DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

CLINIC PROVIDER SPECIFIC POLICY MANUAL

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	Clinic Provider Specific Policy Manual **Revision Table**

Revision Date	Sections Revised	Description
1/1/02	TOC, 3.1.1.1, 4.6, 6.9, 6.1, 10.17	School-based Wellness Center services were provided in an educational setting, but coverage was not added to the Clinic Provider Manual. Family and Children Services section is being deleted because it is not applicable to this manual.
1/1/04	10.9, 10.12	During the process of crosswalking local codes to existing HCPCS codes DMAP assigned two proposed codes for DPH clinic to use when billing for services. However, CMS did not approve the codes assigned (S4516-Multli-disciplinary assessment/evaluation and S4518-Environmental lead testing). Therefore, it is necessary for DMAP to crosswalk previously assigned code to existing HCPCS codes. The newly assigned codes are to be used when billing for dates of service on and after 1/1/04.
4/1/04	10.16	Local codes are being removed from the chart. The billable codes for Mental Health Clinics are expanded to include 90804-90809 and guidelines for billing have been added.
8/19/04	4.1.6, 4.2.3, 4.3.5, 4.4.3, 4.5.4, 4.8.3, 4.9.6, 4.10.3, 4.11.6, 5.1.2, 7.1.2, 8.1.3, 9.0 and 10.0	Revision: The entire Appendix A (Sections 9.0-9.16) is removed. This Appendix contained local codes used by providers to bill DMAP for dates of service prior to 7/1/02. Local codes are no longer used for billing and therefore not needed. Throughout the manual, references to Appendix A are being removed. In Appendix B (Sections 10.0-10.17) the column where the local code appears is being removed.
12/20/05	10.0 Appendix B – HCPCS Procedure Codes, subsection 10.3 Tuberculosis Clinical Service	Revised description of code 86580 and revised description of code 86585 per CPT 2006.
4/11/2008	4.8.2, 5.1.1 and 10.8	Information on dental services has been updated.
9/18/2008	Overview	Removed obsolete wording.
8/17/2011	10.17	Added proper billing code effective 10/01/2010.
10/2/12	1.0, 3.1, 4.6, 4.10, 6.0, 10.10, and 10.17,	Revised to update Clinic Provider Overview, Service Provider listing, Clinic definition, Clinic reimbursement methodology, and create new section for School-Based Wellness Centers.

5/20/13	3.1.1.1.2	Revised language to clarify end dates of coverage for multiple visits.
7/1/14	Table of Contents	Changed “Methadone” to “Medication Assisted Outpatient Treatment Program (MA-OTP)”.
7/1/14	1.0	Language added to clarify the coverage of buprenorphine and naloxone administration and required prior authorization.
7/1/14	3.1.1.3	Changed “Methadone” to “Medication Assisted Outpatient Treatment Program (MA-OTP)”.
7/1/14	7.0 – 7.1.3	Added additional criteria related to the administration of MA-OTPs. Changed “Methadone” to Medication Assisted Outpatient Treatment Program (MA-OTP)”.
7/1/14	10.15	Added billing codes J8499 and T1502. Changed “Methadone” to “MA-OTP”.
9/1/14	1.0 – 1.2	Changed “Methadone” to Medication Assisted Outpatient Treatment Program (MA-OTP).”
3/1/15	7.0 and 8.0	Removed Sections 7.0 and 8.0 from the manual.
1/1/2018	3.1.1.3	Description removed, refer to the **Delaware Adult Behavioral Health Service Certification and Reimbursement Provider Specific Policy Manual**.
1/1/2018	10.15	Removed section 10.15.

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Clinic Provider Specific Policy

1.0 Overview

Most Delaware Medicaid clients are enrolled in a Managed Care Organization (MCO) which is responsible for paying for most of their health care services. Most of the clinic services described in this manual, such as most general medical services, most EPSDT Screening, Medication Assisted Outpatient Treatment Program (MA-OTP) Clinics and mental health clinic services are included in the MCO benefit package (refer to General Policy, Coverage Under the MCO Benefits Package section). The MCO benefit does not include the provision of buprenorphine and naloxone administration. This particular medication is covered via fee-for-service, but does require prior authorization. Medicaid clients who are enrolled with an MCO must receive these clinic services through the MCO, subject to benefit limitations.

