Coding & Billing Guidance Document Review- Family Planning

Q&A November 15 & 16, 2017

1. If a client comes in for a FP service and receives immunizations, do you put a FP modifier on immunizations if the patient has Health Choice?
   Answer: No, you would not put the FP modifier on the immunization codes. See excerpt from the clinical coverage policy 1E-7, page 16, below:

   > Provider(s) shall follow applicable modifier guidelines. Family planning services must be billed with the appropriate code using the FP modifier. ~~. Modifier FP shall not be used on NCHC claims.~~ (this guidance has changed)
   >
   > All providers, except ambulatory surgical centers, must append modifier FP to the procedure code for family planning services. The UD modifier should be used if billing for 340b purchased products.
   >
   > 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.
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   > Excerpt from LTAT Administrative Consultant Winter Newsletter:
   > NCTracks has indicated that they will no longer require the TJ modifier for Health Choice Family Planning patients. The claims should only require an FP modifier and should pay at the usual rate instead of $90. We have not been able to verify that this fix is working properly. If you have examples of claims which paid correctly, please contact ann.moore@dhhs.nc.gov or your regional Administrative Consultant.
   >
   > Recommended billing guidance for NCHC visits in FP:
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   > - Bill the preventive or E&M visit code with the FP modifier. If immunizations are provided during the visit use the 25 modifier as the second modifier on the office visit.
   > - On the immunization administration code, 90471 or 90472, use the TJ modifier but do not use a modifier on the actual immunization.
   > - If a contraceptive is provided use the FP and UD modifiers.
   > - Labs are being paid with and without the FP modifier.

2. Is there a list of common STD services provided during a FP visit that should not be billed to the patient?
   Answer: No STD services covered under 10A NCAC 41A.0204(a) provided to a FP patient should be billed to that patient. Medicaid and third-party payers (with patient's permission) may be billed, but not the patient.

   10A NCAC 41A .0204 CONTROL MEASURES - SEXUALLY TRANSMITTED DISEASES

   (a) Local health departments shall provide diagnosis, testing, treatment, follow-up, and preventive services for syphilis, gonorrhea, chlamydia, nongonococcal urethritis, mucopurulent cervicitis, chancroid, lymphogranuloma venereum, and granuloma inguinale. These services shall be provided upon request and at no charge to the patient.

   One exception is diagnosis of and treatment for for genital warts, which may be billed either to regular Medicaid, private insurance, or to the patient via the Sliding Fee Scale.

3. Can Be Smart patient get a state supplied flu shot?
   Answer: Female patients with Be Smart may get a state supplied flu shot.

4. When citizens present to DSS, they are being referred for a "free" physical under Be Smart even if they have had their tubes tied. DSS is not allowed to ask questions to help screen out citizens that are not eligible. Is there anything being done about this?
   Answer: This is being addressed at the state level.

5. Has anyone had a problem with diagnosis code Z30.45 for patches?
   Answer: Buncombe County Stated they use Z30.49 and that pays.

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

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

6. Will Z30.017 Contraceptive Implant be added to the clinical coverage policy in the future?
   Answer: See number 5 above. Z30.017 is currently billable. If you have claims that are denied using this code, please submit a TCN (via encrypted email only) to Ann Moore at ann.moore@dhhs.nc.gov

7. Client has Medicare and Medicaid would we use 340B?
   Answer: yes

8. There was a question from Catawba regarding slide #10 and how to get the third-party insurance payment information to Medicaid without doing it manually.
   Answer: It is our understanding that both CureMD and Patagonia have a mechanism for crossover claims from private insurance to Medicaid. You may need to contact your vendor for instructions.

9. If a patient has a co-pay of $20.00 and you bill $100.00 to payer but only get $45.00, then does the patient only owe the $20.00?
   Answer: If your agency is "in-network," then the patient only owes the $20.00 co-pay. If the patient is out of network, the patient is charged for all services according to the SFS and no co-pay applies. Per Title X, the patient cannot be charged more in co-pays, deductibles, or co-insurance than they would owe if they did not have insurance and were paying based on the SFS. Therefore, the amount the patient would have been responsible for if they were self-pay must be calculated and compared to the co-pay or other charges not covered by insurance. The patient cannot be charged more than what he/she would have been responsible for on the SFS.

10. If a patient comes in and owes a co-pay, do they still only pay the lesser charges between the co-pay and the charge?
    Answer: If the patient has a co-pay, then they would pay the lesser of the two amounts (copay or SFS amount)

11. Would 340B be used for NC Health Choice?
    Answer: Any Family Planning client is entitled to received 340B drugs and devices. So a NCHC patient seen in Child Health clinic <u>is not</u> eligible for 340B methods, but a NCHC patient seen in Family Planning clinic, with the visit coded and billed to FP Program, <u>is</u> eligible for 340B. Please see details in number 13 below.

12. Does the guidance for the Annual exam and IUD insertion/removal apply to Nexplanon?
    Answer: Yes, it does. It refers to any covered contraceptive device..

