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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.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

#### **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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

*Basic Medicaid Billing Guide:* <http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

### 3.0 When the Procedure, Product, or Service Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

#### 3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are 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 recipient'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 recipient, the recipient's caretaker, or the provider.

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

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

#### **4.1 General Criteria**

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily 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**

- a. TB skin testing is not covered for job or college requirements.
- b. Services of an experimental nature or part of a clinical trial are not covered.

### **5.0 Requirements for and Limitations on Coverage**

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

#### **5.1 Prior Approval**

Prior approval is not required.

#### **5.2 Limitations**

Limitations are listed in **Attachment A: Claims-Related Information**.

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

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; 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

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

- a. Physicians
- b. Nurse practitioners
- c. Physician assistants
- d. Public health nurses (RNs) supervised by the public health nurse (RN) who is responsible for the TB Control Program and who has completed the *Introduction to Tuberculosis Management* course.

## 7.0 Additional Requirements

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

### 7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

### 7.2 Documentation Requirements

Documentation must include the following:

- a. Medical necessity
- b. All components of service
- c. Service time component.

## 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 recipients under 21 years of age
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

## **Attachment A: Claims-Related Information**

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

### **A. Claim Type**

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

### **B. Diagnosis Codes**

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

### **C. Procedure Code(s)**

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. DMA'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 recipient 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.

### **D. Modifiers**

Providers are required to 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**

Co-payments are required for Tuberculosis Control and Treatment Provided in Health Departments.

## **H. Reimbursement**

Providers must bill their usual and customary charges.