In addition to the clinic services included in the MCO benefits package, clients who are enrolled in managed care may also receive the following services as Medicaid wrap around services that are not included in the MCO benefit package and are paid as fee for service: Dental, School Based Wellness Centers, Child Development Watch, Lead Environmental Testing services and Mental Health Clinic services above 20 units in a benefit year.

This manual reflects the policies as they relate to Medicaid clients who are not eligible to enroll in managed care or are in a non-managed care coverage period prior to enrollment in a MCO. These clients may receive any medically necessary clinic services which will be paid as fee for service.

1.1 Service Providers

1.1.1 Clinic services are services provided by:

1.1.1.1 Public health clinics operated by the State of Delaware, Delaware Health and Social Services (DHSS), Division of Public Health (DPH);

1.1.1.2 Local dental clinics or by the Family and Children’s Services;

1.1.1.3 Medication Assisted Outpatient Treatment Program (MA-OTP) Clinics;

1.1.1.4 Mental health clinics that are certified by the Division of Substance Abuse and Mental Health (DSAMH).

1.1.1.5 School Based Wellness Centers (SBWCs) operated by private providers who are not affiliated with DPH.

1.2 Clinic Definition

1.2.1 For purposes of this manual, only DPH clinics (including dental clinics), local dental clinics, Family and Children’s Services, MA-OTP clinics mental health clinics and privately operated school based wellness centers are considered to

be "clinics". “Clinic services” means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical or behavioral health care to outpatients. Not all clinics provide all clinic services.

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2.0 General Criteria

2.1 Provider Responsibilities

2.1.1 All clinics/agencies must meet any applicable federal/state regulations, and they and their staff members must maintain and keep current the appropriate licenses/certification.

2.1.2 The staff members who are employed by the clinic must use medically approved methods of treatment and maintain high professional standards at all times.

2.1.3 The services must be provided only by personnel who are qualified and in a clean, safe environment.

2.1.4 To be reimbursed for services, the clinic must be enrolled with the Delaware Medical Assistance Program (DMAP) and abide by all contract rules/regulations and all policies and procedures of the DMAP.

2.1.5 All services must be under the direction of a physician, or in the case of dental clinics, under the direction of a dentist.

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3.0 Reimbursement

3.1 Methodology

3.1.1 Clinic services are reimbursed a prospective rate per clinic visit according to the specific services.

3.1.1.1 School Based Wellness Center (SBWC) Clinics – SBWC clinic services are reimbursed a prospective visit rate based on reported facility costs. SBWCs may only bill a visit when services are rendered by the following practitioner types:

- Physician
- Physician Assistant
- Nurse Practitioner
- Nurse
- Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Mental Health Counselor
- Registered Dietician

3.1.1.1.1 Prior to October 1, 2010, DMMA only covered one SBWC visit per child per year.

3.1.1.1.2 Effective for dates of service from October 1, 2010 through September 30, 2012, DMMA covered multiple visits per child on the same day for the practitioner types listed in section 3.1.1.1 when either of the following criteria were met. The SBWC was limited to a maximum of two (2) visits per day under the following circumstances:

- The patient suffers a separate illness or injury requiring additional diagnosis or treatment after the first encounter.
- Follow-up to the initial visit is medically necessary. Referrals for a second visit may also be covered when the patient has been identified as being “at risk” for medical conditions captured through the use of a risk assessment questionnaire.

  Where two visits in a single day were billed based on the policy above, the SBWC was limited to only one all-inclusive clinic visit procedure code (identified in Section 10.17) and limited to 2 units of service. Multiple visits were not permitted as separate entries on a single claim.

