

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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**NC Medicaid
Tuberculosis Control and Treatment
Provided in Health Departments**

**Medicaid
Clinical Coverage Policy No: 1D-3
Amended Date: August 15, 2023**

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1.0 Description of the Procedure, Product, or Service

This service refers specifically to tuberculosis (TB) control and treatment in the local health department setting. Service includes medical history on initial visit, update of history on follow-up visits, diagnostic exam, which may include X-rays and laboratory tests, evaluation of current status, treatment for disease and/or prevention, and referral as appropriate.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*.
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply:

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover TB skin testing for job or college requirements.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid shall not require prior approval for tuberculosis control and treatment provided in health departments.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Limitations

There is a maximum of 4 units per day that may be covered for this service.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

The following providers in a local health department setting are eligible to perform this service:

- a. Physicians
- b. Nurse practitioners
- c. Physician assistants
- d. Clinical Pharmacist Practitioners (CPP)
- e. Public Health Nurses

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

| Date | Section Revised | Change |
|----------|--|--|
| 12/01/03 | Section 4.0 | The sentence “This service is not covered when the medical criteria listed in Section 3.0 are not met.” was added to this section. |
| 12/01/03 | Section 5.0 | The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage. |
| 12/01/03 | Section 6.0 | A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees. |
| 12/01/03 | Section 8.0 | Subsection numbers were added to the subsection titles. |
| 12/01/03 | Section 8.0 | Subsection 8.4, Reimbursement Rate, was added to the section. |
| 9/1/05 | Section 2.0 | A special provision related to EPSDT was added. |
| 9/1/05 | Section 8.0 | The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0. |
| 12/1/05 | Section 2.2 | The web address for DMA’s EDPST policy instructions was added to this section. |
| 12/1/06 | Sections 2 through 4 | A special provision related to EPSDT was added. |
| 5/1/07 | Sections 2 through 4 | EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age |
| 7/1/2010 | Throughout | Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.” |
| 11/30/10 | Sections 8.0 / 9.0 | Section 8.0 moved to Attachment A Section 9.0 re-numbered to Section 8.0 |
| 11/30/10 | Section 8.0 | EDPST corrected to EPSDT |
| 11/30/10 | Attachment A | EDS changed to DMA’s fiscal agent |
| 11/30/10 | Sections 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, 7.0, Attachment A | Added language and formatting to comply with standard DMA policy template |
| 3/1/2012 | Throughout | To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1D-3 under |

| Date | Section Revised | Change |
|-------------|------------------------------|--|
| | | Session Law 2011-145 § 10.41.(b) |
| 3/1/12 | Throughout | Technical changes to merge Medicaid and NCHC current coverage into one policy. |
| 10/01/2015 | All Sections and Attachments | Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable. |
| 08/01/2018 | Section 6.1 | Added Clinical Pharmacist Practitioners (CPP) |
| 03/15/2019 | Table of Contents | Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.” |
| 03/15/2019 | All Sections and Attachments | Updated policy template language. |
| 12/31/2019 | Table of Contents | Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.” |
| 12/31/2019 | Attachment A | Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”. |
| 8/15/2023 | All Sections and Attachments | Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023. |

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code

Public health nurses use HCPCS code T1002 - "RN services up to 15 minutes." This code is billable when all of the service components are provided. A maximum of 4 units per day may be billed.

Reimbursement for additional units is considered when documentation supports medical necessity. When additional units deny, request an adjustment using the Medicaid Claim Adjustment Request form and include the medical indication (allergic reaction to treatment, STD and TB visit for the same client on the same date of service, history of false positive complicating treatment, comorbid conditions) with documentation. A corrected claim should not be submitted. NC Medicaid's fiscal agent will perform the adjustment using the adjustment form and the original claim.

T1002 cannot be billed with a preventive medicine, prenatal or treatment code. When another health department provider sees the beneficiary on the same date of service for a separately identifiable medical condition, the health department may bill the appropriate E/M code. The diagnosis on the claim form must indicate the separately identifiable medical condition.

Bill laboratory codes for laboratory tests done on site.

All other providers billing for these services when provided in health departments must use appropriate E/M codes.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

A maximum of 4 units per day may be billed.

F. Place of Service

Health Department

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

Attachment B: Provider Requirements

A. Public Health Nurse

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.