Table of Contents

NC Division of Medical Assistance Core Services Provided in Federally Qualified Health Centers and Rural Health Clinics	Medicaid and Health Choice Clinical Coverage Policy No: 1D-4 Amended Date: February 1, 2018

Related Clinical Coverage Policies

Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:

1A-2, *Preventive Medicine Annual Health Assessment*

3A, *Home Health Services*

1.0 Description of the Procedure, Product, or Service

This policy describes the policies and procedures that are defined as core services provided in a federally qualified health center (FQHC) or a rural health clinic (RHC).

Note: Refer to **Subsection 5.6, Encounter Limits,** for additional information.

1.1 Federally Qualified Health Centers

Section 6404 of Public Law 101-239 (the Omnibus Budget Reconciliation Act of 1989) amended the Social Security Act effective April 1, 1990, to add Federally Qualified Health Center (FQHC) services to the Medicaid program. Implementation of this program with Medicaid began July 1, 1993. The FQHC law established a core set of health care services. Child health assistance in FQHCs is authorized for NC Health Choice beneficiaries in USC 1397jj(a)(5).

1.2 Rural Health Clinics

Congress passed Public Law 95-210, the Rural Health Clinic (RHC) Services Act, in December 1977. The Act authorized Medicare and Medicaid payments to certified rural health clinics for "physician services" and "physician-directed services" whether provided by a physician, physician assistant, nurse practitioner, or certified nurse midwife. The RHC Act established a core set of health care services. Child health assistance in RHCs is authorized for NC Health Choice beneficiaries in 42 USC 1397jj(a)(5).

1.3 Definition of a Core Service

The specific health care encounters that constitute a core service are documented in 42 CFR 405.2411, 42 CFR 405.2463, and 42 CFR 440.20 (b) and (c) and include the following face to face encounters:

a. physician services, and services and supplies incident to such services as would otherwise be covered if furnished by a physician or as incident to a physician's services, including drugs and biologicals that cannot be self administered;
b. services provided by physician assistants and incident services supplied;
c. nurse practitioners and incident services supplied;
d. nurse midwives and incident services supplied;
e. clinical psychologists and incident services supplied; and
f. clinical social workers and incident services supplied.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC 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.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>
None Apply.

b. <u>NCHC</u>
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: http://www.ncdhhs.gov/dma/epsdt/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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 and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC cover the following services in the FQHC and RHC settings:

a. physician services;
b. services and supplies incident to physician services (including drugs and biologicals that cannot be self administered);
c. physician assistant services and services and supplies incident to such services;
d. nurse practitioner services and services and supplies incident to such services;
e. nurse midwife services and services and supplies incident to such services;
f. clinical psychologist services and services and supplies incident to such services;
g. clinical social worker services and services and supplies incident to such services.
h. licensed psychological associate services and supplies incident to such services;
i. licensed professional counselor services and supplies incident to such services;
j. licensed marriage and family therapist and supplies incident to such services;
k. advance practice nurse specialist and supplies incident to such services;
l. clinical nurse specialist and supplies incident to such services; and
m. licensed clinical addiction specialist and supplies incident to such services.

3.2.2 Medicaid Additional Criteria Covered

FQHC and RHC core services are covered when Medicaid-covered services are furnished to Medicaid-enrolled beneficiaries at the clinic, skilled nursing facility, adult care home, other medical facility, or the beneficiary's place of residence by a staff member employed by an FQHC or RHC. Medicaid coverage includes the FQHC and RHC core services defined in 42 CFR 405.2412 through .2415 and 42 CFR 405.2446, .2450 and .2452.

3.2.3 NCHC Additional Criteria Covered

FQHC and RHC core services are covered when NCHC-covered services are furnished at the clinic, other medical facility, or the beneficiary's place of residence by a staff member employed by an FQHC or RHC. NCHC coverage includes the FQHC and RHC core services defined in 42 CFR 405.2412 through .2415 and 42 CFR 405.2446, .2450 and .2452.

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 and NCHC 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 both Medicaid and NCHC

The following services are not covered as core services, but may be separately reimbursable physicians' services. For coverage criteria for these services, refer to DMA's clinical coverage policy page, http://www.ncdhhs.gov/dma/mp/.

a. Health Check services and Heath Choice wellness exams including clinic visits for immunizations (refer to the most recent version of the Health Check Billing Guide at http://www.ncdhhs.gov/dma/healthcheck/) and NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
b. Delivery (Medicaid only)
c. Family planning services listed below:
    1. Depo-Provera when used for family planning;
    2. Norplant removal, including the clinic visit;
    3. Diaphragm fitting, including the cost of the device and the clinic visit;
    4. IUD insertion, including the cost of the device and the clinic visit;
    5. IUD removal, including the clinic visit; or
    6. Implantable contraceptive devices that are Medicaid approved (implant and supplies only, not procedures of insertion, removal, or removal with re-insertion).
d. Diagnostic laboratory services
e. Services provided to hospital patients (including emergency room services)
f. Durable medical equipment
g. Dental services
h. Other ambulatory physician services

i. On-site radiology services (the technical component only)
j. Physician Fluoride Varnish Program

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

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

Prior approval is not required.