3.1.1.1.3 Effective with the implementation of the National Correct Coding Initiative in October 2012, as required under the Affordable Care Act, DMMA will only cover one SBWC practitioner visit per child per day. SBWCs must bill accordingly.

3.1.1.1.4 SBWCs must bill using the procedure code and taxonomy specified in section 10.17 of Appendix B.

3.1.1.1.5 Each SBWC vendor must complete an annual cost report that will be used to create a visit rate for the next rate (calendar) year. The DMAP will request a cost report for each enrolled SBWC vendor.

3.1.1.2 Dental Clinics **-** Reimbursement is based on the usual and customary charges of the providers for each visit.

3.1.1.3 Medication Assisted Outpatient Treatment Program (MA-OTP) Clinic – Refer to the Delaware Adult Behavioral Health Service Certification and Reimbursement Provider Specific Policy Manual.

3.1.1.4 Mental Health Clinics **-** Prospective per visit rates are determined from cost data provided by each provider. Rates are established by the Medicaid/ DSAMH Rate Setting Committee.

3.1.2 Complete, accurate, and timely cost report information is the responsibility of each provider, and is a condition for participation in the DMAP.

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4.0 Services Provided by Division of Public Health

4.1 Family Planning Services

4.1.1 Family planning services are any services that are provided specifically for the purpose of preventing pregnancies. The DMAP does not cover services related to the treatment of infertility.

4.1.2 This service is a client's visit to a scheduled DPH family planning clinic where a direct face-to-face service is provided by a physician or nurse.

4.1.3 Nutrition or medical social work counseling or crisis intervention may be included in the visit for some clients but is not billed as a separate visit.

4.1.4 Services include diagnostic and laboratory tests (specimen collection) performed in the clinic, pregnancy testing, contraceptive counseling, provision of contraceptive supplies, and provision of medications for the treatment of minor acute GYN problems. Also included are paraprofessional outreach staff who provide health education follow-up to assure that women keep annual appointments, liaison with prenatal clinics, and follow-up for abnormal screening results.

4.1.5 Special equipment included in this service are items necessary for colposcopy and cryosurgery, IUD and norplant insertion, and high power exam lights.

4.1.6 When billing the DMAP for a family planning clinic visit (comprehensive) the appropriate procedure code in Appendix B must be used.

4.2 Prenatal (Medical) Service

4.2.1 This service is a client's visit made to a physician, nurse, or nurse midwife to carry out the traditional medical prenatal examinations required throughout pregnancy.

4.2.2 The service includes routine prenatal lab tests and collection of specimens that occur during the clinic visit, medication and prenatal vitamins administered/distributed at the clinic, and routine ultrasound tests for gestational age.

4.2.3 When billing the DMAP for Prenatal services, the appropriate procedure code in Appendix B must be used.

4.3 Tuberculosis Clinical Services

4.3.1 This service is for each visit that is made by a client to a DPH TB clinic.

4.3.2 A visit is defined as one that is made to a scheduled TB clinic where a nurse or physician provides a direct one-on-one, face-to-face, medical or nursing service for the purpose of diagnosing or treating pulmonary disease.

4.3.3 The reimbursement for this visit includes the staff time of physicians, nurses, and paraprofessionals who also carry out TB skin testing to detect new cases, supervise the distribution/administration of preventive and therapeutic medications (sometimes through directly observed drug therapy in clinic, home, or work site), disease investigation to locate and test contacts of a case, service coordination, case tracking, consultation by pulmonary specialty physicians, PPD skin tests, diagnostic sputum collections, x-ray tests and medical interpretation of x-rays, and HIV testing. Also included in the reimbursement is the medical records technician's time for disease reporting and case registry. Special equipment included in the visit are special ultra violet lighting and ventilation systems in clinics to control disease exposure.

4.3.4 Drug (pharmacy) includes medications specifically provided to the client by DPH for the purpose of treating an active case of TB or prophylactic treatment of a person exposed to TB.

