Documentation, Coding and Billing
Guidance Document
Part II

Public Health Nursing and
Professional Development Unit
(PHNPDU)

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This document replaces all prior versions of Coding & Billing Part II
# Contents

**Introduction**                                                                                                           ........................................... 4  
**General Information**                                                                                                    .......................................... 4  
  - Documentation ........................................................................................................................................ 4  
  - Billing .................................................................................................................................................... 5  
  - Standing Orders ................................................................................................................................ 9  
  - Enhanced Role Registered Nurses (ERRN) .......................................................................................... 9  
  - Sliding Fee Scale ................................................................................................................................. 10  
  - Identifying Program Type .................................................................................................................. 10  
  - Establishing Fees ............................................................................................................................... 11  
  - ICD Coding Resources ....................................................................................................................... 13  
**Program Specific Guidelines** ........................................................................................................................................ 14  
  - Child Health (CH) ............................................................................................................................... 14  
  - Immunization ..................................................................................................................................... 18  
  - Sexually Transmitted Diseases ........................................................................................................ 22  
    - STD LABS ....................................................................................................................................... 27  
  - Tuberculosis Control & Treatment .................................................................................................... 28  
  - Communicable Disease ....................................................................................................................... 32  
  - Women’s Health .................................................................................................................................. 32  
    - Maternity/OB Billing .................................................................................................................... 32  
    - Family Planning ............................................................................................................................... 39  
  - Pharmacy ............................................................................................................................................... 54  
  - Laboratory .......................................................................................................................................... 55  
  - Medical Nutrition Therapy (MNT) .................................................................................................... 59  
  - Local Use Codes ................................................................................................................................. 61  
  - Adult Health ....................................................................................................................................... 63  
  - Breast & Cervical Cancer Control Program (BCCCP) ..................................................................... 63  
  - Dental Services ................................................................................................................................. 63  
  - Medicaid Specific Modifiers ............................................................................................................ 64
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>References</td>
<td>67</td>
</tr>
<tr>
<td>Contacts</td>
<td>67</td>
</tr>
<tr>
<td>Appendices</td>
<td>67</td>
</tr>
<tr>
<td>Appendix A Flow Chart for LHD Billing by Patient Types</td>
<td>67</td>
</tr>
<tr>
<td>Appendix B Flow Chart for LHD Billing by Patient Types</td>
<td>68</td>
</tr>
<tr>
<td>Glossary</td>
<td>70</td>
</tr>
<tr>
<td>Quick Links</td>
<td>74</td>
</tr>
</tbody>
</table>
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 clearly 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.

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 provider 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 in your health department, within the last three years, for a billable visit that 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” patient 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 patient 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 patient 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 patient is “established.” Consult your PHNPDU Nursing Consultant if you have questions.

Billing

1. LHDs bill for services using the NPI of the provider who provided services to the client or for the provider/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. Further, 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 particular client to support the visit.

4. To be eligible to bill for procedures, products, and services related to this policy, providers shall:
   a. meet Medicaid or NCHC qualifications for participation;
   b. be currently Medicaid - enrolled; and
c. bill only for procedures, products, and services that are within the scope of
their clinical practice, as defined by the appropriate licensing entity.

5. 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 provider. 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,
   • **LHDs should include specific negotiations in their insurance company contracts.**
     NC Law prohibits LHDs from charging patients for STD screening services. This
     includes collecting insurance copays. We are also prohibited by Family Planning
     from charging a patient 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

6. Encounter Forms:
   a. All services provided should be indicated on the Encounter Form/Superbill
      whether reportable or billable.
   b. 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.
   c. The **Rendering Provider’s** (different then the Billing Provider) 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.
   d. The **Billing Provider** (used when filing your claim) NPI is the health
      department’s NPI. Health Departments also use the health department’s
      taxonomy code. NCTracks requires each LHD to have a health department
      NPI.
   e. All Providers, (except nurses who are not eligible to obtain an NPI), are
      required to use their own NPI. Every mid-level provider should get
      credentialed and obtain an NPI. Mid-level providers do not work under
      standing orders. Only RN’s and LPN’s work under a physician’s standing
      order.
   f. 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 provider of 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. Remember that the CPT code identifies what you did and the ICD code identifies why you did it.

g. ICD codes used on the billing form are to justify the CPT codes. The biller needs to be able to link the ICD code to the respective CPT code which means the provider 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.

h. Providers 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 provider office visit. Remember the highest level provider providing services to the client determines the level of service billed. If the RN/ERRN sees the patient and then asks the provider to come in and see the patient, the visit is billed at the code for the level of visit done by the provider and the LU code would be reported for the RN/ERRN contact. If an RN/ERRN consults with a provider during a visit with a client but the provider does not see the client, it is billed using the code appropriate to the RN/ERRN visit.

7. National Correct Coding Initiative (NCCI)

Due to edits/audits related to the National Correct Coding Initiative, the practice of billing a 99211 and then billing a new visit code has been eliminated. Many local health departments have been billing a 99211 (usually an RN only visit) the first time they see a patient and then bill 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 patient comes in for their first prenatal, Family Planning or Child Health visit. Now that the new 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 patient is “established”. Consult your PHNPDU Nursing Consultant if you have questions.

8. Billing Preventive and E/M visits to Medicaid on the same day-
   a. Medicaid will not reimburse for same day preventive visits and an E/ M (office) visit in any program (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: A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay, and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial.*

b. If a client is seen by a provider for STD 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 provider on the same day and it is not a duplicate billing

c. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy. Effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.

d. STD ERRN- must bill T1002 for Medicaid clients and use 99211 to bill insurance clients.

e. The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.

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

9. 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 providers may use modifier 25 with modifier EP or modifier TJ for preventive medicine service codes (99381 - 99397 and additional screening codes 99406-99409 and 99420) when reported in conjunction with immunization administrative services (90460-99474). Providers 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.

Standing Orders

1. 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 mid-level provider. (Link to the NC Board of Nursing’s document on Standing Orders at: http://www.ncbon.com/myfiles/downloads/position-statements-decision-trees/standing-orders.pdf You will also find helpful information at: www.ncpublichealthnursing.org

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

3. The Rendering Provider’s (different than the Billing Provider) 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.

4. The Billing Provider (used when filing your claim) NPI is the health department’s NPI. Health Departments also use the health department’s taxonomy code. NCTracks requires each LHD to have a health department NPI.

5. All Providers, (except nurses who are not eligible to obtain an NPI), are required to use their own NPI. Every mid-level provider should get credentialed and obtain an NPI. Mid-level providers do not work under Standing Orders. Only RN’s and LPN’s work under a physician’s Standing Order.

Enhanced Role Registered Nurses (ERRN)

1. If you are using ERRNs and billing 3rd party payors, other than Medicaid, make sure that you check and are in compliance with the guidelines consistent with the
insurer’s supervision and “incident to” definitions. ERRNs must have completed the approved training and be rostered in their specific program. For information on these courses and rostering requirements contact the appropriate Branch in NC DPH.

**Sliding Fee Scale**

1. A sliding fee scale can be attached to any program type, except STD 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 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).

**Identifying Program Type**

1. “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 **provider** to determine which problem is driving the visit and to code it to the correct program.

2. Other Services (OS) program type and codes used within the program must be requested using the appropriate form and be approved by the LTAT Branch Head. This program is generally used for services that are billed at a flat rate.
Services that you want to offer at a flat rate and that are not associated with another program can be billed under the OS program with approval of the LTAT Branch Head. **Note:** If these services are billed to Medicaid or third party payors, the same flat rate must be billed to them all. This cannot be used to circumvent sliding to zero for services for program guidelines that require the use of a sliding fee scale.

**Primary Care (PC)**

Children PC program type must be requested using the appropriate form and approved by the LTAT Branch Head, Phyllis Rocco. Services in this program must slide to zero for services to children.

Adult PC program type must be requested using the appropriate form and approved by the LTAT Branch Head, Phyllis Rocco. Services in this program do not have to slide to zero; it is a health department decision.

For additional guidance on use of OS and PC program types, please contact your PHNPDU Regional Nurse Consultant.

