PREVENTIVE SERVICES AND CHRONIC DISEASE MANAGEMENT

Preventive care is a key component to member wellness. North Dakota Medicaid covers preventive services including many A and B grade recommendations from the United States Preventive Services Task Force (USPSTF), recommended immunizations by the Advisory Committee on Immunization Practices (ACIP), and Bright Futures/American Academy of Pediatrics (AAP) recommendations.

Preventive Services covered in this policy:

- Health Tracks/Well-Child Checks
- Adult Well Visits/Screenings
- Sports Physicals
- Standalone Immunization/Vaccine Counseling
- Diabetes Self-Management and Training Services
- Medical Nutrition Therapy
- Tobacco Cessation Counseling
- Preventive Medicine Counseling Risk Factor Reduction
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)

PREVENTIVE MEDICINE SERVICES

Staying current with recommended wellness visits is key to early prevention and treatment of health issues. Preventive medicine services are comprehensive and relate to the age of the patient.

Components of preventive medicine visits

- Comprehensive history and physical exam findings, and
- Age-appropriate
    - counseling/anticipatory guidance/risk factor reduction interventions,
    - screening labs,
    - and tests.

Preventive visits have no major complaint or illness as their focus. Providers should perform a comprehensive

- system review
- past, family, social history
- assessment
- history of pertinent risk factors.

These components differ from a problem-focused exam because they are based on the patient's age and risk factors.

A small or unimportant problem or abnormality that comes up during a preventive medicine evaluation and management (E/M) service should not be reported unless it requires:

- additional work and
- the performance of key components of a problem-oriented E/M service.

WELL CHILD VISITS

Well-child visits in North Dakota are included in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit known as Health Tracks. Recommended frequency of well-child visits are set using the Bright Futures Well Child Periodicity Schedule. The schedule includes descriptions of recommended age-appropriate components.

Recommended Health Tracks/EPSDT Periodicity Schedule:

Newborn	2 months	9 months	18 months	Age 3 through age 20, annually
3-5 days	4 months	12 months	24 months	
1 month	6 months	15 months	30 months	

Inter-periodic Visits

Inter-periodic checkups (check-ups outside the periodicity schedule) should be billed the same as a periodic check-up.

HEALTH TRACKS/WELL-CHILD CHECKS SERVICE REQUIREMENTS

The Health Tracks/Well-Child Checks benefit, using evidence-based screening tools, includes:

- Screening/Examination services:
  - Comprehensive health and developmental history including assessment of physical and mental health development, including substance misuse disorders (see Bright Futures Commonly Used Screening Tools).
  - Comprehensive unclothed physical exam,
  - Appropriate immunization – (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for vaccines),
  - Laboratory tests (including Lead Toxicity screening as appropriate for age and risk factors), and
  - Health education to both children and their caregivers.
- Vision, hearing, and dental screenings are considered part of a Health Tracks/Well-Child Check and cannot be billed separately.

See Health Tracks Early and Periodic Screening, Diagnostic and Treatment «policy» for more information about non-preventive services covered under the Health Tracks benefit.

These additional preventive services may be billed separately using the appropriate CPT code:

- Immunizations and administration (See Immunizations policy for which vaccines are at no cost as part of the Vaccines for Children Program).
- Fluoride Varnish, *See* Health Tracks / EPSDT policy for information on billing and coverage of fluoride treatment,
- Developmental Screenings. *See* Health Tracks / EPSDT policy for information on developmental screening and brief emotional/behavioral assessment which may be billed in conjunction with a preventive medicine service or EPSDT service,
- Maternal Depression Screenings. *See* Health Tracks / EPSDT policy for coverage of maternal depression screenings during a child's first year.

SPORTS PHYSICALS

Sports physicals should be coded as CPT® code 99429-unlisted preventive service along with ICD-10-CM code Z02.5. If a well-child visit and a sports physical occur at the same visit, the provider should bill the well-child visit only.

STAND-ALONE IMMUNIZATION/VACCINE COUNSELING

Stand-alone visits for vaccine counseling visits related to all pediatric vaccines for all members under the age of 21 are covered when provided by a qualified health professional. *See* the Immunizations «policy» more information.