4.3.5 When billing the DMAP for a tuberculosis clinic visit the appropriate procedure code in Appendix B must be used.

4.4 Sexually Transmitted Disease (STD) Services

4.4.1 This service is a per clinic visit that is made by a client to a scheduled DPH/STD session. It is a direct service clinic visit by a client face-to-face with a physician, nurse, or disease investigation specialist for the purpose of diagnosing and treating STD or providing disease investigation and health education services.

4.4.2 Reimbursement includes staff time of nurses, physicians, HIV counselors, disease investigation specialists, and paraprofessionals. In addition to scheduled clinic time, staff time includes activities to identify contacts of an active case and coordinate the contact diagnosis and treatment (contact tracing), health education and counseling necessary to help clients understand and follow through on prevention and treatment, performance of diagnostic tests and drawing of lab specimens in the clinic, and administration of intramuscular and oral medicines. Also included is the time of specially trained HIV counselors who draw specimens for HIV laboratory and counsel the clients about the test and test results. These services may be offered in the clinic or at testing sessions outside of the scheduled clinic in a variety of community sites. Pharmacy costs include drugs necessary for the treatment of active STD (but not HIV drug therapy).

4.4.3 When billing the DMAP for STD services the appropriate procedure code in Appendix B must be used.

4.5 Enhanced Care for "At Risk" Children

4.5.1 This service is a continuation of home visit services following prenatal and post partum SMART START services. Home visits after the baby is born are charged under this service rather than under a SMART START procedure code.

4.5.2 This service is a client visit based on a face-to-face home visit to a family by a nurse, child development specialist, medical social worker, or nutritionist for the purpose of providing family support and therapeutic intervention to prevent developmental delay or ameliorate a condition discovered or assessed during an EPSDT screening visit. A referral for the home visit service is made (or confirmed as medically necessary) by the family primary health care provider, a public health nurse, or a public health/child health clinic.

4.5.3 The service includes nursing assessment of family, home, and child, developmental assessment and developmental guidance, health education, nursing service to help the family carry out home care related to the child's medical condition or disability, family support and counseling, crisis intervention and service coordination, and nutrition assessments and nutrition therapy related to a medically diagnosed abnormal nutritional status or feeding difficulties. The service also includes support services of paraprofessional outreach workers to help the family access services and keep medical appointments. Client transportation is provided directly by DPH staff to medical appointments and staff assistance to arrange transportation through other agencies.

4.5.4 When billing the DMAP for this service the appropriate procedure code in Appendix B must be used.

4.6 Reserved

4.7 Reserved

4.8 Dental Services

4.8.1 DPH operates Dental Clinics which provide EPSDT dental screenings. This service includes all the preventative diagnostic, treatment, and restoration services provided to the child during the year.

4.8.2 Treatment referrals to private dentists are arranged through DPH for children who have treatment or screening needs that fall outside of the range of activities of DPH's dental clinics. These referrals are billed by DPH to the DMAP.

4.8.3 When billing the DMAP for dental services the appropriate procedure codes in Appendix B must be used.

4.9 Child Development WATCH (CDW)

4.9.1 This is a specialty service to carry out the mandate of Part C of the Individuals with Disabilities Education Act (I.D.E.A.) for children birth to three years of age. It includes the functions of early identification, central intake, developmental evaluation and diagnostic assessments, multidisciplinary team case conferences, and care planning and services coordination carried out by a multidisciplinary team.

4.9.2 The yearly charge per client includes the staff time of physicians, nurses, psychologist, PT/OT and speech therapy consultants, Developmental Nurse Specialists, and Clinical Nurse Specialist with specialty training in Pediatrics/Children with Special Health Needs. Medical social work and nutrition consultation is also included.

4.9.3 The diagnostic evaluations include specialty physician consultation by neonatologist, developmental pediatricians, and neurologists. The evaluation includes a hearing evaluation for each child. For other specialty evaluations that might be needed by a child, the family is referred to a private provider who bills Medicaid directly.

4.9.4 The service also includes a home visit family assessment by a professional staff member of the team. This is a part of the multidisciplinary team evaluation process.