**Establishing Fees**

1. North Carolina law¹ 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;

1¹North Carolina General Statute 130A-39(g)

2. How do we set fees?
   a. Health Department fees are set based on the cost to provide the service. If you need assistance with this process, contact your Administrative Consultant.
   b. 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”; i.e., you may not vary your charge by payor source but you may accept a variety of reimbursements as full payment for that service (e.g. 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, Administrative Code 15A NCAC 21B .0109 (a)(2) and (3) may apply: “If a local provider imposes any charges on clients for maternal and child health services, such charges:...(2) will not be imposed on low-income individuals or their families; (3) will be adjusted to reflect the income, resources, and family size of the individual receiving the services.” This means that, in all cases for WCH Programs, the sliding fee scale must be applied and it must slide to zero ($0.00).

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 private insurance (3rd party payors) a different way. Example: STD & TB - LHD may bill a T1002 to Medicaid and some private insurers. Some private insurers only accept 99211. Verify with each insurance carrier which codes they accept.

8. Flat Fees- A number of factors influence whether a LHD may apply a “flat fee” to a service provided in the health department:
   - the description of the service;
   - whether the service is provided to individuals with Medicaid coverage, private insurance and/or self-pays;
   - whether third-party payors 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. 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](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.)

- For rural and small practices:
  [http://www.roadto10.org](http://www.roadto10.org)
Program Specific Guidelines

Child Health (CH)

A. It is very important to check the Health Check Billing Guide (HCBG) (http://surveygizmolibrary.s3.amazonaws.com/library/12181/HCBilling_Guide_201311.pdf) published by the NC Division of Public Health (DMA) as a Special Bulletin usually between April and July. The most current document was published in July 2013 and updated Sept 2015 (last 3 pages).

B. Child Health Periodic (preventive/physical) and Inter-periodic visits (sick/problem) are all coded to Health Check (HC) program type in Health Information System (HIS) regardless of payor source. As a reminder, the EP modifier must be used when the payor source is Medicaid. EP modifier is an abbreviation for EPSTD, (Early Periodic Screening, Diagnosis, & Treatment) which is administered by Medicaid to provide services to beneficiaries under age 21. It is allowable to append the EP modifier for all payor sources to be consistent and avoid confusion for staff even though it is not required for third party insurance.

The EP modifier must be included on all components for the periodic and inter-periodic visit types including:
- immunization administration,
- vision,
- hearing,
- developmental and
- health risk assessments and/or behavioral risk assessment codes.

EP modifier is an abbreviation for EPSTD, (Early Periodic Screening, Diagnosis & Treatment) which is administered by Medicaid to provide services to beneficiaries under age 21. EP is a required modifier for all Health Check claim details with the exception of codes for vaccine products. **NOTE: See the HCBG 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.**

C. CH program type in HIS includes 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. **Please be sure to enter all reportable services when a Child Health visit occurs.** It is no longer
necessary to split out child health services between Child Health (CH) & Health Check (HC) programs.

D. Completion of Forms: A 99080 may be used when providers complete a physical form. If a form is presented during the visit for completion, it should be considered a part of the visit and the patient would not be charged for completion of the form. In this case, the 99080 would be “reported” and the patient would not be charged. If the form is brought in at a later date for completion, agencies could charge for the service using the 99080. Since most insurance companies will not pay this code, agencies need to inform patients that this is a non-covered service, and they may be responsible for the charge.

E. Urinalysis is a billable service if medically indicated. It is not part of the Periodic or Inter-periodic visit and not recommended. There must be documented symptoms or identified risks to bill for a urinalysis or any other laboratory service (as a stand-alone service, as part of a sick/problem visit, or along with a preventive service). It must be supported with an appropriate ICD code to explain why the service is being provided/requested, and the appropriate CPT code must also be included. This is the same as lab services provided in any other program type.

F. Child Health cannot bill an E/M (Problem visit) and a Prevention visit (Well Child Exam) on the same day. DPH recommends that providers complete the prevention visit and treat the acute illness. If the child is too sick to cooperate with the completion of the prevention visit, then you should conduct the visit as a problem visit and reschedule the prevention visit (per Beth Daniel, Associate Director, Clinical & Practitioners Services, NC DMA, verbal verification 1/28/16).

G. Screenings
   1. ASQ-3
      ○ Developmental screening is a required component at ages 6, 12, 18 and 24 months of age and 3, 4, and 5 years of age using either the ASQ-3 or PEDS structured developmental screening tool.
      ○ Providers will report CPT code 96110 and EP modifier; no additional revenue is generated;
   2. HEEADSSS, PSC, and ASQ-SE
      ○ Validated screening tools used to complete psychosocial/behavioral assessments when indicated by routine surveillance;
      ○ Providers will bill CPT code 99420 and EP modifier; if completed and billed this will generate additional revenue;
○ HEEADSSS is built into the Bright Futures Visit Documentation forms for adolescents starting at 11 years of age; staff should bill for the HEEADSSS
○ when completing this section of the BF visit documentation form;
○ If the provider feels that completing a PSC would be beneficial to further assess positive risk factors that were identified in the HEEADSSS, then the provider can bill for 2 units of the CPT Code 99420 and EP modifier; this will generate additional revenue for completing both the HEEADSSS and PSC;

3. PSC can be completed as needed for psychosocial/behavioral health assessments for ages 6-10 years of age as well.

4. CRAFFT Screening Tool

a. Alcohol and Substance Abuse Screening and Brief Intervention
   o This tool is built into the back of the Bright Futures Visit Documentation forms. Providers would complete this assessment if any positive risk factors for alcohol/substance abuse were identified in the HEEADSSS screening tool;
   o The provider can bill for the CRAFFT if there are at least 2 positive risk factors on the CRAFFT and the provider spent a minimum of 15 minutes of time providing intervention and referral;
   o The provider will bill CPT Code 99408 and EP modifier for a CRAFFT with 2 positive risk factors and a minimum of 15 minutes of intervention/referral.
   o The provider will bill CPT Code 99409 and EP modifier for a CRAFFT with 2 positive risk factors and a minimum of 30 minutes of intervention/referral.
   o Additional revenue is generated if completed and billed;

b. Smoking and Tobacco Use Cessation and Counseling
   o The provider can bill CPT code 99406 and EP modifier if at least 3-10 minutes of counseling has been provided to the client.
   o The provider can bill CPT code 99407 and EP modifier if greater than 10 minutes of more intensive counseling has been provided to the client.
   o Note: Counseling cannot be billed if provided to the parent/guardian instead of the client.

c. Modified Checklist for Autism in Toddlers (M-CHAT)
   o Screening for autism spectrum disorder is required at 18 & 24 months of age using a validated screening tool;
o M-CHAT and M-CHAT Revised with Follow-Up (M-CHAT R/F) are validated screening tools used to identify children between 16 and 30 months of age who are at risk for autism spectrum disorders;

o Providers will bill CPT code 99420 and EP modifier; additional revenue is generated if completed and billed;

d. M-CHAT/HEEADSSS/PSC/ASQ-SE – share the same CPT code 99420.

A. The following information must be shared related to the provision of family planning services during a Health Check or Child Health visit:

1. General information that includes the health benefits of abstinence, and the risks and benefits of all contraceptive options;

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

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

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

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

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

J. 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 (per Peter Andersen, WCH Acting Section Chief).

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

K. 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 private 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.

Immunization


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

C. 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.

D. National Drug Codes (NDCs) should NOT be reported to Medicaid for vaccines. NDC numbers are specific to drugs/medications and do not apply to immunizations/vaccines. These are two different things.