5.2 Regulatory Requirements

FQHC and RHC providers shall comply with the federal regulations cited in 42 CFR 405, 42 CFR 440.20 (b) and (c), 42 CFR 491, and any other applicable state and federal laws and regulations.

5.3 Definition of a Core Visit

As defined by 42 CFR 405.2463, a core visit shall be a professional service that is rendered during a face-to-face encounter by a physician or other health professional listed in this policy. If the only services rendered during a visit are "incident to" services ordinarily performed by a nurse, technician, or office assistant (such as taking blood pressure and temperature, giving injections, or changing dressings), the visit does not constitute a core visit. This rule applies even when "incident to" services are performed by a physician, nurse practitioner, physician assistant, or other health professional.

The following services are also defined as core visit services and are billed as such:

a. Home health services provided in accordance with 42 CFR 405.2416 and 10A NCAC 250.0201. Home health services are subject to the requirements and limitations in Clinical Coverage Policy 3A, *Home Health Services* (http://www.ncdhhs.gov/dma/mp/).
b. Adult health assessments for Medicaid beneficiaries aged 21 years and older:

   An adult health assessment is a package of components, defined in 42 CFR 405.2448 that shall be provided at every annual screening. The only components that can be billed separately by FQHC and RHC providers are screening mammograms and

diagnostic laboratory components. Refer to Clinical Coverage Policy 1A-2, *Preventive Medicine Annual Health Assessment*, on DMA's Web site at http://www.ncdhhs.gov/dma/mp/. An immunization cannot be billed in conjunction with a core visit.

c. Family planning services;
d. Antepartum (prenatal) care and postpartum care for Medicaid beneficiaries;
e. Outpatient diabetes self management training for beneficiaries with diabetes;
f. Nebulizer treatments; or
g. Electrocardiograms (EKGs).

5.4 Components of a Core Visit

A core visit, as defined by CMS, includes any of the following components. If the encounter with a beneficiary is only for one of the services, the service is not separately billable as a core service or as a physician service:

a. drugs and biologicals that cannot be self-administered;
b. all injectable medications, including Depo-Provera if prescribed for purposes other than family planning (Depo-Provera injections used for family planning are not covered as a core service);
c. immunizations for recipients aged 21 years and older; or
d. smoking and tobacco use cessation counseling.

5.5 Service Limits

Medicaid and NCHC service limits are subject to prior approval requirements, service requirements, and limitations stated in applicable policies. Additionally, FQHCs and RHCs shall comply with the following:

a. Core visits for "other health" visit, such as behavioral health services by the clinical social worker (LCSW) clinical psychologist, licensed psychological associate (LPA), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), advance practice nurse practitioners certified in psychiatric nursing, advance practice psychiatric clinical nurse specialists (CNS), and licensed clinical addiction specialists (LCAS) are subject to the requirements and limitations specified in 42 CFR405.2450 ,405.2452 and 405.2463 (B) (3).

   Note: When working with dual eligible individuals (Medicare/Medicaid) only licensed clinical social workers (LCSW) and licensed psychologists (doctorate level) are recognized by Medicare.
b. The adult health assessment service is subject to the requirements and limitations specified in 42 CFR 405.2448 and in Clinical Coverage Policy 1A-2, *Preventive Medicine Annual Health Assessment* (http://www.ncdhhs.gov/dma/mp/).

5.6 Encounter Limits

As documented in 42 CFR 405.2463(b)(1)(2), core service encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same date of service and at a single location, constitute a single visit and are limited to one encounter per day, except when one of the following conditions exists:

a. After the first encounter, the beneficiary appears or presents with or suffers illness or injury requiring additional diagnosis or treatment; or

b. The beneficiary has a medical visit and an "other health" visit, such as a behavioral health visit. Core service visits for behavioral health are subject to the requirements and limitations specified in 42 CFR 405.2450 and 405.2452.

