

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.

Table of Contents

1.0	Description of the Procedure, Product or Service.....	1
1.1	General.....	1
1.2	Pediatric	2
1.3	Definitions	3
2.0	Eligibility Requirements	4
2.1	Provisions.....	4
2.1.1	General.....	4
2.1.2	Specific	4
2.2	Special Provisions.....	4
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age	4
3.0	When the Procedure, Product, or Service Is Covered.....	5
3.1	General Criteria Covered	5
3.2	Specific Criteria Covered.....	5
3.2.1	Specific criteria covered by Medicaid	5
3.2.2	Medicaid Additional Criteria Covered.....	7
4.0	When the Procedure, Product, or Service Is Not Covered.....	7
4.1	General Criteria Not Covered	7
4.2	Specific Criteria Not Covered.....	7
4.2.1	Specific Criteria Not Covered by Medicaid.....	7
4.2.2	Medicaid Additional Criteria Not Covered.....	7
5.0	Requirements for and Limitations on Coverage	7
5.1	Prior Approval	7
5.1.1	Prior Approval Requirements for Medicaid Beneficiaries	7
5.2	Prior Approval Requirements	8
5.2.1	General.....	8
5.3	Additional Limitations or Requirements	8
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service	8
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	8
6.2	Provider Certifications	8
7.0	Additional Requirements	9
7.1	Compliance	9
8.0	Policy Implementation/Revision Information.....	10
	Attachment A: Claims-Related Information	13
	A. Claim Type	13

B.	International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)	13
C.	Code(s).....	13
D.	Modifiers.....	14
E.	Billing Units.....	14
F.	Place of Service	14
G.	Co-payments	14
H.	Reimbursement	15

Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1K-7, Prior Approval for Imaging Services

1-I Dietary Evaluation and Counseling and Medical Lactation Services

1.0 Description of the Procedure, Product or Service

1.1 General

Bone Mass Measurement (BMM) is a radiologic procedure performed for quantifying bone mass, measuring changes in bone mass over time, or assessing bone quality. BMM can be used to establish the diagnosis of osteoporosis, to assess an individual's risk of fracture, or to determine the efficacy of osteoporosis drug therapy.

Osteoporosis is a debilitating disease in which bones become fragile and more likely to break. Any bone can be affected, but osteoporosis of the hip, spine, and wrist are of special concern, as fractures at these sites can be associated with significant morbidity and mortality. Osteoporosis is a common disorder of reduced bone strength that predisposes one to an increased risk for fractures in older individuals. The standard criterion for the diagnosis of osteoporosis in postmenopausal women and older men is a T-score of less than -2.5 at the lumbar spine, femur neck, or total hip by bone mineral density testing. The results of a bone density test are expressed either as a "T" or a "Z" score. T-scores represent numbers that compare the condition of your bones with those of an average young person with healthy bones where Z-scores represent numbers that compare the condition of your bones with those of an average person your age.

While BMM can be performed using a variety of systems approved by the Food and Drug Administration (FDA), only Dual Energy X-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (hips, pelvis, spine), can be used to diagnose osteoporosis based on WHO T-score criteria.

- a. The categories for diagnosis are:
 1. Normal (T-score -1.0 and above);
 2. Low bone mass, referred to as osteopenia (T-score between -1.0 and -2.5);
 3. Osteoporosis (T-score -2.5 and below); and
 4. Severe osteoporosis (T-score -2.5 and below with history of a fracture).

If either the spine or hip is not evaluable, then the 33% radius (sometimes called one-third radius) may be used for diagnostic purposes if it is the lowest of the skeletal sites measured. of the non-dominant forearm for diagnosis using DXA.

- b. The following methods are established procedures of bone mass measurements of the axial (central) or peripheral skeleton:
 1. Dual Energy X-Ray Absorptiometry (DXA);
 2. Quantitative Computed Tomography (QCT); and
 3. Ultrasound bone density measurement.

1.2 Pediatric

A diagnosis of osteoporosis in children from infancy to adolescence should not be made on the basis of densitometric criteria alone. T-scores, ethnic or race adjusted Z-scores must be used. Low bone mineral content (BMC) or bone mineral density (BMD) is defined as a BMC or areal BMD Z-score that is less than or equal to -2.0, adjusted for age, gender and body size, as appropriate.

The finding of one or more vertebral compression (crush) fractures is indicative of osteoporosis, in the absence of local disease or high-energy trauma. In such children and adolescents, measuring BMD adds to the overall assessment of bone health. In the absence of vertebral compression (crush) fractures, the diagnosis of osteoporosis is indicated by the presence of both a clinically significant fracture history and a BMD Z-score less than or equal to -2.0.

A clinically significant fracture history is one or more of the following:

- a. two or more long bone fractures by age of 10 years; or
- b. three or more long bone fractures at any age up to age 19 years.

A BMC BMD Z-score greater than -2.0 does not preclude the possibility of skeletal fragility and increased fracture risk.

T scores must not appear in pediatric DXA reports. The term osteoporosis must not appear in pediatric DXA reports without knowledge of clinically significant fracture history. Low bone mineral mass or bone mineral density is the preferred term for pediatric DXA reports when BMC or areal BMD Z-scores are less than or equal to -2.0 standard deviation (SD).