E. Immunization Administration (for Child Health/Health Check)

For information regarding consent/authorization for immunizing minors, please refer to:
1. Administration Codes
   a. 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.
   b. Claims billed with CPT immunization administration codes 90460 and 90461
      (effective for dates of service on and after January 1, 2011, for Medicaid recipients
      through 18 years of age) on and after July 1, 2011, will deny.
   c. 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.
   d. 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.
   e. Do NOT append the EP or TJ modifier to the CPT vaccine product codes.
   f. Do NOT report the National Drug Code (NDC) with the CPT vaccine product
      code.
   g. All of 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.
   h. CPT vaccine codes for the vaccines administered must be reported or billed, as
      appropriate, even if administration codes are not being billed.
   j. 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.
   k. Refer to individual bulletin articles on specific vaccines for additional billing
      guidelines.
   l. Providers 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
m. purchased vaccine is administered to this age group, Medicaid will reimburse providers for the vaccine product and the administration fee.

n. 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.

p. Remember, for NCHC recipients, do NOT append the EP modifier to the CPT immunization administration code (90471-90474). Use TJ modifier for these services.

q. Medicaid patients 21 years of age and over are responsible for the $3.00 copay when they receive immunizations.

r. 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 providers may use modifier 25 with modifier EP or modifier TJ for preventive medicine service codes (99381 -99397 and additional screening codes 99406-99409 and 99420) when reported in conjunction with immunization administrative services (90460-99474). Providers 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.

F. Vaccines for Children (VFC) Program

1. 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 providers across the state.

2. Participating health care providers must administer these vaccines according to NC Immunization Program (NCIP guidelines).
3. Providers may not charge patients 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.

4. 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 patients 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.

5. who are Medicaid or Medicare recipients are considered covered, or insured, for this purpose.) Details on which patients are currently covered by NCIP vaccine may be found at: http://www.immunize.nc.gov/providers/coveragecriteria.htm

6. 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.
   a. 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 providers 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 patient.
   b. 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.
   c. 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.
   d. 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 Basic Medicaid and NC Health Choice Billing Guide, Section 12, for details regarding the NCHC eligibility groups and the billing and claims processing of Health Choice claims.

* Health Choice is a comprehensive health coverage program for low-income children; it is not Medicaid. Children whose family income is too high to qualify for Medicaid and too low to afford private insurance may be eligible for Health Choice.

G. Purchased Vaccines

1. Providers must use purchased vaccines for Health Check (Medicaid) 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 providers for the vaccine product and the administration fee. DO NOT CHARGE THESE CLIENTS A $3.00 CO-PAY. Vaccine procedure codes must always be included on the claim.

2. Purchased vaccines 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.

H. 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.

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 Diseases

STD Clinical Coverage Policy- Treatment in Local Health Department

1. The following providers in a LHD setting are eligible to provide STD services:
   - Physician (billed by E/M codes)
   - 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 private insurance).

Every provider should receive an orientation to the STD Program and agree to provide services according to DPH STD Program guidelines.

2. Currently Rostered STD Enhanced Role Registered Nurses (STD ERRN) who have completed the STD Enhanced Role training course, may provide services to clients seeking STD evaluation and can bill Medicaid for these services if the STD ERRN conducts the interview, performs the physical examination, orders the appropriate testing and provides appropriate treatment and counseling. The STD ERRN uses the T1002 for Medicaid covered clients, or may bill private insurance if allowed by the client’s plan using 99211 or T1002 with the client’s permission.

3. T1002 is billed in units. One unit = ERRN services for each full 15 minute increment. The T1002 is billable when all of 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. Service components include the following:
   a. Provide essential STD services which are defined as:
      o medical history,
      o sexual risk assessment,
      o a physical examination inclusive of the upper and lower body,
      o laboratory testing,
      o treatment (as needed),
      o counseling and referral necessary for the evaluation of individuals with an exposure to, or symptoms suggestive of, a sexually transmitted infection.
   b. In the public health setting, essential STD services would include primary prevention such as STD screening in asymptomatic clients based upon the client’s site(s) of exposure.
   c. A maximum of 4 units per day may be billed per client. The time spent for each visit must be documented in the medical record. Time is defined as total time spent; for instance, 30 minutes time spent = 2 units. The documentation recording the STD service components provided should support the number of units billed. If additional units are needed (beyond 4), refer to STD Clinical Coverage Policy for instructions.
4. If during a Child Health, Family Planning/Be Smart, Maternity or other program visit the clinician needs to rule out STDs to meet standards of care, the client cannot be charged for the STD testing and treatment services. The client should be evaluated using the same standard of care and medical record documentation as if they were being evaluated in the STD clinic. Even in these clinics **within the Health Department**, the 340B STD drugs may be given to the client for treatment; however, all follow-up on the STD must be done in the program in which they were evaluated and/or treated (per CD Branch).

5. At the current time, most STD services cannot be charged to the client but can be charged to Medicaid and other third party payors with the client’s permission. If you bill insurance, you must use 99211 or T1002 for a nurse visit or a higher E/M code for mid-level providers or physicians. Remember that if the client presents as being concerned about having a reportable STD or presents in an STD Clinic, nothing related or required for STD evaluation is billable to the patient. Exceptions to this rule apply only for tests and procedures not offered by the NC SLPH or not required by the DPH STD Program.

**Exceptions include:**

- You may charge a patient for any STD lab the patient requests that is not offered through NC SLPH. For example, the SLPH does not offer Chlamydia testing for males. Therefore if the patient 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 STD 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 STDs (e.g., herpes serology, Hepatitis C, BV)

- Clients who receive follow-up treatment of warts after the diagnosis is established.

6. Non-STD Enhanced Role Nurses providing STD services should use the non-billable STD visit code LU242 for reporting services provided to the client since they cannot bill for the services provided. *(By Agreement Addenda it is preferred that STD ERRN provide services to STD clients, but a registered nurse having demonstrated competency can administer treatment per standing order, obtain client history and provide client-centered counseling).*
7. Mid-level providers and physicians should bill Medicaid and may bill third party payors (with the patient’s permission) using the appropriate E/M codes for the level of service provided. Third party payors (Medicaid and private insurance) can be charged for STD services. *NOTE that in this case billing private 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.*

8. Billing when two different providers (different NPI numbers) see client same day:
   a. When a client receives STD services billed with E/M or T1002 code and is also seen by another health department provider 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 providers involved (with two NPI numbers).

9. Billing Preventive and E/M visits to Medicaid on the same day
   a. 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: A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial.*
   b. If a client is seen by a provider for STD 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 provider on the same day, and it is not a duplicate billing
   c. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN in order to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across two different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals a full 15 mins.) of care provided.
d. STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.

e. The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.

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

10. Additional Billing Scenario:

- When a “Be Smart” client is scheduled for the STD ERRN visit and upon interview thinks she has “BV again”, can the client be switched to provider schedule and charged for the clinic visit? We do not recommend switching the client to the provider. You should:
  - See the client in STD clinic but do not bill “Be Smart”.
  - If you switch a “Be Smart” client to a provider 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 STDs this may significantly reduce your supply of 340B drugs available to treat clients that the health department is mandated to treat.*

11. Human Papilloma Virus (HPV):

- Once HPV is diagnosed (in any clinic), the health department can see the patient 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 patient 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 STD and therefore does not fall under the “not billable to clients” stipulation.
STD LABS

If the NC SLPH does not provide a test, insurance can be billed with the patient’s consent and patients 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 STD Contract Addenda, which give additional circumstances for billing clients.

2. Modifiers with Labs
Valid billing with a modifier:
   o Modifier-59: Distinct Procedural Service, different site or organ system, for example, multiple sources collected for screening culture GC (modifier -59)
   o Modifier-90: Specimen sent to a reference laboratory for processing.
   o Modifier-91: Repeat Clinical Diagnostic Lab test. Note: This modifier may not be used when tests are:
     a) rerun to confirm initial results;
     b) due to testing problems with specimens or equipment;
     c) for any other reason when a normal, one time, reportable result is all that is required.

   For example, when a provider 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

   o XE – Separate Encounter: A service that is distinct because it occurred during a separate encounter.
   o XS – Separate Structure: A service that is distinct because it was performed on a separate organ/structure.
   o 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.

*As of the date of publication of this document Medicaid is not currently set up to reimburse LHDs using these modifiers. As soon as this is corrected, you will be notified, and we will include the information in our quarterly updates to the Coding & Billing Guidance Document.

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.