4.9.5 Service coordination is a mandated Part C service that is provided by the team, but staff time and Family Service coordinator staff positions for service coordination are not included in this service. That service is billed as an administrative EPSDT case management service directly to the DMAP.

4.9.6 When billing the DMAP for this service the appropriate procedure code in Appendix B must be used.

4.10 Reserved

4.11 Child Health Services (EPSDT Screening)

4.11.1 This service is a client visit to a scheduled DPH Child Health or immunization clinic or an immunization or screening service (such as a blood lead test) provided during a WIC visit.

4.11.2 This is a one-on-one, face-to-face visit provided by a physician, nurse, or nutritionist to conduct well child exams and provide anticipatory guidance,

developmental screening, screening tests appropriate for age, nutrition assessment and intervention for medically diagnosed nutrition problems, immunization, and treatment of minor acute illness. Service coordination and follow-up of abnormal screening results is included.

4.11.3 Staff time for outreach and early case finding to improve immunization rates and to conduct lead poisoning screening is included in the cost of this service. Immunization registry costs are also included. This service may be billed under two distinct screens:

4.11.4 Full EPSDT Screen: This screen may be billed when a child is seen for a well child exam according to the EPSDT periodicity schedule which includes up to seven visits from birth to one year old, three visits during the second year of life, and annually through 20 years of age. An interperiodic screen may be billed any time a repeat full screening visit is requested by the family or a professional because of some concern about a possible abnormality.

4.11.5 Child Health Clinic Visit for Partial EPSDT Screen, Immunization, Acute Illness, or Follow-Up Visit: This service is billed for any interim visit to a child health clinic or other partial screening visit which is provided by a physician, nurse, nurse practitioner, or nutritionist in between regularly scheduled full screening visits or as follow-up for abnormal screening tests or illness.

4.11.6 When billing the DMAP for these services the appropriate procedure codes in Appendix B must be used.

4.12 Lead Environmental Testing Services

4.12.1 This service includes the service necessary to conduct an inspection of the primary residence of a child with an elevated blood lead level to locate the source of lead exposure. Included in the reimbursement is the time necessary to complete the inspections which may require several visits.

4.12.2 When billing the DMAP for this service the appropriate procedure code in Appendix A or Appendix B must be used.

4.12.3 Reserved.

5.0 Local Dental Clinics

5.1 General Criteria

5.1.1 Many local dental clinics have enrolled in the DMAP in order to provide some EPSDT dental screening and treatment services to DMAP clients.

5.1.2 When billing the DMAP for these services the appropriate procedure code in Appendix B must be used.

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6.0 School-Based Wellness Centers

6.1 General Criteria

6.1.1 School-Based Wellness Centers (SBWCs) are housed in a school. SBWC services are provided within the Wellness Center and by SBWC personnel. SBWC services are made available only to the students enrolled at the school where the Wellness Center is located.

6.1.2 Parental or guardian consent must be obtained as per Title 13, Chapter 7 Subchapter I of Delaware Code before a student may receive SBWC services.

6.1.3 Policies and procedures must be established and followed to assure that, to the extent practical and legally permissible, there is communication with the student's parents and other community-based health care providers who are treating the student to ensure that the child obtains all needed services and to prevent duplication of care. Administrative procedures should also be established and followed regarding the sharing of medical records in accordance with all State and Federal confidentiality laws (including but not limited to Title X).

6.1.4 SBWC services are provided by health professionals including: physicians, physician assistants, nurse practitioners, visiting nurses, clinical psychologists, licensed clinical social workers, licensed professional mental health counselors, and registered dieticians. Licensure requirements for each practitioner type are specified in the Title 24 of the Delaware Code, Professions and occupations and in the Delaware Administrative Code.