13. What is the latest information regarding billing both Medicaid and Health Choice?
    Answer: Regarding billing 340B to NC Health Choice and Medicaid, The WH nurses identified on 11/15/17 that you bill both Medicaid and NCHC the acquisition cost.

    Under the Physicians' Drug Program DMA Clinic Policy 1B at https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1B.pdf it states the following:

    5.3.5 340-B Federal Drug Pricing Program – page 6

    The PDP reimburses for drugs billed to Medicaid and NCHC by 340-B participating providers who have registered with the Office of Pharmacy Affairs (OPA) at http://opanet.hrsa.gov/opa/CE/CEMedicaidextract.aspx. The 340-B federal pricing program provides access to reduced-price prescription drugs.

    H.2 340-B Drugs – page 9
    The PDP reimburses for drugs billed for Medicaid and NCHC beneficiaries by 340-B participating providers who have registered with the OPA at http://opanet.hrsa.gov/opa/CE/CEMedicaidextract.aspx. Providers billing for 340-B drugs shall bill the cost that is reflective of their acquisition cost. Providers shall indicate that a drug was purchased under a 340-B purchasing agreement by appending the "UD" modifier on the drug detail.

14. When a Be Smart patient has a Mirena inserted and the next week has another inserted due to the initial Mirena fell out, they billed for the 2nd insert & 2nd Mirena. The insertion was paid for & the Mirena itself was denied. Reason: 00069 – Denied due to not in accordance with medical policy guidelines. The code used to re-bill was z30.433. Just checking to see if we should be paid for the 2nd Mirena
    Answer: that the 2nd device would not be covered in this situation, because the 30-day rule applies. The 30-day rule does not apply when a contraceptive device has been in place for at least 30 days and is removed and replaced at the same visit. For clients for whom the IUD "falls out," the clinic should provide a bridge method of the patient's choice, then replace the IUD at least 30 days after the first IUD was inserted. Similarly, f clients wish to switch IUD brands within the first 30 days of IUD insertion, the provider should give the patient the option to either 1) remove the IUD today and use a bridge method until the next IUD can be inserted, or 2) leave the IUD in place until at least 30 days after insertion, and then have an IUD removal and new IUD insertion at the same visit.

15. Is it OK to still use 96372 for private insurance?

Answer: For Depo only visits, the agency may bill either 96372 or 99211. However, this must be consistently billed. If the patient is seen by the provider for a separately identifiable service, and the RN then administers Depo, it would only be appropriate to bill the 96372 for the Depo and append the 25 modifier to the E&M code for the provider visit.

16. Can a Positive pregnancy test be billed in the maternal health clinic?
    Answer:
    If the pregnancy test was performed in the FP clinic, but the result is positive, then the visit may be converted to a Maternal Health visit for billing purposes, provided agency policy/procedure/protocol supports this practice. Although FPW/Be smart will not pay for pregnancy testing services provided in the MH clinic, all payor sources must be billed in the MH clinic when the pregnancy test result is positive, if this is the agency's practice. In other words, an agency may not bill some positive pregnancy tests under the FP program and others under the MH program based on the patient's payor source. For self-pay patients, positive pregnancy test visits billed in the MH clinic must slide based on where the patient falls on SFS.

17. What type of visit is the pregnancy test done in the above question.
    Answer: The pregnancy test would need to be positive to bill in MH.As stated above, agency policy/procedure/protocol would need to direct that ALL positive pregnancy tests for clients who are seen for the purpose of pregnancy testing (i.e. a "Pregnancy Test Only" visit) are billed under the Maternal Health program. Pregnancy tests conducted in STD clinic for the purpose of determining appropriate care may <u>not</u> be billed to the patient regardless of it being negative or positive.

18. Question regarding return check fees. Can we send to the District Attorney?
    Answer: Title V or Title X funds may be used to cover return check fees. The uninsured/SFS Maternal Health patient or any FP patient should never be billed for returned check fees. Please see the April 26th 2017 memo from Kelly Kimple and refer to question 20, below. It is recommended that the patient not be billed.
    Memo from April 26th, 2017 will be added to the DPH/LHD website along with this Q&A document.

19. How do you set the acquisition price for 340B Nexplanon? Understanding that the price is subject to change at any time.
    Answer: Any birth control device (IUD or Implant) is subject to change. You can take an average cost from over 1 year to set acquisition cost.

20. For clarification, can we use the Title X funds to pay the county back when we have returned checks from patients?
    Answer: Yes, if it is for Family Planning you can. You may need to identify an internal code to keep track of these charges. You can then apply that number to cost of the returned checks and pay the county that amount. The uninsured/SFS Maternal Health patient or any FP patient should never be billed for returned check fees. Please see the April 26th 2017 memo from Kelly Kimple (posted on DPH/LHD website)

21. Should all services via FP program included an FP mod when billing Medicaid? If yes, even if the client is in FP program for postpartum visit being billed to MPW?
    Answer: Typically yes but there are some exceptions including immunizations and postpartum exams using the 59430 CPT code. In these cases you would not use the FP modifier. See additional details in question #1 above.