**Miscellaneous Billing Guidance:**

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

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

**Tuberculosis Control & Treatment**

**Clinical Coverage Policy- Tuberculosis Treatment in Local Health Department**

(guidance below as per TB Consultant 9-14-15)

1. The following providers 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.

2. **TB Disease or Contacts:**

   a. Per GS 130A-144 “the local health department shall provide, at no cost to the patient, 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 payor the LHD must assure that the patient 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 patient. Medicaid does not require that a co-pay be collected due to this law. If you bill private insurance, then you would need to negotiate the copay issue with the insurance company.

   b. 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. The T1002 visits are for the 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 = a full 15 minutes. Procedure code T1002 cannot be billed on the same day that a preventive medicine service is provided.

   c. A maximum of 4 units per day may be billed per client. The time spent for each visit must be documented in the medical record. Time is defined as total time spent; for instance, 30 minutes time spent = 2 units. The documentation recording the TB service components provided should support the number of units billed.

   d. 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)

   e. 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 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.

f. 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 your vendor is unable to support the use of LU codes, you may need to work out a different mechanism for reporting state supplied TB SKIN TEST.

g. If the client has private insurance and an RN is providing monthly assessments, you can bill private insurance with the client’s permission using 99211 or T1002 provided the components to support the 99211 or T1002 are necessary and documented. Other providers eligible to bill private insurance would use the appropriate E/M code for the level of service, provided the components to support the E/M code are necessary and documented.

h. When a client receives a billable TB service (billed using an E/M code) and is also seen by the same health department provider 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 provider on the same date of service …… no 25 modifier is needed.

i. Billing Preventive and E/M visits to Medicaid on the same day
1. 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: A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay, and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial.
2. If a client is seen by a provider for STD 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 provider on the same day and it is not a duplicate billing
3. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.

4. **STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.**

5. **The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.**

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

3. **TB Skin Test (TST) and Interferon Gamma Release Assays (IGRA’s) for Employment, College or other non-mandated reasons**

   a. 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.

   b. TST’s and IGRA’s can be provided as a flat fee service as long as the client does not qualify as “free” per TB program guidelines because the TB program does not have a required sliding fee scale.

   c. If the only service that a client comes in for is a skin TST or IGRA 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 TST or IGRA, then that TST or IGRA should go under the program that the client is seen in. The basic rule is that the TST or IGRA was then related to the program that brought the client in and is determined by the purpose of the visit.
Miscellaneous Billing Guidance:
At the current time, Medicaid does not reimburse for any TB services provided in the home setting. These services are identified as “clinic based services” only.

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 STD or TB. 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.

2. 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 payors 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

Clinical Coverage Policy- Obstetrics 1E-5

Clinical Coverage Policy- Pregnancy Medical Home 1E-6

Fetal Surveillance 1E-4
1. Maternal Health (prenatal) clients may have health department prenatal services paid for in a variety of ways. Those include Medicaid, Medicaid for Pregnant Women (MPW), Presumptive Eligibility (PE), 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.

2. Medicaid for Pregnant Women
Female recipients of all ages with Medicaid for Pregnant Women (MPW) coverage are eligible for pregnancy-related antepartum, labor and delivery, and postpartum care as well as services for conditions that—in the judgment of their physician—may complicate pregnancy. The eligibility period for MPW coverage ends on the last day of the month in which the 60th postpartum day occurs. Not all clients will be eligible to receive MPW benefits; however, they may be eligible for Presumptive Eligibility (also a Medicaid program).

3. Presumptive Eligibility
Presumptive Eligibility (PE) allows for a pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid to receive ambulatory antepartum care, including pharmacy, laboratory, and diagnostic tests, while her eligibility status is being determined. Presumptive Eligibility extends from the date of approval through the end of the following month. For example, if a client applies for PE on 9/15/15 and is approved, they will be eligible through 10/31/15.

Presumptive eligibility should be completed as early as possible for all women with positive pregnancy tests. Applying for PE at the health department allows the client to attest to income. Language in the Maternal Health Agreement Addenda has been updated to include completion of presumptive eligibility determination early in pregnancy to ensure access to prenatal care services as soon as possible. Please see NCAPPHNA WHNC Fall 2015 Report excerpt below:

Presumptive Eligibility – 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 presumptive eligibility determination AND referral for Medicaid 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 their pregnancy. This is regardless of their 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 their pregnancy. The goal is to reduce this barrier to care for all pregnant women. Please make sure that completion of presumptive eligibility determination and referral for Medicaid eligibility determination is completed as early as possible for women accessing prenatal care services.

4. Third Party Insurance
Some health departments file third party insurance for many (if not all) of their services. This varies by health department and may depend on whether or not they participate (are in network) or do not participate with specific insurance carriers. Third party insurance is always billed at 100% of the charge, and any remaining balance (minus copays) is billed to the client based on where they fall on Sliding Fee Scale.

5. Self-Pay Clients
Clients who do not have Medicaid, Presumptive or third party insurance will have charges assessed based on their financial eligibility and where they fall on the Sliding Fee Scale.

6. Package vs Individual service billing
Health Departments that do not provide full scope OB care must bill for antepartum services using the following:

- **Antepartum Package Services codes:**
  - 59425 - Antepartum care only, 4-6 visits
  - 59426 - Antepartum care only, 7 or more visits.

- **Individual Antepartum Services**
  Individual antepartum services (use of E/M codes) are covered if
  - a. a pregnancy is high risk and requires more than the normal amount of services for a routine pregnancy, or
  - b. antepartum care is initiated less than three months before delivery, or
  - c. the recipient is seen by a provider between one (1) and three (3) office visits as specified in Clinical Coverage Policy- Obstetrics
As of 3/1/2012 self-pay clients seeking prenatal care from a LHD should be billed using the appropriate E/M codes and if applicable, the appropriate sliding fee. If the client receives “presumptive Medicaid coverage” for any period during the pregnancy, those visits and services that are covered by Medicaid cannot be billed to the client.

LHDs cannot bill the prenatal package for visits until the client delivers, transfers care to another provider or moves to outside the county of residence. For guidance on how to report each prenatal visit without billing, please contact your Regional Women’s Health Consultant.

If there was no pre-defined high-risk condition, then the termination of pregnancy date should be used as the end date/delivery date. This low risk pregnancy may be billed with a package code if four or more visits were completed before the termination. If less than four visits were provided an E&M code can be billed for each visit. If the client was previously diagnosed with a high risk condition this pregnancy all visits could be billed with E&M codes, provided the documentation supports high-risk status based on the diagnosis and more than normal number of visits for the client’s gestational age.

7. Pregnancy Medical Home (PMH) services are defined as managed care services to provide obstetric care to pregnant Medicaid beneficiaries with the goal of improving the quality of maternity care, improving birth outcomes, and providing continuity of care. Remember that PMH services need to be billed under the rendering provider identified on the CCNC contract.

8. Billing for PMH services:

**Incentive code S0280**: Providers shall bill this incentive code after the pregnancy risk screening tool has been completed.

**Incentive code S0281**: Providers shall bill this incentive code after the postpartum visit is completed. The provider billing S0281 must be the same provider that bills the postpartum visit. DMA will only pay this incentive if an OB package code that includes postpartum care,* is billed. **In order for providers to receive reimbursement for incentive code S0281, they must bill within 60 days of the date of delivery.**

OB package and global codes that include postpartum care are as follows:

- **59400** – Global fee-Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care;
- **59510** – Global fee-Routine obstetric care including antepartum care, cesarean delivery, and postpartum care;
- **59410** – Postpartum package-Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care;
- **59515** – Postpartum package- Cesarean delivery only; including postpartum care, or
- **59430** – Postpartum care only (separate procedure). *typically used by most health departments due to not providing delivery.*

**Billing Scenarios for Postpartum Care & PMH:**

1. Patient who received a bilateral tubal ligation at the time of delivery returns to the LHD within 60 days of delivery for her 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 Pregnancy Medical Home contract with Community Care of NC (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. Patient returns to LHD within 60 days of delivery for her postpartum visit. She needs to begin a contraceptive method and is seen in the Family Planning Clinic. Patient receives a Depo-Provera injection. LHD bills **59430** for the postpartum package, **S0281** for the PMH postpartum incentive with diagnosis code **Z39.2**. The depo injection **J1050 FP UD** billed with diagnosis **Z30.013** (initial injection) or **Z30.42** (surveillance of injection if the depo was provided at the hospital post-delivery).