6.1.5 SBWC services are limited to Medicaid-covered services as specified in the Medicaid State Plan and include the following:

Physical Health

- Assessment, diagnosis and treatment of minor illness/injury
- Screening/referral for treatment of chronic conditions such as high blood pressure, diabetes and asthma
- Routine physicals
- Immunizations, in accordance with DPH guidelines
- Dispense non-prescription medications
- Prescribe medications
- Perform follow-ups as requested by family physician
- Perform minor laboratory tests (STD testing, blood draws, throat cultures, urine analysis, pregnancy testing)
- Perform referral for services not provided on site including primary care physicians, HIV, etc.
- Diagnosis and treatment of sexually transmitted diseases*

*(Not available at all locations)

Health Education & Nutrition

- Classroom & group education/counseling
- Individual weight management
- Special diets
- Sports nutrition
- Prenatal/postpartum nutrition

Mental Health & Substance Abuse

- Individual counseling
- Individual and family counseling
- Referral for long-term counseling and evaluation

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7.0 Reserved

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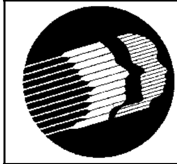
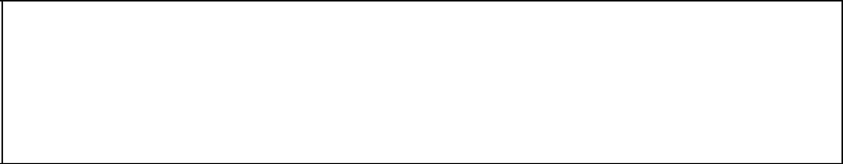

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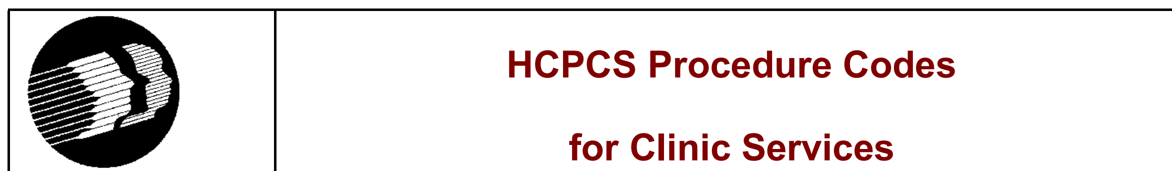

10.0 Appendix B – HCPCS Procedure Codes

When billing the DMAP for dates of service provided on and after 7/1/02 clinic service providers are required to use the procedure codes listed below.

10.1 Family Planning Services

Code(s)	Description
99201-99205	New patient, office or outpatient visit
99211-99215	Established patient, office or outpatient visit
S0610	Annual gynecological examination; new patient
S0612	Annual gynecological examination; established patient

When billing the above codes the modifier FP (family planning) must be used.

10.2 Prenatal (Medical) Services

Code(s)	Description
99201-99205	New patient, office or outpatient visit
99211-99215	Established patient, office or outpatient visit

When billing the above codes the modifier TH (Obstetrical treatment service, prenatal or postpartum) must be used.

10.3 Tuberculosis Clinical Service

Code(s)	Description
36415	Routine venipuncture or finger/heel/ear stick for collection of specimen(s)
86580	Tuberculosis, Intradermal
86585	Tuberculosis, Tine Test (For dates of service through 12/31/05)

10.4 STD Services

Code(s)	Description
99201-99205	New patient, office or outpatient visit
99211-99215	Established patient, office or outpatient visit

10.5 Enhanced Care for “At Risk” Children

Code(s)	Description
S9123	Nursing care in the home; by registered nurse, per hour

S9124	Nursing care in the home by licensed practical nurse, per hour
S9470	Nutritional counseling, dietitian

10.6 Specialty Services

Code(s)	Description
	These codes are discontinued. Services no longer provided
99201-99205	New patient, office or outpatient visit
99211-99215	Established patient, office or outpatient visit

10.7 Adult Health Screening Services

Code	Description
	These codes are discontinued. Services no longer provided

10.8 Dental Services

Code	Description
	Providers must bill for services using codes from the most current version of the Current Dental Terminology procedure code book updated and published by the American Dental Association.

