

Update to “Tuberculosis Clinic Benefit Criteria to Change for Texas Medicaid”

Information posted September 4, 2009

This is an update to an article that was published on this website on August 7, 2009, titled “Tuberculosis Clinic Benefit Criteria to Change for Texas Medicaid.” Procedure code 99211 has been removed from the table of codes that must be billed within the 90 days immediately preceding the date directly observed therapy (procedure code H0033) is performed. Also, procedure code H0033 has been removed from the table of codes that must be billed on the same date of service as procedure code 99001. The complete, updated article is as follows:

Effective for dates of service on or after September 1, 2009, benefit criteria for tuberculosis clinics will change for Texas Medicaid.

Tuberculosis (TB) clinics must be enrolled in Texas Medicaid and provide services in accordance with Title 1, *Texas Administrative Code* (TAC), §354.1371. Per Texas Department of State Health Services (DSHS) policy, TB clinics must develop and operate under a set of written policies and procedures that specify the criteria for licensed and non-licensed staff to provide services. The policies and procedures must include the following:

- The personnel file requirements for staff who provide directly observed therapy (DOT).
- The training and supervision that are required for outreach workers to be considered qualified to perform the assigned services.
- The written delegation protocol for services that are not performed by a physician, advanced practice nurse (APN), or physician assistant (PA).
- The documentation that is required for all client encounters.

Physician Evaluation and Management (E/M) Visits

The following services will be a benefit for TB clinics when they are performed by a physician, APN, or PA in the clinic:

Procedure Code	Client Age Range	Reimbursement Rate
99201	Birth through 20 years of age	\$28.87
99201	21 years of age or older	\$26.04
99202	Birth through 20 years of age	\$45.56
99202	21 years of age or older	\$41.09
99203	Birth through 20 years of age	\$61.56
99203	21 years of age or older	\$55.52

Procedure Code	Client Age Range	Reimbursement Rate
99204	Birth through 20 years of age	\$90.07
99204	21 years of age or older	\$81.24
99205	Birth through 20 years of age	\$111.98
99205	21 years of age or older	\$101.00
99211	Birth through 20 years of age	\$14.96
99211	21 years of age or older	\$13.49
99212	Birth through 20 years of age	\$25.04
99212	21 years of age or older	\$22.59
99213	Birth through 20 years of age	\$37.64
99213	21 years of age or older	\$33.95
99214	Birth through 20 years of age	\$52.86
99214	21 years of age or older	\$47.68
99215	Birth through 20 years of age	\$81.38
99215	21 years of age or older	\$73.40

A physician's presence is not required to perform services covered by procedure code 99211; however, the physician must provide direct supervision, i.e., the physician must be present in the clinic and immediately available to furnish assistance and direction at the time service is provided.

Clients with latent TB infection (including those in a high-risk group) and those with active TB disease must be seen by a physician every 90 days throughout the course of treatment. A physician must evaluate each client with active or latent TB disease before the client is discharged from TB treatment.

A new patient examination will be limited to clients who have not received services in the same TB clinic within the prior 36 months. Only one physician evaluation/management (E/M) visit will be paid per day, per client, per provider.

Non-Physician Services

The following non-physician services may be provided under established clinic protocols.

Initial TB Screening

The initial TB screening will be a benefit when the screening is performed by a registered nurse (RN) or licensed practical nurse/licensed vocational nurse (LPN/LVN) in

the clinic. TB clinics should use procedure code T1023 to submit claims for initial TB screening. Procedure code T1023 may be reimbursed as follows:

Procedure Code	Reimbursement Rate
T1023	\$90.96

This initial screening includes, but is not limited to, the following:

- Brief mental and physical assessment
- Exposure history
- Referral for lab or X-ray
- Referral for social or other medical services
- Other assessment

Before TB treatment can begin, either an initial TB screening (procedure code T1023) or new patient examination (procedure code 99201, 99202, 99203, 99204, or 99205) must be performed. If treatment is initiated based on the initial TB screening, a new patient examination must be performed by a physician within 90 days of the date of service for the initial TB screening, or subsequent DOT will be denied.