Note: Service is limited to a maximum of three encounters per day when the conditions of the above paragraphs are met. Written documentation shall be provided to justify more than three core visits billed on the same date of 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 or NCHC 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 General Requirements

As indicated in 42 CFR 491.3, FQHCs and RHCs shall be certified for participation with Medicare to qualify for participation with Medicaid and NCHC and shall be licensed pursuant to state and local laws as required by 42 CFR 491.4(a).

FQHCs and RHCs shall ensure that, as required by 42 CFR 491.4(b), staff are licensed, certified, or registered in accordance with state law.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries 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 DMA'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: August 1, 1998

Revision Information:

Date	Section Revised	Change
09/01/2009	Throughout	Initial promulgation of current coverage, with the following specific revisions.
09/01/2009	Section 1.0	Updated the definition of the service to reflect the allowance of a mental health visit on the same day as a core service without the submission of additional medical documentation with the claim.
09/01/2009	Section 5.3	Added information about billing for Implanon and its insertion, removal, or removal with re-insertion.
09/01/2009	Section 5.4	Deleted the reference to Clinical Coverage Policy 8A.
09/01/2009	Section 5.5	Deleted the reference to Clinical Coverage Policy 8A; changed the maximum allowable encounters per date of service from two to three.
09/01/2009	Attachment A	Added the modifiers HI (other health visits) and SC (visits which occur after the first encounter) which are required when billing for a core service visit; added information about billing for Implanon and its insertion, removal, or removal with re-insertion.
07/01/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administration oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
02/15/2011	Throughout	Updated standard DMA template language.
02/15/2011	Subsection 1.3	Definition converted to a list format.
02/15/2011	Attachment B.11	Clarification of reimbursement for current existing coverage for behavioral change intervention.
08/01/2011	Subsection 3.4.d	Deleted postpartum care
08/01/2011	Subsection 3.4.l	Deleted obstetrics services
08/01/2011	Subsection 5.3.c	Added the words “any one of”
08/01/2011	Subsection 5.3.d	Added postpartum care
08/01/2011	Subsection 5.4	Added the words “any of”
08/01/2011	Subsection 5.4.d	Deleted “and” Added “or”
08/01/2011	Subsection 5.6	Corrected citation to read, “As documented in 42 CFR 405.2463(b)(1)(2)”
08/01/2011	Attachment B	Moved “Billing Guidelines” from Attachment A to Attachment B
08/1/2011	Attachment B.10	Added information about antepartum and postpartum care as a core service and billing delivery or C-section only codes when billing for a delivery
11/02/2011	Subsection 3.2	Added information about the other health professionals that can provide core services
11/02/2011	Subsection 5.3	Deleted “Implanon” Added “implantable contraceptive devices that are Medicaid approved”

Date	Section Revised	Change
11/02/2011	Subsection 5.5	Added information about the other health professionals that can provide core visits for "other health" visit, such as behavioral health services
03/12/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1D-4 under Session Law 2011-145, § 10.41.(b)
09/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
09/01/2012	Section 1.0	Deleted "The N.C. Medicaid and N.C. Health Choice programs cover these services as a core service but also allows for "other health" visits, such as behavioral health services, to occur on the same day without the submission of additional documentation with the claim. **Note:** Prior to the implementation of mental health reforms, the N.C. Medicaid program allowed one core service visit per day. If an additional visit on the same day occurred, providers were asked to submit documentation supporting the necessity for the visit. In effect, this practice led RHCs and FQHCs to schedule appointments for their beneficiaries with behavioral health issues on subsequent days, which created a barrier to care and treatment. The implementation of mental health reforms in North Carolina has resulted in the recognition of needed changes to this practice and promotes the delivery of services to improve mental health."
09/01/2012	Section 1.1	Deleted "to which Medicaid beneficiaries are entitled. Medicaid and NCHC FQHC services are defined as either *core* or *other ambulatory* services"
09/01/2012	Section 1.1	Added "Child health assistance in FQHCs is authorized for NC Health Choice beneficiaries in 42 USC 1397jj(a)(5)."
09/01/2012	Section 1.2	Deleted "to which Medicaid beneficiaries are entitled. Medicaid and NCHC FQHC services are defined as either *core* or *other ambulatory* services"
09/01/2012	Section 1.2	Added "Child health assistance in RHCs is authorized for NC Health Choice beneficiaries in 42 USC 1397jj(a)(5)."
09/01/2012	Section 3.2	Deleted " FQHC and RHC core services include the following"
09/01/2012	Section 3.2	Added "Medicaid and NCHC cover the following services in the FQHC and RHC settings"
09/01/2012	Section 3.2.1	Deleted "to"

