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#### Related Clinical Coverage Policies

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
2A-1, *Acute Inpatient Hospital Services*  
2B, *Nursing Facilities*  
8B, *Inpatient Behavioral Health Services*  
8D-1, *Psychiatric Residential Treatment Facilities for Children under the Age of 21*  
8D-2, *Residential Treatment Services*

## 1.0 Description of the Procedure, Product, or Service

Out-of-state services are defined as services outside of the borders of North Carolina (NC). Medically necessary care and services provided within 40 miles of the NC border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia are covered to the same extent and under the same conditions as medical care and services provided in NC, with the **exception of the services found in Subsection 4.2** of this policy.

### 1.1 Definitions

- a. **Emergency Medical Condition** (42CFR§489.24(b))
  1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
    - A. serious impairment to bodily functions; or
    - B. serious dysfunction of any body organ or part.
  2. **For Medicaid beneficiaries only**, with regard to pregnant women having contractions:
    - A. that there is inadequate time to effect a safe transfer to another hospital before delivery; or
    - B. that the transfer may pose a threat to the health or safety of the woman or her unborn child.
- b. **Out-of-State providers**: Providers located outside the NC border.
  1. **Contiguous area providers**: Providers located within 40 miles of the NC border will be reimbursed to the same extent and under the same conditions as medical care and services provided in NC.
  2. **Non-Contiguous area providers**: Providers located more than 40 miles from the NC border.

## 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. 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 defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

**3.0 When the Procedure, Product, or Service Is Covered**

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

**3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider..

## 3.2 Specific Criteria Covered

### 3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover medically necessary care and services when provided more than 40 miles from the NC border if the out-of-state care and services meet any of the following criteria:

- a. are more reasonably available than can be provided by an enrolled in-state provider and have been prior approved by DMA or DMA's designee prior to rendering the services; or
- b. the care and services are provided in any one of the following situations:
  1. emergency as defined in **Subsection 1.1(a)**;
  2. where the health of the beneficiary would be endangered if the care and services were postponed until the beneficiary returns to North Carolina; or
  3. where the health of the beneficiary would be endangered if travel were undertaken to return to North Carolina.

**Note:** As soon as medically appropriate, the beneficiary shall return to North Carolina, as no services are covered unless those services meet the specific criteria in **Subsection**

### 3.2.1.

### 3.2.2 Medicaid Additional Covered Criteria

Out-of-state services are provided to a foster child who is a ward of the State of North Carolina and living in a foster home more than 40 miles from the border.

### 3.2.3 NCHC Additional Criteria Covered

None Apply.

### 3.2.4 Ambulance Services

Refer to the *forthcoming* Ambulance Services policy.

## 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**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. 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 acute inpatient hospital services when the criteria in **Section 3.0** of this policy are not met.

#### 4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover the following services when provided in non-contiguous states by out of state providers:

- a. Children's Developmental Service Agency (CDSA);
- b. Community Alternatives Program (CAP);
- c. Program of All-Inclusive Care for the Elderly (PACE);
- d. Private Duty Nursing (PDN); and
- e. Durable Medical Equipment (DME).

#### 4.2.3 NCHC Additional Criteria Not Covered

- a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover the following services when provided in non-contiguous states by out of state providers:
  1. Critical Access Behavioral Health Agency (CABHA);
  2. Home Health;
  3. Home Infusion Therapy (HIT); and
  4. Hospice
- b. 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 (PA)

The provider shall obtain prior approval for all non-emergency out-of-state services (with the exception of services provided to Medicaid beneficiaries who are foster children).

If the service or procedure requires prior approval for Medicaid and NCHC beneficiaries, the provider shall request that prior approval when requesting approval for out-of-state services.

Prior approval is granted only for the specific facility requested. Prior approval cannot be transferred to another facility nor may a beneficiary be transferred from one out-of-state facility to another without obtaining additional prior approval for the new facility.

Prior approval for non-emergency care limitations do not apply to foster children who are Medicaid beneficiaries and have been placed in homes outside North Carolina except if

the procedure or service specifically requires prior approval as part of its Medicaid coverage in any location.