3. Patient returns to LHD within 60 days of delivery for her postpartum visit. Patient 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:
   - “25” modifier cannot be used with the insertion code (58300) when 59430 is billed because 59430 is a package code.
   - The FP modifier must be used on the contraceptive device and insertion code 58300, if the LHD is using 340 B stock.
The provider must include an appropriate diagnosis code for the contraceptive method and method counseling.

LHD bills 59430 for the postpartum package and S0281 for the postpartum incentive with ICD-10 Z39.2. Also bill 58300 FP for the IUD insertion with ICD-10 of Z40.30 and the appropriate HCPCS code for the IUD. (J7300 FP UD for the ParaGard IUD, J7301 FP UD for the Skyla IUD, J7302 FP UD for the Mirena IUD).

**Postpartum Care Services:** Postpartum care services are covered through the end of the month in which the 60th postpartum day occurs based on DMA Clinical Coverage Policy 1E-5 “Obstetrics”

4. This is when MPW coverage ends. Beneficiaries in other categories of Medicaid coverage may still be able to receive postpartum follow-up care after the end of the month which the 60th postpartum day occurs.

5. Postpartum visit now = AED for “Be Smart”!

Patients who have their postpartum visit while insured under Medicaid for Pregnant Women (MPW) sometimes enroll in “Be Smart” Medicaid when their MPW expires. In the past these patients needed an annual exam appointment after their postpartum visit to meet “Be Smart” billing requirements. “Be Smart” claims require that the annual exam date (AED) be documented to be reimbursed for contraceptive and other services provided under this coverage.

6. Effective October 1, 2015, (per WH Consultants) DMA will now allow the CPT code 59430 (postpartum package code) to meet the annual exam date (AED) requirement for the “Be Smart” program. Providers can list the date of the postpartum visit as the AED on “Be Smart” claims. DMA will include this change in a pending Medicaid Bulletin article (not published as of 2/1/16).

For additional guidance, please see Pregnancy Medical Home Clinical Coverage Policy at http://www.ncdhhs.gov/dma/mp/1E6.pdf

Since it is not unusual for a maternity client to be seen by more than one provider during her pregnancy, each health department has to decide under which provider’s NPI to bill the global or package and write that decision into policy. A few examples would be billing the global or package code under:

- The initial provider seen by the client
- The last provider seen by the client
- The provider providing the PP visit
9. Billing Preventive & E/M visits to Medicaid on the same day:
   a) 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: A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial.*
   b) If a client is seen by a provider for STD 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 provider on the same day and it is not a duplicate billing.
   c) Billing STD services provided by the STD ERRN - The four (4) components of the STD exam do not have to be provided by the same STD ERRN to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals a full 15 mins.) of care provided.
   d) STD ERRN - must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.
   e) The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.
   f) TB nurse must bill TB services to Medicaid using T1002 and bill insurance using 99211 or T1002.

10. 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 Anderson, WCH Acting Section Chief).

11. Birthing Classes
   Refer to Birthing Classes-Clinical Coverage Policy 1M-2

12. Smoking and Tobacco Use Cessation and Counseling
   o The provider can bill CPT code 99406 if at least 3-10 minutes of counseling has been provided to the client.
   o The provider can bill CPT code 99407 if greater than 10 minutes of more intensive counseling has been provided to the client.
   o Note: Counseling cannot be billed if provided to the parent/guardian instead of the client.

For additional program guidance please contact your Regional Maternal Health Consultant or visit the program website at http://whb.ncpublichealth.com/

Family Planning

Clinical Coverage Policy- Family Planning/Be Smart 1E-7

1. General Tips regarding Family Planning Billing

a. Specific Criteria Covered by Medicaid FP, NCHC and “Be Smart”:
   Medicaid FP, NCHC 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:
   1. The “fitting” of diaphragms;
   2. Birth control pills;
   3. Intrauterine Devices (IUD’s) (including Mirena, Paragard, and Skyla);
   4. Contraceptive injections (including Depo-Provera);
   5. Implantable contraceptive devices (including Implanon and Nexplanon);
6. Contraceptive patch (including Ortho Evra);
7. Contraceptive ring (including Nuva Ring);
8. Emergency Contraception (including Plan B and Ella);
9. Screening, early detection and education for Sexually Transmitted Infections (STIs), including Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS);
10. Treatment for STIs; and
11. Lab services (refer to Attachment A, Section C, Item 1 of the Clinical Coverage Policy)

b. Sliding fees apply to all FP services according to Family Planning Program guidelines.
c. 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 private insurance.
d. 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.
e. DMA requires that the Annual Exam Date (AED) be placed in the “initial treatment date” area on the claim form for the initial annual exam and accompanying laboratory procedures and all inter-periodic visits, except pregnancy tests.

In an effort to ease the transition to the “Be Smart” program, prevent duplication of services and minimize the burden for Medicaid beneficiaries, the N.C. Division of Medical Assistance (DMA) is now allowing beneficiaries, transitioning to the “Be Smart” program from other Medicaid programs, to use the comprehensive annual, physical or postpartum exams received under these programs to meet the “Be Smart” annual exam requirement. To meet the comprehensive annual or physical exam requirement, the beneficiary is allowed one of the three options below:

1. Receive the MPW postpartum exam in the 365 days prior to enrollment as the required comprehensive annual or physical exam; or,
2. Receive the regular Medicaid comprehensive annual or physical exam in the 365 days prior to enrollment; or,
3. Receive the comprehensive annual or physical exam under the “Be Smart” program prior to receiving other “Be Smart” services.
The list of procedure codes that meet the comprehensive annual or physical exam requirement under the “Be Smart” Family Planning Medicaid 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.


Effective October 1, 2015, (per WH Consultants) DMA will now allow the CPT code 59430 (postpartum package code) to meet the annual exam date (AED) requirement for the “Be Smart” program. Providers can list the date from the postpartum visit as the AED on “Be Smart” claims. DMA will include this change in a pending Medicaid Bulletin article (not published as of 2/1/16)

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

b. 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.

c. 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 mid-level provider or a physician because the nurse is unavailable, that 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 provider. When a client presents for that same type visit and sees a mid-level provider, and it is noted in the history that the client is having severe headaches or other problems requiring the judgment of the mid-level or MD provider, then the visit should be billed at the appropriate higher level
d. Providers 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 BeSmart. Do not charge both an administration fee and an office visit for Depo-Provera. There are two ways to bill for Depo-Provera:
  - If you only administer Depo-Provera, you should bill J1050 FP UD, for Depo and the administration fee 96372 FP
  - If you evaluate and document the client condition, then you may bill the appropriate office visit code, based on documented components completed and J1050 FP UD, for Depo-Provera.

e. 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 provider. For example, Sue comes for her annual FP exam and the provider 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 provider who prescribed it and not the provider/nurse who gives it. This should remain constant until a new prescription is written (whether it is for Depo or a different method.)

f. Effective January 1, 2007, National Drug Codes (NDCs) must be used when billing/reporting HCPCS codes (drugs/medications i.e. Depo, Nexplanon, etc.) to Medicaid. Do not use NDC numbers when billing/reporting immunizations/vaccines. NDC numbers are specific to drugs/medications and do not apply to immunizations/vaccines. These are two different things. Note: National Drug Codes are a universal drug identification number. They identify the manufacturer of the drug and are assigned by the FDA.

g. It is recommended that the nurse/provider administering the drug be responsible for documentation of the NDC number required for billing purposes.

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

1. 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 provider, not just LHD providers) 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.
2. LHDs that bill for IUDs, Nexplanons, 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.

3. 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.

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.

We also realize that some health departments may need to create more than one price per CPT or HCPCS code. If that is the case, use the following procedure when billing through HIS. Health departments using other billing vendors should develop a similar process for use with that system.