Date	Section Revised	Change
09/01/2012	Section 4.2	Added "and Health Choice wellness exams, and the Basic Medicaid and Health Choice Billing Guide at http://www.ncdhhs.gov/dma/basicmed/), Delivery (Medicaid only), c. Family planning services listed below: Norplant removal, including the clinic visit; Diaphragm fitting, including the cost of the device and the clinic visit; IUD insertion, including the cost of the device and the clinic visit; IUD removal, including the clinic visit; or Implantable contraceptive devices that are Medicaid approved (implant and supplies only, not procedures of insertion, removal, or removal with re-insertion).
09/01/2012	Section 4.3	Deleted "NCHC covers pills, IUD, implantable contraceptive devices that are Medicaid approved, Depo Provera and Ortho Evra"
09/01/2012	Section 5.1	Deleted "for Medicaid and NCHC beneficiaries"
09/01/2012	Section 5.3	Deleted "Components" and added "Definition" Deleted "not separately reimburseable and added "billed as such"
09/01/2012	Section 5.3.b	Added "for Medicaid beneficiaries aged 21 years and older"
09/01/2012	Section 5.3.c	Added "Family planning services"
09/01/2012	Section 5.3.d	Deleted "Immunizations and injectable medications for Medicaid beneficiaries aged 21 years and older"
09/01/2012	Section 5.3.b	Deleted "The immunization given during the core visit is reported without billing the administration fee, Family planning services, except any one of those listed below: Depo-Provera injections for contraception; Norplant removal, including the clinic visit; Diaphragm fitting, including the cost of the device and the clinic visit; IUD insertion, including the cost of the device and the clinic visit; IUD removal, including the clinic visit; or Implantable contraceptive devices that are Medicaid approved (implant and supplies only, not procedures of insertion, removal, or removal with re-insertion)."

Date	Section Revised	Change
09/01/2012	Section 5.4	**8.1 Added "Components of a Core Visit** A core visit, as defined by CMS, includes any of the following components. If the encounter with a beneficiary is only for one of the services, the service is not separately billable as a core service or as a physician service: a. drugs and biologicals that cannot be self-administered; b. all injectable medications, including Depo-Provera if prescribed for purposes other than family planning (Depo-Provera injections used for family planning are not covered as a core service); c. immunizations for recipients aged 21 years and older; or d. smoking and tobacco use cessation counseling.
09/01/2012	Section 5.4.b	Deleted "Annual visit limit does not apply to NCHC"
09/01/2012	Section 5.5.a	Added "clinical" Deleted "licensed and (doctorate level)'
09/01/2012	Section 6.1	Added "and NC Health Choice" Deleted "FQHCs and RHCs that meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for FQHC and RHC core services when the service is within the scope of their practice."
09/01/2012	Section 7.2	Deleted "Records Retention, as mandated by 42CFR 491.10, each FQHC and RHC shall maintain a clinical record system in accordance with written policies and procedures. The records shall be retained for at least six years from the date of the last entry. Copies of records shall be furnished upon request. The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502)."
09/01/2012	Section 8.0	Deleted "Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY." Added "Section 10.31(a) Transition of NC Health Choice Program administration oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services."

Date	Section Revised	Change
09/01/2012	Attachment A:C	Deleted "health check visit" and Added "child wellness exam" Added "For a NCHC child wellness exam (ages 6 through 18 years of age), FQHC and RHC bill under the FQHC and RHC provider number using the billing code that describes the service provided." Deleted "code T1015 and Added CPT codes 99381, 99382, 99391 and 99392"
09/01/2012	Attachment A:G	Added "for NCHC beneficiaries" Deleted "but co payments may apply to NCHC beneficiaries"
09/01/2012	Attachment A: F	Deleted "to" and added "in" Deleted "home" and added "facility" Added "or"
09/01/2012	Attachment B:7	Deleted "physician service"
09/01/2012	Attachment B: 8	Added "for family planning"
09/01/2012	Attachment B:9	Deleted "immunizations only or injections only" and Added "injections only or adult immunizations only" is not a core visit. Deleted "A clinic visit for injections only or adult immunizations only is not a core visit. Deleted "The FQHC or RHC shall maintain a record of the number of injections and shall not bill for a core visit."
09/01/2012	Attachment B:11	Deleted "Behavior Change Interventions, Individual service(s) that include smoking and tobacco use cessation counseling visit and alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services) are covered Medicaid services but are not separately billable as a core service or an ancillary service. The services must be rendered as a component of a primary core service visit." Added and Deleted "Procedure codes 99406- Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes and 99407- Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes are covered services but are not separately billable as a core service or an ancillary service. The services must be rendered as a component of a primary core service visit."
09/01/2012	Attachment B:12	Added "The services described by procedure code 99408 (alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes and procedure code 99409 (alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services (greater than 30 minutes) should be billed using T1015 with the HI modifier."