**Note:** Referral for treatment by the beneficiary's primary care provider does not constitute PA for out of state services or for other services that require PA.

## **5.2 Prior Approval Requirements**

### **5.2.1 General**

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

## **5.3 Acute Inpatient, Outpatient and Observation Hospital Services for Medicaid and NCHC Beneficiaries**

Refer to clinical coverage policy 2A-1, *Acute Inpatient Hospital Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>, for prior approval information.

## **5.4 Emergency Treatment Follow-Up Care for Medicaid and NCHC Beneficiaries**

Providers rendering out-of-state emergency treatment shall refer beneficiaries to a North Carolina provider for follow-up care. If DMA determines that follow-up care is more reasonably available out-of-state, the out-of-state provider shall obtain PA. The written PA request shall be made to DMA's designee, and the guidelines for out-of-state services shall be followed. Beneficiaries who are being sent out of state shall be informed by the provider that follow-up for services will occur in NC facilities.

Refer to clinical coverage policy 2A-1, *Acute Inpatient Hospital Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>, for prior approval information.

## **5.5 Ambulance Services for Medicaid and NCHC Beneficiaries**

Refer to the forthcoming Ambulance policy for prior approval information.

## **5.6 Nursing Facility Services for Medicaid Beneficiaries**

Refer to clinical coverage policy 2B, *Nursing Facilities*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>, for prior approval information.

## **5.7 Inpatient Behavioral Health Services for Medicaid and NCHC Beneficiaries**

Refer to clinical coverage policy 8B, *Inpatient Behavioral Health Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>, for prior approval information.

## **5.8 Residential Treatment Services for Medicaid beneficiaries under the age of 21 years and NCHC Beneficiaries**

Refer to clinical coverage policies 8D-1, *Psychiatric Residential Treatment Facilities for Children under the Age of 21* and 8D-2, *Residential Treatment Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>, for prior approval information.

## **6.0 Provider(s) 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 DMA'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:** July 19, 1988

### Revision Information:

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
08/01/2011	All sections and attachment(s)	New policy documenting current coverage.
03/01/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 2A-3 under Session Law 2011-145, § 10.41.(b)
01/15/2013	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
01/15/2013	Section 1.0	Changed first sentence to refer to services provided out of state, removed reference to within 40 miles of border here.
01/15/2013	Section 4.3 2 <sup>nd</sup> paragraph	Made wording the same as Subsection 4.4 to read non coverage in non-contiguous states vs non coverage out of state.
01/15/2013	Section 5.3	Changed from 2 separate references to one references since Behavioral health policy is now combined policy.
01/15/2013	Attachment A (h)	Added reference to NCHC SPA for reimbursement.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA'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)

Institutional (UB-04/837I transaction)

When emergency services are provided, the hospital provider shall indicate that the service performed was a true emergency by using emergency codes on the claim form.

### B. International Classification of Diseases, 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.

### 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.

Refer to the applicable clinical coverage policy on DMA's website:  
<http://www.ncdhhs.gov/dma/mp/>.

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

Provider(s) shall follow applicable modifier guidelines.

### **E. Billing Units**

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

### **F. Place of Service**

Inpatient, Outpatient, Office, Ambulance.

### **G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

### **H. Reimbursement**

Institutional Providers shall bill their usual and customary charges.

Out-of-state Medicaid providers are reimbursed in accordance with North Carolina State Plan Amendments 4.19-A and 4.19-B. A copy of the State Plan can be accessed at: <http://www.ncdhhs.gov/dma/plan/>.

NCHC Out-of-state providers are reimbursed in accordance with North Carolina State Plan Amendment 7.2.2 and 8.4.3. A copy of the State Plan can be accessed at: [http://www.ncdhhs.gov/dma/provider/Health\\_Choice\\_FINAL\\_SPA10\\_12212012.pdf](http://www.ncdhhs.gov/dma/provider/Health_Choice_FINAL_SPA10_12212012.pdf)

### **I. Provider Fee Schedules**

For provider-specific fee schedules refer to <http://www.ncdhhs.gov/dma/fee/>.