1. Take all the affected CPT and HCPCS codes
2. Add a “letter” at the end of the code to indicate which payor that code should be with.
   For ex. J7307=Nexplanon
   - J7307ud = Medicaid - reflect only the acquisition/purchase cost
   - J7307P=Self pay – reflect the usual and customary (U&C) charge of the product
   - J7307C= Commercial insurance - reflect the usual and customary charge of the product
3. Explain in your local policy and procedure how you plan to bill for these services.
4. Obtain approval for all new and revised fees through the Board of Health and County Commissioners.
4. IUD CPT Code Changes

Effective January 1, 2016, CMS will discontinue use of the HCPCS code J7302 for 52mg levonorgestrel-releasing IUDs and begin using the following codes:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Long Description</th>
<th>Short Description</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7297</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration</td>
<td>Levonorgestrel iu 52mg 3 yr</td>
<td>Liletta®</td>
</tr>
<tr>
<td>J7298</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 5 year duration</td>
<td>Levonorgestrel iu 52mg 5 yr</td>
<td>Mirena®</td>
</tr>
</tbody>
</table>

- HCPCS codes for the 13.5mg levonorgestrel-releasing IUD (J7301) (brand name Skyla®) and the intrauterine copper contraceptive (J7300) (brand name ParaGard®) remain unchanged. Providers should consult all third-party payers to confirm specific coding requirements.

- Provider(s) shall follow applicable modifier guidelines. Family planning services must be billed with the appropriate code using the FP modifier (not just method related services). For guidance on billing Health Choice claims for FP services please see page 54, #10. It is allowable to append the FP modifier for all payor sources to be consistent and avoid confusion for staff even though it is not required for third party insurance.

- Agencies are encouraged to provide prescriptions for clients with Medicaid or insurance prescription coverage for oral contraceptives, Ortho Evra 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 DMA directly. See decision-making flow charts at the end of this document for additional guidance (Appendixes A and B).

- 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).
• Family planning diagnosis code must always be in the first position when billing for FP clinic services.

• The UD modifier indicates that the contraceptive was purchased through the 340B Drug Pricing Program.

Additional guidance can also be found in the following Physician’s Drug Program Clinical Coverage Policy under the reimbursement section:
http://www2.ncdhhs.gov/dma/mp/1B.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.

• 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; 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. 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. If the problem requires follow-up with another provider 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 & 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: A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial.
• If a client is seen by a provider for STD 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 provider on the same day, and it is not a duplicate billing.

• Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN in order to bill Medicaid for the provision of the STD service. This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016. The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.

• STD ERRN- must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.

• The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.

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

• 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 Anderson, WCH Acting Section Chief).

• Smoking and Tobacco Use Cessation and Counseling
  o The provider can bill CPT code 99406 if at least 3-10 minutes of counseling has been provided to the client.
  o The provider can bill CPT code 99407 if greater than 10 minutes of more intensive counseling has been provided to the client.
  o Note: Counseling cannot be billed if provided to the parent/guardian instead of the client.

• Pap Test Fee
  o If the client has insurance or 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. There would not be a claim filed with the insurance company by anyone in this case. The health department would be required to notify the client about this prior to services being rendered.
o **Do Not** charge clients with Medicaid for Pap test processing. The lab that performs & interprets the test is responsible for billing Medicaid directly.

o Health Departments should negotiate rates with their reference lab.

**BeSmart**

BeSmart providers can bill 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://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E-7.pdf).

1. **Annual Examination**
   An annual examination must be completed on all “Be Smart” program beneficiaries. **The annual examination must be performed for all beneficiaries prior to the rendering of any other family planning services.** However, for established patients, if emergent or urgent contraceptive services are needed, beneficiaries are allowed limited office visits prior to their annual examination. **BeSmart allows for one (1) annual exam/preventive visit per 365 days.**

2. **Six medically necessary inter-periodic visits are allowed per 365 calendar days under the “Be Smart” option.** 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. **The AED is required on all claims for inter-periodic visits with the exception of pregnancy tests.** 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://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1E-7.pdf). The primary purpose of the 6 inter-periodic visits is to provide contraceptive services which are why it is not recommended the health department use the 6 inter-periodic visits for STD services on a routine basis. It is recommended that the health department prioritizes method-related concerns for the six inter-periodic visits.

   The contraceptive method may necessitate an evaluation in FP clinic, so 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 patients on pills, patches and Depo may be sent to the STD clinic for complaints of discharge. If the six inter-periodic visits have been exhausted, and the patient returns to the FP clinic for a method related concern (not caused by an STD), then the health department can bill the patient on the SFS for those services.
Providers 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 BeSmart. Do not charge both an administration fee and an office visit for Depo-Provera. There are two ways to bill for Depo-Provera:

- If you only administer Depo-Provera, you should bill J1050 FP UD, for Depo and the administration fee 96372 FP

- If you evaluate and document the client’s condition, then you may bill the appropriate office visit code, based on documented components completed and J1050 FP UD, for Depo-Provera.

3. **Contraceptive Services, Supplies and Devices**
   a. **Emergency Contraceptives**
      Emergency contraceptives are a covered service. The appropriate office visit code may be billed separately.
   b. **Pharmaceutical Supplies**
      All eligible drugs for “Be Smart” Family Planning will have a family planning indicator (modifier) on the drug file (including birth control pills, Depo-Provera, Ortho Evra, Nuva Ring). The dispensing fee is based on regular Medicaid rules. **There is a 6 (six) prescription limit per month with no override capability.** Providers are not allowed to distribute “brand medically necessary” (DAW1) 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.
      **Note:** The AED is not required on “Be Smart” Family Planning program prescriptions.
   c. **Birth Control Pills**
      Birth control pills may be dispensed through a pharmacy. A beneficiary may receive up to a 3-month supply. When provided in by a clinic, the clinic provider may bill S4993.
   d. **Diaphragms**
      “Be Smart” Family Planning beneficiaries can choose a diaphragm as a birth control method. A provider can fit the patient and bill using the appropriate CPT code for diaphragm fitting. However, the program does not cover the actual diaphragm.
   e. **Injectable Drugs**
      Depo-Provera contraceptive injection is a covered service. Use the diagnosis code for contraceptive management. The appropriate office visit code may be billed separately.
f. **Intrauterine Devices (IUDs)**
   The codes for IUD insertion correspond to the specific intrauterine device (IUD). When billing for IUD insertion, CPT code 58300 is used. The CPT code for removal of IUD is 58301. Each of these codes includes an office visit.

g. **Implantable Devices**
   The “Be Smart” Family Planning program covers only the removal of Norplant. The global period for 11976 is one (1) pre-care day and ninety (90) post-operative days.

   Providers should not bill a separate inter-periodic office visit code for CPT codes 57170 (Diaphragm), 58300 (Insertion IUD), and 58301 (Removal of IUD); an office visit component is included in the reimbursement. CPT codes 57170, 58300, and 58301 are included in the six inter-periodic visit limitation.

   When diaphragm fitting, intrauterine device insertion, or removal of an intrauterine device occurs during an annual examination, providers must only bill the appropriate annual examination procedure code.

4. **Laboratory Procedures**
   The following laboratory procedures are only allowable for the “Be Smart” 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. Pregnancy tests and sexually transmitted infection/HIV screening can be performed during an annual examination visit and any of the six (6) inter-periodic visits allowed under the program.

   Urinalysis, Blood count, and Pap test may only be performed once during an annual or inter-periodic visit.

   a. **Pap Test**
      Providers 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 (BeSmart 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. Providers who do not perform the lab test should not bill the Pap tests. Only the provider who actually 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. Providers shall perform the repeat Pap test within 180 calendar days of the first Pap test. Providers shall include the ICD-10-CM diagnosis R87.615 as the secondary diagnosis on the appropriate claim.

5. HIV and Sexually Transmitted Infections Screenings
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.

a. HIV Screening
The “Be Smart” Family Planning program allows screening for HIV during the annual examination or the six inter-periodic visits allowed under the “Be Smart” program. This is a recommended screening and should be completed as necessary and appropriate. Providers must include the ICD-10-CM Diagnosis Z11.4 as the secondary diagnosis on the appropriate claim. Providers must include the Annual Exam Date on all claims submitted for “Be Smart” Family Planning services. The AED is the date of the annual examination.

b. STI Screening
A total of no more than six (6) STI screenings per 365 days are also covered under the “Be Smart” Family Planning program performed in conjunction with an annual examination or after an annual exam has been in paid history. Providers must include the AED on all claims submitted for “Be Smart” Family Planning services. The AED is the date of the annual examination.

