and treatment of sexually transmitted diseases (STI) provided in the LHD setting. Service includes medical history, diagnostic examinations for sexually transmitted diseases, laboratory tests as medically indicated, treatment as indicated, and referral as appropriate
- **TB SKIN TEST-** Tuberculin Skin Test

- **Title V-** Federal funding for Women's & Children's Health programs
- **Title X-** Federal funding for Family Planning
- **VFC-** The Vaccines for Children (VFC) Program helps provide vaccines to children whose parents or guardians may not be able to afford them. This helps ensure that all children have a better chance of getting their recommended vaccinations on schedule. Vaccines available through the VFC Program are those recommended by the Advisory Committee on Immunization Practices (ACIP). These vaccines protect babies, young children, and adolescents from 16 diseases.
  Funding for the VFC program is approved by the Office of Management and Budget (OMB) and allocated through the Centers for Medicare & Medicaid Services (CMS) to the Centers for Disease Control and Prevention (CDC).
  CDC buys vaccines at a discount and distributes them to grantees—i.e., state health departments and certain local and territorial public health agencies—which in turn distribute them at no charge to those private physicians' offices and public health clinics registered as VFC Physician or Advanced Practice Practitioners.
- **WIC-** The **Special Supplemental Nutrition Program for Women, Infants and Children** (**WIC**) is a federal assistance program of the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA) for healthcare and nutrition of low-income pregnant women, breastfeeding women, and infants and children under the age of five.
- **340-B-** Federal program for purchasing drugs/medications at a reduced rate

Quick Links

General Information
Billing
OPA- Title X Program Requirements April 2014

Standing Orders:
www.ncpublichealthnursing.org

ICD Coding Resources:
http://publichealth.nc.gov/lhd/icd10/training.htm
http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10QuickStartGuide20150622.pdf
http://www.roadto10.org/

Child Health
Health Check Program Guide:
https://files.nc.gov/ncdma/documents/Providers/Programs_Services/EPSDT/Health-Check-Program-Guide-2018-04-01.pdf

Immunization
Health Check Program Guide:
https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services
http://www.immunize.nc.gov/providers/coveragecriteria.htmhttp://www.immunize.nc.gov/providers/index.htm

Sexually Transmitted Infections
STI Clinical Coverage Policy- Treatment in Local Health Department
http://epi.publichealth.nc.gov/cd/lhds.html

Tuberculosis Control & Treatment
Clinical Coverage Policy- Tuberculosis Treatment in Local Health Department

Communicable Disease
http://epi.publichealth.nc.gov/cd/lhds.html

Women's Health
Maternity/OB Billing
Clinical Coverage Policy- Obstetrics
Clinical Coverage Policy Pregnancy Medical Home 1-E6
Clinical Coverage Policy 1-E4 Fetal Surveillance
NCAPHNA_WHNC_Fall_2015 Report

Birthing Classes-Clinical Coverage Policy 1M-2
http://whb.ncpublichealth.com/

Family Planning
Clinical Coverage Policy- Family Planning/FP Medicaid
Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information.
Physician Drug Program:
http://www2.ncdhhs.gov/DHB/mp/1B.pdf
Attachment A, C1 of the Clinical Coverage Policy
Clinical Coverage Policy- Attachment B, section B
http://whb.ncpublichealth.com/

Pharmacy
Physician Drug Program:
http://www2.ncdhhs.gov/DHB/mp/1B.pdf

Laboratory
https://slph.ncpublichealth.com/

Medical Nutrition Therapy (MNT)
Clinical Coverage Policy- Dietary Evaluation & Counseling (MNT)

Medicaid Specific Modifiers
NC Division of Health Benefits