To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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1.0 Description of the Procedure, Product, or Service

Approximately 40 percent of all individuals with epilepsy have medically refractory seizures. Primarily generalized seizures are the most common type of intractable seizures in children; while in adults, complex partial seizures are the most common intractable seizure type. Medically refractory seizures are those seizures that are not completely controlled by medical therapy. That means that seizures continue to occur despite treatment with a maximally tolerated dose of a first-line anti-epilepsy drug (AED) as monotherapy or in at least one combination with an adjuvant medication. The terms "intractable" or "medically refractory" are interchangeable.

In the past 10 years, significant advances have occurred in surgical treatment for epilepsy and in medical treatment of epilepsy with newly developed and approved medications. Despite these advances, however, 25–50 percent of patients with epilepsy experience breakthrough seizures or suffer from debilitating adverse effects of antiepileptic drugs. Vagus Nerve Stimulation (VNS) has been investigated as a treatment alternative in patients with medically refractory partial-onset seizures for whom surgery is not recommended or for whom surgery has failed.

Vagus Nerve Stimulation (VNS) is performed by an implantable stimulator as a treatment for refractory seizures. VNS treatment sends preprogrammed, intermittent electrical pulses through the vagus nerve in the neck to the brain. These pulses originate in a small generator device that is implanted in the chest. The exact mechanism of the antiepileptic effects of VNS are not fully understood, but the procedure may reduce the severity or the frequency of seizures in selected candidates who have an intact vagus nerve.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in Section 3.0 of this policy.
b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.

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

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific
(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid
None Apply.

b. NCHC
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary’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 beneficiary’s right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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
缺陷、生理或心理疾病，或一种状况” [健康问题]；也就是说，提供者文件证明了服务、产品或程序如何满足所有EPSDT标准，包括纠正或改进或保持受益人的健康状况，使其处于最佳状态，补偿健康问题，防止其恶化，或防止其他健康问题的出现。

b. EPSDT和优先审批要求

1. 如果服务、产品或程序需要优先审批，那么受益人未满21岁这一事实不能消除优先审批的要求。

2. 重要额外信息关于EPSDT和优先审批可以在NCTracks提供者索赔和计费援助指南中找到，也可以在EPSDT提供者页面中找到。网站地址如下。

   NCTracks提供者索赔和计费援助指南：
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT提供者页面：https://medicaid.ncdhhs.gov/

2.2.2 EPSDT不适用NCHC受益人

2.2.3 医疗选择特别条款针对一个健康选择受益人的年龄6岁至18岁

NC Medicaid将拒绝为NCHC受益人支付不满足此政策第3.0节标准的费用。只有受到NCHC州计划和NC Medicaid临床覆盖政策、服务定义或计费代码覆盖的NCHC受益人的服务才能被覆盖。

3.0 当程序、产品或服务被覆盖时

注：参阅第2.2.1节有关EPSDT例外政策限制的说明。

3.1 一般覆盖标准

NC Medicaid和NCHC将覆盖与这一政策相关的程序、产品或服务，当其在医学上必要的时候，包括：

a. 该程序、产品或服务是个性化的、具体的，且与治疗中的疾病或伤害的症状或确诊一致，且不超出受益人的需求；

b. 该程序、产品或服务可以在安全条件下提供，且没有同样有效且更为保守或更经济的治疗方法在全州范围内可用；

c. 该程序、产品或服务的提供方式不主要是为了受益人、受益人的监护人或提供者的便利。
3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC
Medicaid and NCHC cover VNS for the treatment of seizures when it is determined to be medically necessary because BOTH of the following criteria are met:

a. The beneficiary has medically refractory* seizures; AND
   *Medically refractory means
   1. seizures that occur in spite of therapeutic levels of anti-epileptic drugs; OR
   2. seizures that cannot be treated with therapeutic levels of anti-epileptic drugs because of intolerable adverse side effects.

b. The beneficiary has failed or is not eligible for surgical treatment.

3.2.2 Medicaid Additional Criteria Covered
None Apply.

3.2.3 NCHC Additional Criteria Covered
None Apply.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered
Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in Section 2.0;
   1. the beneficiary does not meet the criteria listed in Section 3.0;
   2. the procedure, product, or service duplicates another provider’s procedure, product, or service; or
   3. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC
Medicaid and NCHC shall not cover VNS for the treatment of seizures for indications that do not meet the criteria in Subsection 3.2.1; and for

a. beneficiaries who can be treated successfully with anti-epileptic drugs.

b. treatment of beneficiaries with depression.

c. treatment of essential tremor.

d. treatment of headaches.

e. treatment of obesity.

4.2.2 Medicaid Additional Criteria Not Covered
None Apply.
4.2.3 NCHC Additional Criteria Not Covered

NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No nonemergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall not require prior approval for VNS.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

None Apply.

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

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.
7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).
8.0 Policy Implementation/Revision Information

Original Effective Date: December 1, 1994

Revision Information:

<table>
<thead>
<tr>
<th>Date</th>
<th>Section Revised</th>
<th>Change</th>
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<tbody>
<tr>
<td>07/01/2012</td>
<td>Throughout</td>
<td>Initial promulgation of current coverage for Medicaid and NCHC.</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>All Sections and Attachments</td>
<td>Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.</td>
</tr>
<tr>
<td>06/01/2018</td>
<td>Subsection 4.2.1</td>
<td>Removed outdated information, “Other service exclusions or limitations may apply. Refer to A Consumer’s Guide to North Carolina Health Care Coverage Programs for Families and Children: North Carolina Health Choice and Medicaid.”</td>
</tr>
<tr>
<td>02/01/2019</td>
<td>Attachment A</td>
<td>Added 95976, 95977, 95983, and 95984. Deleted 95974, +95975, 95978, and +95979.</td>
</tr>
<tr>
<td>03/15/2019</td>
<td>Table of Contents</td>
<td>Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”</td>
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<tr>
<td>03/15/2019</td>
<td>All Sections and Attachments</td>
<td>Updated policy template language.</td>
</tr>
<tr>
<td>12/12/2019</td>
<td>Table of Contents</td>
<td>Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”</td>
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<tr>
<td>12/12/2019</td>
<td>Attachment A</td>
<td>Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.</td>
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<tr>
<td>09/15/2020</td>
<td>Attachment A (F)</td>
<td>Revised Place of Service to include Independent Diagnostic Testing Facilities (IDTF) for CPT codes 95976, 95977, 95983, and 95984</td>
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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

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<tr>
<th>ICD-10- Code(s)</th>
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<tr>
<td>G40.001</td>
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<td>G40.009</td>
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<td>G40.309</td>
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<td>G40.311</td>
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C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers
Providers are required to follow applicable modifier guidelines.

E. Billing Units
Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service
Inpatient Hospital, Outpatient Hospital, and Independent Diagnostic Testing Facility (IDTF) for services 95976, 95977, 95983, and 95984.

G. Co-payments
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement
Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/