6. Consultation for Sterilization
The “Be Smart” Family Planning program will cover consultation for a sterilization procedure. When a provider refers a beneficiary to another provider
for a sterilization procedure, then the provider performing the sterilization procedure must select one of the following codes when providing consultation to the beneficiary. **Beneficiaries are allowed two consultations for sterilization per lifetime.**

7. **Miscellaneous Billing Instructions**
   a. Inter-periodic & Non-biodegradable drug delivery Implant (i.e. Nexplanon): provider shall not bill a separate inter-periodic office visit code when billing for CPT codes 11981 (Insertion), 11982 (removal), 11983 (insertion & removal); an office visit component is included in the reimbursement for “Be Smart” beneficiaries. You may also be reimbursed for the device using the appropriate HCPCS code.
   b. Interperiodic & Diaphragm fitting: provider 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 “Be Smart” beneficiaries.
   c. Interperiodic & IUD: provider shall not bill a separate inter-periodic office visit code when billing for CPT codes, 58300 (IUD Insertion), or 58301 (IUD Removal); an office visit component is included in the reimbursement for “Be Smart” beneficiaries. You may also be reimbursed for the device using the appropriate HCPCS code.
   d. Annual exam & Non-biodegradable drug delivery Implant (i.e. Nexplanon): providers can be reimbursed for insertion, removal, and removal with reinsertion of implantable device in addition to the annual exam. You may also be reimbursed for the device using the appropriate HCPCS code.
   e. Annual exam & Diaphragm: providers must only bill the appropriate annual examination procedure code.
   f. Annual exam & IUD: providers must only bill the appropriate annual examination procedure code. You may also be reimbursed for the device using the appropriate HCPCS code.
   g. If a provider 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 **“Be Smart” program beneficiaries.**
   h. **Providers must include the AED on all claims for an annual examination and laboratory procedures, with the exception of the pregnancy test.**
   i. Postpartum visit now = AED for “Be Smart”: Patients who have their postpartum visit while insured under Medicaid for Pregnant Women
(MPW) sometimes enroll in “Be Smart” Medicaid when their MPW expires. In the past, these patients needed an annual exam appointment after their postpartum visit to meet “Be Smart” billing requirements. “Be Smart” claims require that the annual exam date (AED) be documented to be reimbursed for contraceptive and other services provided under this coverage.

j. To ease the transition to the “Be Smart” program, prevent duplication of services and minimize the burden for Medicaid beneficiaries, the N.C. Division of Medical Assistance (DMA) is now allowing beneficiaries transitioning to the “Be Smart” program from other Medicaid programs to use the comprehensive annual, physical or postpartum exams received under these programs to meet the “Be Smart” annual exam requirement. To meet the comprehensive annual or physical exam requirement, the beneficiary is allowed one of the three options below:

1. Receive the MPW postpartum exam in the 365 days prior to enrollment as the required comprehensive annual or physical exam; or,
2. Receive the regular Medicaid comprehensive annual or physical exam in the 365 days prior to enrollment; or,
3. Receive the comprehensive annual or physical exam under the “Be Smart” program prior to receiving other “Be Smart” services.

The list of procedure codes that meet the comprehensive annual or physical exam requirement under the “Be Smart” Family Planning Medicaid 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://ncdma.s3.amazonaws.com/s3fs-public/documents/files/Medicaid_Bulletin_2016_02.pdf

k. An ICD-10-CM diagnosis related to family planning services must be the primary diagnosis on the claim form.

8. Billing Preventive & E/M visits to Medicaid on the same day:
   a. 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: A Health Check screening assessment and an office visit cannot be paid initially on the same date of service. One claim will pay, and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial.*

b. If a client is seen by a provider for STD 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 provider** on the **same day** and it is not a duplicate billing.

c. Billing STD services provided by the STD ERRN-The four (4) components of the STD exam do not have to be provided by the same STD ERRN in order to bill Medicaid for the provision of the STD service. *This is a clarification in the Medicaid STD Clinical Service Policy, effective 3/30/2016.* The service can still be split across 2 different days and can be provided by a different STD ERRN on each day, billing T1002 per unit (equals 15 mins.) of care provided.

d. **STD ERRN**- **must bill T1002 for Medicaid clients and use 99211 or T1002 to bill insurance clients.**

e. **The non-STD ERRN may bill insurance using 99211 or T1002 for STD treatment only visits. Non-STD ERRNs may not bill a 99211 to Medicaid for STD treatment only visits.**

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

9. **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. 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. 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 HSIS Service Screen data field for “Be Smart” Family Planning 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 “Be Smart” Family Planning program.


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) AND the TJ modifier in the second modifier field (to match the Health Choice CPT and diagnosis codes). Please contact your CH or PHNPDU Nursing Consultants with questions related to this combined service.

**Note:** As of 7/25/16 we are aware that billing by the above guidelines will result in a denial of the service. However, this is the correct way to bill in these circumstances. You may continue to bill using both the FP and TJ, receive a denial and rebill- we have been told that this issue is on the NC Tracks list of edits that needs to be fixed. Or, you may choose to bill using just the TJ modifier and receive $90.00 reimbursement for the Health Choice exam.

For additional program guidance, please contact your Regional Women’s Health Consultant or visit the program website at [http://whb.ncpublichealth.com/](http://whb.ncpublichealth.com/)

**Pharmacy**

1. 340b Drugs

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

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

b. 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 provider, not just LHD providers) 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.

c. LHDs that bill for IUDs, Nexplanons, 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.

d. 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.

e. 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.

f. 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.

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

Additional guidance can also be found in the following Physician’s Drug Program Clinical Coverage policy under the reimbursement section: http://www2.ncdhhs.gov/dma/mp/1B.pdf.

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 provider performed microscopy procedure (PPMP), moderate & high complexity designations.

QW is used for waived tests, and you only have to 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.

1. 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 STD 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;
  - For all non-Medicaid, outside lab bills the LHD based on negotiated/contracted rate. The LHD may then bill the client at their fee based on SFS.
  - 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 STD 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.

- **Scenario C:**
If the SLPH doesn’t provide a specific test, insurance can be billed with the patient's consent and patients 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. If lab test requested under any WCH program, then the fee must slide.

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; or for any other reason when a normal, on-time, reportable result is all that is required. -e.g. Provider 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.

*As of the date of publication of this document Medicaid is not currently set up to reimburse using these modifiers. As soon as this is corrected you will be notified and we include the information in our quarterly updates to the Coding & Billing Guidance Document.

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.

3. **Venipuncture/Specimen Collection**
   a. The physician or lab shall bill directly for lab fees.
   b. The only fee that a physician may bill, if the physician sends the lab work to an independent lab, is for venipuncture collection 36415. 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.
   c. 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.
   d. The amount you bill the client for a CPT code for lab work done in your LHD 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.

4. **Handling Fee**
   Use CPT code 99000 for Handling, transfer and/or conveyance of specimen from the physician’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.
5. **Pap Test Fee**
   For non-Medicaid covered Pap tests that are sent to an outside lab for processing, the LHD may bill the appropriate CPT code with the 90 modifier and appropriate CPT Code (with HPV co-test) with the 90 modifier. **Do Not** charge for Pap test processing to clients with Medicaid. The lab that performs & interprets the test is responsible for billing Medicaid directly.

6. **Fern Test**
   a. The fern test is used for PROM (premature rupture of membranes) in a prenatal patient 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.
   b. 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.
   c. CMS categorizes the fern test as a provider 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 mid-level provider (and higher) can perform the test, **not** a lab tech or nurse.
   d. 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 patient as long as they are aware that they may be responsible for payment because it is a non-covered service.

   **For additional program guidance, please contact your Regional NC State Lab for Public Health Consultant or visit the program website at [http://slph.ncpublic.com/](http://slph.ncpublic.com/)**

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**Medical Nutrition Therapy (MNT)**

1. Dietary evaluation and counseling provided in public agencies, private agencies, clinics, physician or medical diagnostic clinics, and physician offices shall be performed by:
   a. Dietitian/Nutritionist, currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable); OR
   b. a registered dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

   It is the responsibility of the provider 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 provider agency.

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.

   1. 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.

   2. 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.

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

   4. Service Limitations
      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 provider. 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 provider.

