




- ▶ You will be listening to this webinar via your computer speakers. **There is no call in number.**
- ▶ Please use the chat box to ask your questions; We will be compiling a Q&A document once we have all the answers to your questions.
- ▶ The webinar slides will be posted as soon as possible after Thursday's presentation.




Coding & Billing Guide March 2019 Updates

DPH PHNPDU LTAT Consultants


March 2019



NC DMA has
been changed
to NC DHB
throughout the
document.



Regular Medicaid has
been changed to
Traditional Medicaid
throughout the
document.



BeSmart has
been changed
to FP Medicaid
throughout the
document.

Child Health Program Updates



Tobacco Cessation and Counseling page 26

- The Tobacco Cessation and Counseling section has been modified to reflect verbiage in Maternal Health section. This was done in order to be consistent when providing similar guidance throughout. Specific guidance that relates to Child Health has been retained.

Sports Physical Guidance

Page 31

- Deleted reference to Sports Physical Memo. The memo is currently being revised.

~~Billing Sports Physicals-Please see Memo from Phyllis Rocco (4/19/17) on NC DPH website~~

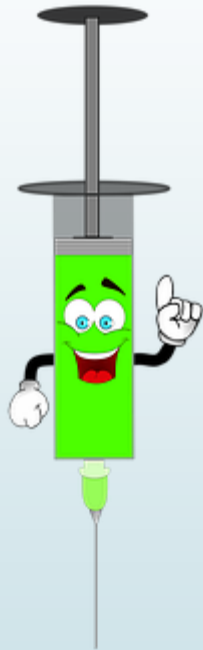
NCHC FP physicals

Deleted notation regarding verification of fix by NCtracks to pay NCHC FP physicals at the correct rate. We have heard from numerous counties that these are now being paid correctly.

- 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. ~~We have not been able to verify that this fix is working properly.~~

Immunization Update for Flu

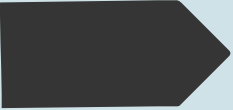
Page 35,74



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

STI/Communicable Disease Updates

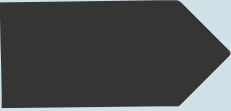




Clarification of the Two-Step Tuberculosis (TB) Test Process and Billing (Adult Care homes, Nursing homes, Health Departments) Page 51

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.



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

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

1. Bill the first part of the test using CPT 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.

Clarification of what program to bill services rendered for Company Billing

Page 53

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.

Maternal Health Updates

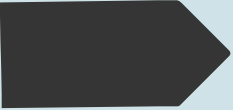




Maternal Health: Expanded explanation of what services are covered by MPW

Page 55

- **NC Division of Health Benefits 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: ~~condition(s) that may complicate a pregnancy and the postpartum period. ▪ 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 NC Division of Health Benefits, including MPW are exempt from co-pays for medical care and prescriptions
- ~~Coverage ends on the last day of the month in which the 60th postpartum day occurs~~



Maternal Health: Additional information regarding Billing for Antepartum Care

Page 58

- Any visit provided in relation to the pregnancy, even with a nurse only visit/& initial laboratory studies, is considered part of the global billing and should not be submitted separately (unless the client leaves care after 3 visits or less) o The 99211 may be reported, not billed specific to this example
- 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 NC Medicaid 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 NC Medicaid along with the one or two additional visits, rather than billing a package code.

CPT codes that may **NOT** be billed separately during Antepartum Care

Page 61

- Specific CPT Codes may be billed in addition to the prenatal clinical services as identified in **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.



CPT Codes 96153 & 96154

- 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



Dental care is included for clients with:

- Full NC Medicaid NC 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 NC Medicaid and pregnant women

Family Planning Updates



Deletion of specific NDC numbers for Makena 17-P

Page 76

- **Utilize CPT code 99211 (supportive documentation is present) and • HCPCS J1726 (Makena®) and**
 - NDC
- they include: • ~~64011024301 and 64011024702~~ or
- HCPCS J3490 (Compound 17P NDCs for all compounds and
 - Invoice from compounding pharmacy

Utilize CPT code 96372 and

- HCPCS J1726 (Makena®) and
- NDC the includes: • ~~64011024301 and 64011024702~~ or

New information: Family Planning eligible Pharmaceuticals

Page 78

- 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
information:
Family Planning
eligible
Pharmaceuticals
continued

Additional ICD-10 Codes that may now be used for Family Planning.

Page 78

- 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



Additional ICD-10 Codes that may now be used for Family Planning continued

- 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

CPT Codes that can now be used in Family Planning.

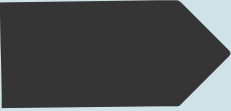
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New CPT Codes effective 1/1/19 which may be used in the FP setting are:

- 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.

- 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.

New information
related to billing
Preventive visit at
the time of
IUD/Implants,
insertion or removal



New information related to billing Preventive visit at the time of IUD/Implants, insertion or removal continued

- 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, the provider may bill for the inter-periodic visit (E&M) 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.

Billing Scenario for ECP billing

- 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.
- ~~If the agency dispenses, and they have purchased using 340B they may bill Medicaid their acquisition cost (with HCPCS code S5000-generic or S5001-brand name) and append the UD modifier and NDC.~~
- If the client does not have Medicaid...agency can set fees using the HCPCS codes HCPCS code S5001 or S5001



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