WELL ADULT VISITS

Preventive Services

Preventive services performed at adult annual wellness visits vary based on the patient's age and risk factors. Visits may include:

Cancer

- Breast cancer screening (mammogram)
- Cervical cancer screening (women ages 21-65)
- Colorectal cancer screening (adults ages 45-75)
- Lung cancer screening (adults ages 50-80 with history of smoking)

- Skin cancer prevention

Chronic Conditions

- Abdominal aortic aneurysm screening (men 65-75 who have ever smoked)
- Depression screening and follow-up plan
- Hepatitis B infection screening (adults at risk of increased infection)
- Hepatitis C screening (adults ages 18-79)
- Hypertension/High blood pressure screening
- Latent Tuberculosis (TB) infection screening (adults at increased risk)
- Osteoporosis screening (women ages 65+, high risk women <60)
- Prediabetes and Type 2 Diabetes screening (adults 35-70 who are overweight or obese)
- Statin use for prevention of cardiovascular disease (adults ages 40-75)

Health Promotion

- Fall prevention in older adults (ages 65+)
- Healthful diet and physical activity for cardiovascular disease counseling
- Tobacco use cessation interventions
- Intimate partner violence screening and counseling
- Unhealthy drug and/or alcohol use screening and behavioral counseling interventions
- Screening for anxiety

Reproductive Health

- Chlamydia and Gonorrhea screening (sexually active women 24 and younger, older women at risk)
- Contraceptive services and counseling, including postpartum women
- Human immunodeficiency virus (HIV) screening (adults ages 21-65 and older others at increased risk)
- Sexually Transmitted Infections (STI) counseling (adults at high risk; all sexually active women)
- Syphilis screening (adults at increased risk)

Pregnancy

- Breastfeeding services and supplies
- Breastfeeding primary care interventions
- Folic acid supplement to prevent neural tube defects
- Healthy weight and weight gain in pregnancy, behavioral counseling interventions
- Interventions for tobacco smoking cessation

- Screenings
  - Asymptomatic bacteriuria
  - Depression
    - Maternal depression screening (CPT© code 96161) performed **in conjunction with** a child's Health Tracks screening, Well Child Visit, or any other pediatric visit, as a risk assessment for the child **anytime within the child's first year**.
  - Gestational diabetes and diabetes mellitus after pregnancy
  - Hepatitis B
  - HIV
  - Preeclampsia
  - Rh(D) incompatibility
  - Syphilis

Well-Woman Care

Recommendations for preventive health care screenings and services for well-woman visits can be found at the Women's Preventive Services Initiative (WPSI).

Coverage for Colorectal Cancer Screening Services

Description of Service	**Age, Frequency and Risk Criteria**
Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) 82270, 82272, 82274, or G0328	Ages 45 to 85; once every 12 months
Multi-target stool DNA test - Cologuard™ 81528 and G0464	Ages 45 to 85; once every 3 years for asymptomatic, average risk individuals
Screening Colonoscopy, Sigmoidoscopy or Barium Enema G0105, G0104 or G0120 45378, 45380, 45381, 45382, 45384, 45385, 45388, 45389, 45390, 45391, 45392, 45393, 45398	High-risk individuals*: No minimum age requirement; once every 24 months

Screening Colonoscopy, Sigmoidoscopy or Barium Enema G0121 or G0104 45378, 45380, 45381, 45382, 45384, 45385, 45388, 45389, 45390, 45391, 45392, 45393, 45398	Average risk individuals: ages 45 to 85; once every 10 years

Note to providers: If during a screening colonoscopy or sigmoidoscopy, a lesion/growth is detected which results in biopsy/removal of growth, the appropriate diagnostic procedure classified as colonoscopy with biopsy/removal should be billed rather than the screening procedure. Diagnostic and therapeutic colonoscopies are also covered by ND Medicaid.

If the results of a stool test are positive or abnormal, the member's follow-up colonoscopy is part of the screening process and not a diagnostic procedure.

*According to the Centers for Medicare and Medicaid Services, a patient is high-risk for colorectal cancer if they have any of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of adenomatous polyps; or
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

BILLING GUIDELINES

Provider Type	Revenue Code	Procedure Code
FQHC	0521	9938x / 9939x
RHC	0521	9938x / 9939x
IHS	0519	9938x/9939x
LPHU	N/A	
All other providers	N/A	9938x / 9939x

Per CPT® "If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99202-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

The provider's electronic signature on the claim is the attestation of the medical necessity of both services, including an assurance that the following requirements are met.