10.9 Child Development WATCH

Code	Description
S4516	Multi-disciplinary assessment/evaluation. (Use this code when billing for dates of service on and before 12/31/03.)
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter. (Use this code when billing for dates of service on and after 1/1/04.) When billing code S4516 the modifier TL (Early intervention/individualized Family Service Plan) must be used.

When billing the above code the modifier TL (Early intervention/individualized Family Service Plan) must be used.

10.10 Reserved

10.11 Child Health Services – EPSDT Screening

Code(s)	Description
99381	Initial comprehensive preventive medicine, new patient age under 1 year
99391	Established patient periodic preventive medicine
99382	New patient early childhood (age 1-4 years)
99392	Established patient early childhood (age 1-4 years)
99382	New patient early childhood (age 1-4 years)

99392	Established patient early childhood (age 1-4 years)
99383	New patient late childhood (age 5-11 years)
99384	New patient adolescent (age 12-17 years)
99393	Established patient late childhood (age 5-11 years)
99394	Established patient adolescent (age 12-17 years)
99385	New patient 18-39 years
99395	Established patient 18-39 years
99381	New patient initial preventive medicine
99391	Established patient periodic preventive medicine
99431	Newborn care history and examination
99432	Normal newborn care
99382	New patient early childhood (age 1-4 years)
99392	Established patient early childhood (age 1-4 years)
99382	New patient early childhood (age 1-4 years)
99392	Established patient early childhood (age 1-4 years)
99383	New patient late childhood (age 5-11 years)
99384	New patient adolescent (age 12-17 years)
99393	Established patient late childhood (age 5-11 years)
99394	Established patient adolescent (age 12-17 years)
99385	New patient 18-39 years
99395	Established patient 18-39 years

10.12 Lead Environmental Testing

Code	Description
S4518	Environmental lead testing. (Use this code for dates of service on and before 12/31/03.)
T1029	Comprehensive environmental lead investigation, not including laboratory analysis, per dwelling. (Use this code for dates of service on and after 1/1/04.)

10.13 Reserved

Code	Description

10.14 Reserved

Code	Description

10.15 Reserved

Code	Description

10.16 Mental Health Clinic Services

Code	Description
90804	Individual psychotherapy insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20-30 minutes face-to-face with the patient.
90805	Individual psychotherapy insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20-30 minutes face-to-face with the patient; with medical evaluation and management
90806	Individual psychotherapy insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face-to-face with the patient
90807	Individual psychotherapy insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face-to-face with the patient; with medical evaluation and management
90808	Individual psychotherapy insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75-80 minutes face-to-face with the patient
90809	Individual psychotherapy insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75-80 minutes face-to-face with the patient; with medical evaluation and management

When billing the DMAP for CPT codes 90804 – 90809 the following guidelines shall be followed:

- Any face-to-face service from 15-40 minutes shall be coded and billed at the “approximately 20-30 minute” rate
- Any face-to-face service from 41-70 minutes shall be coded and billed at the “approximately 45-50 minute” rate
- Any face-to-face services lasting 71 or more minutes shall be coded and billed at the “approximately 75-80 minute” rate.

10.17 School-Based Wellness Center Services

Code	Description
G9001	Coordinated care fee, initial rate. (used for dates of services through 09/30/2010)
T1015	Clinic visit/encounter, all inclusive (use for dates of service. 10/01/2010 and after)

Only providers enrolled with DMAP with a taxonomy of 261QS1000X may bill the DMAP for the codes listed above.

SBWC claims for a family planning service must include the modifier FP (family planning) to enable them to be identified as a family planning claim.

Family planning services and supplies described in section 1905(a)(4)(C) of the Social Security Act are limited to those services and supplies whose primary purpose is family planning and which are provided in a family planning setting, including:

- *Approved methods of contraception*
- *Sexually transmitted infection testing, Pap smears and pelvic exams (Note: The laboratory tests done during an initial family planning visit for contraception include a*

Pap smear, screening tests for STI/STDs, blood count, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.)

- *Drugs, supplies or devices related to womens' health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements (subject to the national drug rebated program requirements.)*
- *Contraceptive management, patient education and counseling.*