Procedure code T1023 will be limited to one per rolling year, any provider, and will be denied if billed on the same date of service by any provider as a physician E/M procedure code.

Subsequent Nursing Services

Subsequent nursing services will be a benefit when performed by an RN or LPN/LVN in the clinic, home, or other setting. TB clinics should use procedure code T1002 or T1003 to submit claims for these services. Procedure codes T1002 and T1003 will be denied if billed on the same date of service by any provider as a physician E/M procedure code:

Procedure codes T1002 and T1003 will be limited to a combined maximum of eight 15-minute units per day, per client. Billing units will be determined as follows:

- Minutes of nursing services may only be billed per calendar day and cannot be accumulated over multiple days.
- A minimum of 8 minutes is required for one unit of service to be billed. If the total number of minutes is less than 8, a unit of service cannot be billed.
- If more than one unit of service is billed, every unit except the last one must be for the full 15 minutes. The last unit must still meet the minimum 8-minute requirement.
- Time spent in contact investigations will not be reimbursed.

Procedure codes T1002 and T1003 may be reimbursed for each 15-minute unit as follows:

Procedure Code	Reimbursement Rate
T1002	\$12.97
T1003	\$9.05

Procedure codes T1002 and T1003 will be denied if billed on the same date of service by any provider as procedure code T1023.

Procedure code T1003 will be denied if billed on the same date of service by any provider as procedure code T1002.

Directly Observed Therapy (DOT)

DOT will be a benefit when performed in the clinic (place of service [POS] 1), home (POS 2), or other setting (POS 9). TB clinics should use procedure code H0033 to submit claims for DOT. Procedure code H0033 may be reimbursed as follows:

Procedure Code	Place of Service	Reimbursement Rate
H0033	Clinic (POS 1)	\$5.44
H0033	Home (POS 2), Other (POS 9)	\$24.00

Procedure code H0033 will be denied if it is billed on the same date of service by any provider as the following procedure codes:

Procedure Codes				
99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
T1002	T1003	T1023		

DOT will be denied if one of the following procedure codes has not been billed by any provider within the 90 days immediately preceding the date DOT is performed:

Procedure Codes				
99201	99202	99203	99204	99205
99212	99213	99214	99215	T1023

Throughout the course of treatment, an examination must be performed by a physician every 90 days, or subsequent DOT will be denied.

Procedure code H0033 will be limited to one per day, with a maximum of five per week, per client, any provider.

Ancillary Services

Radiology

Procedure codes 71010, 71020, 71021, 71022, 71030, and 71035 will be a benefit for TB clinics when they are performed in the clinic.

Laboratory

Procedure codes 81025, 86580, 86701, 86703, 89220, and 99001 will be a benefit for TB clinics when they are performed in the clinic. TB clinics must bill procedure codes

86701 and 86703 with modifier QW as a *Clinical Laboratory Improvement Amendments (CLIA)*-waived test.

Procedure code 99001 may be reimbursed only when billed on the same date of service as one of the following procedure codes:

Procedure Codes				
99201	99202	99203	99204	99205
99211	99212	99213	99214	99215
T1002	T1003	T1023		

Intravenous (IV) Infusion

Procedure codes 96365, 96366, 96367, 96368, 96374, and 96375 will be a benefit for TB clinics when they are performed in the clinic.

Drugs

Procedure codes J0278, J1840, J1956, J2020, J2280, and J3000 will be a benefit for TB clinics when they are performed in the clinic. Procedure codes J2020 and J2280 will be new benefits for Texas Medicaid and may be reimbursed as follows:

Procedure Code	Reimbursement Rate
J2020	\$30.23
J2280	\$2.81

Injectable medications that also have an oral formulation (procedure codes J2020, J2280, and J3000) must be billed with modifier KX to indicate the oral formulation is not appropriate for the client.

TB clinics may bill Texas Medicaid only for drugs that were purchased. If the clinic receives free drugs from DSHS or another source, the clinic may not bill Texas Medicaid for those drugs. All medication claims will be subject to retrospective review.

For more information, call the TMHP Contact Center at 1-800-925-9126.