Requirements for providing Preventive and Focused Problem (E/M) care same day:

- Provider documentation must support billing of both services. Providers must create separate notes for each service rendered in order to document medical necessity.
- In deciding on appropriate E/M level of service rendered, only activity performed "above and beyond" that already performed during a Health Tracks/adult wellness visit is to be used to calculate the additional level of E/M service. If any portion of the history or exam was performed to satisfy the preventive service, that same portion of work should not be used to calculate the additional level of E/M service.
- All elements supporting the additional E/M service must be apparent to an outside reader/reviewer.
- The note documenting the focused (E/M) encounter should contain a separate history of present illness (HPI) paragraph that clearly describes the specific condition requiring evaluation and management.
- The documentation must clearly list in the assessment the acute/chronic condition(s) being managed at the time of the encounter.

LIMITATIONS

- ND Medicaid will not reimburse HCPCS code S0302 – EPSDT screening and CPT code 9938x/9939x – Preventive Medicine Services on the same date of service.
- Adult wellness screenings are limited to one per calendar year.

DIABETES SELF-MANAGEMENT AND TRAINING (DSMT) SERVICES

Diabetes self-management and training (DSMT) services may be provided by pharmacists, and licensed registered dieticians and registered nurses with diabetic educator credentialing.

BILLING GUIDELINES

G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes.

G0109 – Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Diabetic educator credentialed registered nurses are not ND Medicaid-enrollable providers for these services. This service is billed incident-to the licensed supervising practitioner.

MEDICAL NUTRITION THERAPY

Medical nutrition therapy consists of counseling for individuals in relation to the nutritive and metabolic processes of the body. Medical nutrition therapy may be provided by Medicaid-enrolled licensed registered dieticians. If a licensed registered dietitian does not enroll with ND Medicaid, they may provide medical nutrition therapy under the supervision of a practitioner enrolled with ND Medicaid. Licensed registered dietitians rendering medical nutrition therapy under the supervision of a practitioner must follow “incident to” requirements.

COVERAGE LIMITATIONS

To receive payment, a licensed registered dietician must enroll as an independent Medicaid provider or be part of a clinic or FQHC.

Nutritional services are allowed up to four (4) hours per calendar year without service authorization. Additional services may be authorized if determined to be medically necessary.

COVERED SERVICES

HCPCS/ CPT Code	Description
G0270	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face w/ patient, each 15 minutes
97804	Medical nutrition therapy, group (2 or more individuals), each 30 minutes

NONCOVERED SERVICES

- Exercise classes
- Nutritional supplements for the purpose of weight reduction

Instructional materials and books

TOBACCO CESSATION COUNSELING

Tobacco cessation counseling is covered for all North Dakota Medicaid members.

SERVICE REQUIREMENTS

Counseling must be provided face-to-face by or under the supervision of a physician or other health care professional who is

- legally authorized to furnish such services under state law within their scope of practice, and
- enrolled as a ND Medicaid provider.

CPT© Code: 99406 – Smoking and tobacco cessation counseling visit; intermediate, greater than three minutes up to 10 minutes.

CPT© Code: 99407 - Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes.

PREVENTIVE MEDICINE COUNSELING RISK FACTOR REDUCTION

Counseling risk factor reduction services are for the purpose of promoting health and preventing illness or injury.

COVERED SERVICES & LIMITS

Preventive medicine counseling risk factor reduction services are face-to-face, time-based, and separate from E/M services. These are separate visits from preventive medicine visits (CPT® 99381-99397) which include counseling, anticipatory guidance, and risk-factor reduction interventions.

Prevention medicine counseling risk factor reduction services are for people without specific illnesses where the counseling might otherwise be part of the treatment.

Preventive medicine counseling and risk factor reduction interventions provided outside of a preventive medicine visit to promote health and illness/injury prevention may be reported using the codes in this policy. Services will vary with age and patient circumstances such as: family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory results available at the time of the encounter.