Date	Section Revised	Change
09/01/2012	all sections and attachment(s)	Replaced "recipient" with "beneficiary."
09/15/2012	Attachment B:2	Deleted "For an "other health" visit, such as a behavioral health visit, the medical director's NPI number is placed in block 33 of the CMS-1500 claim form."
09/15/2012	Attachment B:3	Deleted: "The NPI number of the medical provider rendering the service, or of the supervisory physician, shall be entered in block 33 of the CMS-1500 claim form. If an "other health" visit, such as a behavioral health visit, and a medical visit occur on the same day, the medical director's NPI number is placed in block 33 of the CMS 1500 claim form."
09/15/2012	Attachment B:2	Added: "The NPI number of the medical provider rendering the service, or of the supervisory physician, shall be entered in block 33 of the CMS-1500 claim form."
09/15/2012	Attachment B:3	Added: "For an "other health" visit, such as a behavioral health visit, the medical director's NPI number is placed in block 33 of the CMS-1500 claim form."
09/15/2012	Attachment B:4	Added: "If an "other health" visit, such as a behavioral health visit, and a medical visit occur on the same day, the medical director's NPI number is placed in block 33 of the CMS 1500 claim form."
09/15/2012	Attachment B:6	Added: "technical component of the"
10/15/2012	Subsection 4.3	Deleted "Note: Long-term care includes skilled nursing facilities and adult care homes."
10/15/2012	Attachment A, item F	Deleted "**Note:** NCHC does not provide services in an adult care home, long-term care facility, ICF or foster home."
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.
02/01/2018	Attachment B	Updated Billing Guide

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, 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.

For a medical visit, FQHC and RHC core services are billed under the FQHC and RHC provider number using the HCPCS code T1015 (clinic visit/encounter, all-inclusive).

For a child wellness exam, FQHC and RHC bill under the FQHC and RHC provider number using the billing code that describes the service provided.

For a NCHC child wellness exam (ages 6 through 18 years of age), FQHC and RHC bill under the FQHC and RHC provider number using the billing code that describes the service provided.

CPT Code(s)		
99381	99385	99393
99382	99391	99394
99383	99392	99395
99384		

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.

"Other health" visits, such as behavioral health visits, shall be billed with modifier HI.

Use modifier SC to bill non–behavioral health visits that occur after the first encounter in which the beneficiary appears with, presents with, or suffers illness or injury requiring additional diagnosis or treatment.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
One visit = one encounter.

F. Place of Service

Medicaid: Clinic, Skilled nursing facility, adult care home, beneficiary's home, school, other medical facilities

NCHC: Clinic, beneficiary's home, school, other medical facilities

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, see: http://www.ncdhhs.gov/dma/fee/

Attachment B: Billing Guidelines

1. Claims for core services are billed with the FQHC's or the RHC's NPI number.
2. The NPI number of the medical provider is not entered in block 33 of the CMS-1500 claim form, when billing a core visit or other health service core visit.
3. If an "other health" visit, such as a behavioral health visit, and a medical visit occur on the same day as a core visit., CMS clinic bills T1015 (HI) for the behavioral health visit and T1015 for the medical visit.
4. When an on-site radiology service and a core service are performed on the same date of service, the FQHC or RHC bills on two separate claims: the professional encounter is included under the T1015 and the technical component of the radiology service using the FQHC or RHC-rendering provider number.
5. Laboratory services furnished by the FQHC or RHC are not core services and are reimbursed based on the fee schedule allowable for the FQHC or RHC.
6. The insertion, removal, or removal with re-insertion of implantable contraceptive devices that are Medicaid approved is included in the core service and is not separately reimbursed to the FQHC or RHC. The drug itself is separately reimbursable.
7. An FQHC or RHC that is not enrolled in the pharmacy program bills Depo-Provera injections for family planning on the CMS-1500 claim form under the FQHC or RHC rendering provider NPI number.
8. Antepartum care and postpartum care are core services. They are not reported using the all-inclusive CPT obstetrics procedure codes that include antepartum and/or postpartum care. The number of antepartum (core service) visits is unlimited and is determined by the physician's assessment and documentation for medical necessity. When the FQHC or RHC provider performs the delivery, the FQHC or RHC bills the delivery only or C-Section only codes.
9. The services described by procedure code 99408 (alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services; 15-30 minutes and procedure code 99409 (alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST) and brief intervention (SBI) services (greater than 30 minutes) should be billed using T1015 with the HI modifier.