

## **Table of Contents**

1.0	Description of the Service.....	1
2.0	Eligible Recipients.....	1
2.1	General Provisions.....	1
2.2	EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age.....	1
3.0	When the Service Is Covered.....	2
3.1	General Criteria.....	2
4.0	When the Service Is Not Covered.....	2
4.1	General Criteria.....	2
4.2	Specific Exclusions.....	2
5.0	Requirements for and Limitations on Coverage.....	3
6.0	Providers Eligible to Bill for the Service.....	3
7.0	Additional Requirements.....	3
8.0	Billing Guidelines.....	3
8.1	Claim Type.....	3
8.2	Diagnosis Codes That Support Medical Necessity.....	3
8.3	Procedure Code(s).....	3
8.4	Reimbursement Rate.....	4
9.0	Policy Implementation/Revision Information.....	4

## **1.0 Description of the 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**

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/medbillcaguide.htm>

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

### 3.0 When the 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, see **Section 2.0** of this policy.

#### 3.1 General Criteria

Services are covered when they are medically necessary.

### 4.0 When the 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, see **Section 2.0** of this policy.

#### 4.1 General Criteria

This service is not covered when the medical criteria listed in **Section 3.0** are not met.

#### 4.2 Specific Exclusions

- 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

Limitations are listed in **Section 8.0**, Billing Guidelines.

## 6.0 Providers Eligible to Bill for the Service

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

Documentation must include the following:

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

## 8.0 Billing Guidelines

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

### 8.1 Claim Type

CMS-1500 (HCFA-1500)

### 8.2 Diagnosis Codes That Support Medical Necessity

Providers must bill the most specific diagnosis to support medical necessity.

### 8.3 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. EDS 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.

#### **8.4 Reimbursement Rate**

Providers must bill their usual and customary rates.

### **9.0 Policy Implementation/Revision Information**

**Original Effective Date:** October 1, 2002

**Revision Information:**

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
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