The following types of counseling and risk factor reductions are covered:

- Prevention of cavities in children younger than 5
- Healthy weight and weight gain in pregnancy
- Healthy diet and physical activity for cardiovascular disease prevention in adults with risk factors
- Sexually transmitted infections for adolescents and adults
- Tobacco use in adolescents and children
- BRCA-related cancer, risk assessment
- Perinatal depression
- Weight loss to prevent obesity and related morbidity and mortality in adults
- Falls prevention in community-dwelling older adults
- Skin cancer prevention – all ages
- Obesity in children and adolescents
- Breastfeeding

TELEHEALTH

Preventive medicine counseling and risk factor reduction may be rendered via telehealth. See Telehealth policy for telehealth requirements.

NONCOVERED SERVICES

- Cannot be billed as part of a preventive medicine visit (CPT® 99381-99395)
- Services lasting less than 8 minutes

BILLING AND REIMBURSEMENT

99401	15 minutes
99402	30 minutes

E/M services may be reported separately with a 25 modifier when performed with preventive medicine counseling risk factor reduction services.

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is meant to prevent or reduce substance use through early intervention. This can prevent health-related consequences, diseases, accidents, and injuries related to substance use. SBIRT is an evidence-based, early intervention for people with substance use disorders and those at risk of developing those disorders.

COVERED SERVICES & LIMITS

Pre-Screening patients for substance use should occur as part of preventive and E/M visits. **This screening is not separately billable but must precede SBIRT services**. Screen all patients using this Brief Health Screen and follow the interpretation instructions. Patients with answers of "yes" or "1 or more" should receive full screens using validated, approved screening instruments listed in this policy.

SBIRT Components

SBIRT has three parts:

1) Screening
   To assess a patient for risky substance use behaviors with standardized assessment tools. This shows a patient's substance use severity and identifies the appropriate treatment level.
2) Brief intervention
   This allows a patient to be more aware and understanding of their substance use and motivates behavioral change. It is a short conversation between patient and provider to increase the patient's awareness of risky substance use behaviors. The provider gives feedback, motivation, and advice.
3) Referral to treatment
   Refer patients who screen as needing additional services to brief therapy or specialty care treatment.

Approved SBIRT screening tools:

- World Health Organization's (WHO) Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)
- Opioid Risk Tool – OUD (ORT-OUD)

Tools specifically for Youth

- Screening to Brief Intervention (S2BI)
- Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD)
- CRAFFT (ages 12-21)

Resource: SBIRT Toolkit (SBIRT (Early Intervention) | Health and Human Services North Dakota)

SBIRT Providers and Training

Providers must be trained and qualified to render SBIRT services within their scope of practice. Providers can complete an online SBIRT training if they have not received training on SBIRT.

Services may be rendered by health care professionals supervised by one of the below-listed licensed practitioners if trained and qualified to render SBIRT services within the scope of practice applicable to their profession, while following all applicable laws, rules, and board of practice regulations. Services must be billed by physicians, dentists, or providers considered Other Licensed Practitioners (currently LCSWs, LPCCs, LPCs, LMFTs, LACs, Licensed Psychologists, Nurse Practitioners, Physicians Assistants, and Clinical Nurse Specialists).

Limits

Members are limited to 4 SBIRTs per calendar year. Medically necessary SBIRTs beyond this limit require service authorizations.

Screening and counseling services are included in the comprehensive nature of preventive medicine visits (CPT® 99381-99397) and will not be separately reimbursed.

SERVICE AUTHORIZATION

Service authorization is required for SBIRTs exceeding the 4 per calendar year limit.

TELEHEALTH

SBIRT may be rendered via telehealth if providers document member pre-screening and the member's score which indicates the need for a full screen. Providers must also document the member's standardized assessment score. See Telehealth policy for telehealth requirements.

NON-COVERED SERVICES

- Pre-screens conducted as a part of preventive and E/M visits are not separately billable.
- SBIRT services lasting less than 15 minutes are not separately billable.

DOCUMENTATION REQUIREMENTS

Documentation must include:

- Screening instrument used and screening results;
- Brief intervention delivered; and
- Referral for further treatment if appropriate.

Documentation must support the time spent on this service, either the start and stop time or total time spent with the member.

BILLING AND REIMBURSEMENT

99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

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SBIRT is not a separately reimbursable service outside the all-inclusive rate/encounter rate.»

RELATED POLICIES:

Health Tracks
Immunizations
Telehealth

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