   5. Medical Record Documentation
      Medical record documentation shall be maintained for each beneficiary, in the medical records of the beneficiary’s primary care provider for at least six (6) years, and shall include, at a minimum:
• The date of service.
• The presenting problem.
• A summary of the required nutrition service components.
• The signature of the qualified nutritionist providing the service.
• The beneficiary’s primary care or specialty care provider’s order for the service.

Billing Units
Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

1. CPT code 97802 MNT: initial assessment & intervention
   a. Each 15 minutes of service equals 1 billing unit.
      • Service is limited to a maximum of 4 units per date of service.
      • Service cannot exceed 4 units per 270 calendar days.

2. CPT code 97803 MNT: reassessment & intervention
   a. Each 15 minutes of service equals 1 billing unit.
      • Service is limited to a maximum of 4 units per date of service.
      • 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.

Local Use Codes

Local Use Codes (LU codes) are designated and controlled by The LTAT Branch Head. Additions to the LU codes list may be requested through by emailing
The current list is available on the HIS Library Website:

**Approved LU Codes**

https://wss01.dhhs.state.nc.us/sites/dhhs/DPH/HIS%20Library/Training%20System%20Manuals/LU%20Codes%20Revised%20Effective%205%201%2015.pdf

1. Local use codes - LU codes may be used to **report or bill** services that are NOT billable by a CPT or HCPCS code. These codes are **NOT** recognized by any third party payor source. They were established to provide a means for local agencies to account for time spent by the staff providing these services, to report locally defined services rendered, and to be able to charge flat or sliding fees directly to clients since the service is not billable to a third party payor source. Local codes may not be used to differentiate fees for the same service billed to clients versus those having a third party payor. Your fee for a service must be billed with the same code and same fee to everyone, **“Your charge is your charge”**.

2. Do **NOT** use any modifiers with the LU codes. This includes the Medicaid only EP and FP modifiers.

3. LU Codes that have historically been used to bill for limited physicals, nurse only visits or for other services that mirror a CPT definition have been retired. The decision to retire these codes was based on; increased liability for offering an abbreviated service, changes in best practice at the national level, standards of care and correct coding initiative requirements. Please visit the HIS web address above to view the retired codes.

4. New LU Codes for capturing non-billable ERRN services have been added to the LU code set. These codes are to be used to report the ERRN services when the visit results in a higher level provider seeing the patient. Example: STD ERRN provides an STD assessment and discovers an abnormal finding of rash. The ERRN calls in the provider who diagnoses the rash. The visit is now billed under the provider’s name and to give credit the ERRN for seeing the patient, an LU code is used to report the service provided by the ERRN.

5. If your system does not accommodate the use of the LU Codes, please consult your vendor for further guidance.
Adult Health

1. Procedures and E/M codes
When providing a procedure, you will bill the procedure code alone (i.e. colposcopy). 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
LHDs may perform pre-employment physicals provided they follow appropriate clinical and billing guidelines. The CPT code selected should best align with a complete adult physical and must be provided by a midlevel provider or physician. 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). The LHD is permitted to have a “flat fee” in an agreement with an organization that is different from the fee charged to individuals. You would still follow “your charge is your charge” mantra, but you can accept different levels of reimbursement.

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 patient 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 provider must submit a new claim for D0145 only.
Medicaid Specific Modifiers

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.
- **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 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 provider 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 patient’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 patient, on the same date by the same provider. Medicaid will not determine the major procedure for the provider. It is the provider’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.

- **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 provider 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.)

- **Modifier 59- Modifier 59 Guidance from Centers for Medicare and Medicaid Services (CMS) 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 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. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

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 provider 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.
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.

*As of the date of publication of this document Medicaid is not currently set up to reimburse using these modifiers. As soon as this is corrected you will be notified and we include the information in our quarterly updates to the Coding & Billing Guidance Document.

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.

**Consultation Codes:**

- The only 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 patient’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.
- DMA website should be reviewed regularly for monthly General Medicaid and Special Bulletins as well as Clinical Policy Manuals and Billing Guidelines [NC Division of Medical Assistance](https://dma.ncdhhs.gov/)
- Contact your program consultants or PHNPDU Nursing consultant for coding questions.

Contacts:

PHNPDU Nurse Consultants:
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LTAT Administrative Consultants:
Kathy Brooks: (336) 212-1678
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Phyllis Rocco, RN – Head, Public Health Nursing and Professional Development Unit (919) 707-5131

NCDPH Regional Nurse Consultant Directory [http://ncpublichealthnursing.org/phn_dirc.htm](http://ncpublichealthnursing.org/phn_dirc.htm)

Appendices

Appendix A Flow Chart for LHD Billing by Patient Types
(Oral Contraceptive Pills, Patch, Ring and Emergency Contraception)
1) H.D. bills financial source for labs, exam, visit, etc. (i.e., DMA/private insurance or self-pay on sliding fee scale) using appropriate ICD-10 codes with FP modifier.

2) Clients who have Medicaid and/or private insurance take prescription (not voucher) to pharmacy of their choice and that individual pharmacy will bill DMA/private 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 Patient Types
(Depo, IUDs: Mirena/Paragard and Implants: i.e. Nexplanon)
1) H.D. bills financial source for labs, exam, visit, etc. (i.e., DMA/private insurance or self-pay on sliding fee scale) using appropriate ICD-10 codes with FP modifier.

2) Clients who have Medicaid/FPW and/or private insurance receive method from H.D. 340B purchased inventory and H.D. bills using FP and UD modifiers to DMA (no UD modifier for private 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.
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 providers, health care facilities, and third party payors and enhances the health care provider’s control of the reimbursement process.
- **DMA** - Division of Medical Assistance
- **DPH** - Division of Public Health
- **DSM** - Diabetes Self-Management
- **E/M** - Evaluation & Management (CPT codes)
- **EP** - Modifier required on all Medicaid claims to identify services rendered to recipients under the age of 21
- **EPI** - Communicable Disease
- **ERRN** - Enhanced Role Registered Nurse - CHERRN: At the completion of the CHERRN program, Registered 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
STDERRN: At the completion of the STD Nurse Clinician Program, Registered Nurses will be able to independently:

- Perform and document an STD assessment.
- Identify and treat specified STDs by standardized protocols and standing orders.
- Develop a working knowledge of specimen collection and laboratory procedures as they relate to STD assessment and treatment.
- Provide STD patient education, risk reduction counseling and follow-up for STDs, utilizing a client-centered approach.
- Integrate STD risk assessment into the patient assessment process.

- **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

- **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

- **LU**- Local Use (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.

• **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 providers across the state. Participating health care providers 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/STD**- Sexually Transmitted Infections/Diseases- diagnosis and treatment of sexually transmitted diseases (STD) 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 providers.

- **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**

**Documentation**

Documentation Guidance from LTAT Branch Head

**Billing**

OPA- Title X Program Requirements April 2014

**Standing Orders**


www.ncpublichealthnursing.org

**PC/Primary Care**

(to be added)

**ICD Coding Resources**

http://publichealth.nc.gov/lhd/icd10/training.htm


http://www.roadto10.org/

**Child Health**

Health Check Billing Guide

http://www2.ncdhhs.gov/dph/wch/aboutus/childrenyouth.htm

**Medicaid**
**Immunization**
Health Check Bulletin


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

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

**Sexually Transmitted Diseases**
STD 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 1E-6

Fetal Surveillance 1E-4

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Birthing Classes-Clinical Coverage Policy 1M-2

http://whb.ncpublichealth.com/
Family Planning
Clinical Coverage Policy - Family Planning/Be Smart

Please refer to the February 2016 Medicaid Bulletin, page 16 for additional information.

http://www2.ncdhhs.gov/dma/mp/1B.pdf

Attachment A, C1 of the Clinical Coverage Policy

Clinical Coverage Policy - Attachment B, section B

http://whb.ncpublichealth.com/

Pharmacy
http://www2.ncdhhs.gov/dma/mp/1B.pdf

Laboratory
http://slph.ncpublic.com/

Medical Nutrition Therapy (MNT)
Clinical Coverage Policy - Dietary Evaluation & Counseling (MNT)

Local Use Codes (LU Codes)
phyllis.rocco@dhhs.nc.gov

Approved LU Codes

Medicaid Specific Modifiers
NC Division of Medical Assistance