In beneficiaries-with primary bone disease, or at risk for a secondary bone disease, a DXA may be performed when:

- a. the patient may benefit from interventions to decrease their elevated risk of a clinically significant fracture, and
- b. the DXA results influence management.

DXA must not be performed, if safe and appropriate positioning of the child cannot be assured.

Baseline DXA Report

Baseline DXA reports must contain the following information:

- a. DXA manufacturer, model, and software version;
- b. Referring licensed physician or other licensed non-physician practitioner;
- c. Beneficiary age, gender, race or ethnicity, weight, and height;
- d. Relevant medical history including previous fractures;
- e. Indication for study;

- f. Tanner Stage of bone age results, if available;
- g. Technical quality;
- h. BMC and areal BMD;
- i. BMC or areal BMD Z-score;
- j. Source of reference data for Z-score calculations;
- k. Adjustments made for growth and interpretation; and
- l. Recommendations for the necessity and timing of the next DXA study are optional.

DXA Interpretation and Reporting in Children and Adolescents

DXA is the preferred method for assessing BMC and areal BMD.

DXA Interpretation and Reporting in Children and Adolescents includes:

- a. The posterior-anterior (PA) spine and total body less head (TBLH), are the preferred skeletal sites for performing BMC and areal BMD measurements in most pediatric subjects. Other sites may be useful depending on the clinical need;
- b. If a follow-up DXA scan is indicated, the minimum interval between scans is 6-12 months;
- c. Soft tissue measures in conjunction with whole body scans may be helpful in evaluating beneficiaries with chronic conditions associated with malnutrition (such as anorexia nervosa, inflammatory bowel disease, cystic fibrosis), or with both muscle and skeletal deficits (such as idiopathic juvenile osteoporosis);
- d. The hip (including total hip and proximal femur) is not a preferred site for measurement in growing children due to significant variability in skeletal development and lack of reproducible regions (of interest);
- e. In children with short stature or growth delay, spine and TBLH BMC and areal BMD results should be adjusted. For the spine, adjust using either BMAD or the height Z-score. For TBLH, adjust using the height Z-score.
- f. An appropriate reference data set must include a sample of healthy representatives of the general population sufficiently large to capture variability in bone measures that takes into consideration gender, age, and race or ethnicity; and
- g. When upgrading densitometer instrumentation or software, it is essential to use reference data valid for the hardware and software technological updates.

1.3 Definitions

T-score – a standardized score comparing bone marrow density to average values to young, healthy women.

Z-score – is a measure of how many standard deviations below or above the population mean a raw score is.

Areal BMD – bone mineral content, measured by DXA, divided by the bone area in square centimeters.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in
 1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*;
- b. Provider(s) shall verify each Medicaid 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.

2.1.2 Specific

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

- a. **Medicaid**
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: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid 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 Medicaid

- a. Medicaid shall cover BMM when it is medically necessary: and
 1. Ordered and provided by or under the general supervision of a licensed physician or other licensed non-physician practitioner within the scope of his or her practice. General supervision is defined in 42 CFR 410.32(b) (3) (i);

2. Provided in an office or similar facility other than a hospital outpatient department or clinic; and
 3. Performed with a DXA system that is approved and regulated by the FDA.
- b. Medicaid shall cover BMM when the health record documents that the beneficiary meets the medical indications for **at least one** of the categories listed below:
1. A female beneficiary determined to be estrogen deficient and at clinical risk for osteoporosis or low bone mineral content based on medical history and other findings;
 2. A beneficiary with vertebral abnormalities, as demonstrated by an X-ray, that are indicative of osteoporosis, osteopenia, low bone mineral content, or vertebral fracture;
 3. A beneficiary at risk of osteoporosis or low bone mineral content due to long-term medication including:
 - A. Long-term (anticipated or actual) glucocorticoid therapy equivalent to 5.0 mg of prednisone, or greater, per day, for three months or greater
 - B. Long-term or excess thyroid replacement therapy with evidence for hyperthyroidism
 - C. Long-term anti-convulsant therapy for three months or greater
 - D. Long-term heparin therapy for one month or greater or
 - E. Long-term Depo-Provera therapy (for two years or greater)
 4. A beneficiary with primary hyperparathyroidism;
 5. A beneficiary being monitored to assess the response to or efficacy of FDA-approved drug therapy for low bone mineral content;
 6. A beneficiary with a history of low non-traumatic (fragility) fractures or pathologic fracture; or
 7. A beneficiary with other conditions or currently receiving medical therapies known to cause low bone mass including celiac disease, cerebral palsy, anorexia nervosa and hypogonadism.
 8. Peripheral measurement of BMD will be considered medically necessary:
 - A. If the hip-spine or hip-hip cannot be done or the patient is over the table limit for weight: or
 - B. For hyperparathyroidism, where the forearm is essential for diagnosis.
- c. Dual energy X-Ray Absorptiometry (DXA), bone density study for one or more sites is the only BMM test covered by Medicaid for the monitoring of drug therapy for osteoporosis or low bone mineral content drug therapy. Refer to **Attachment A, Section C** for the applicable CPT code.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover BMM based on age factor alone for:

- a. A female Medicaid beneficiary 65 year or older; or
- b. A male Medicaid beneficiary 70 year or older.

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 a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid 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 Medicaid

Medicaid shall not cover BMM for the CPT codes listed in **Attachment A, Section C, C.2.**

- a. Bone mineral density measurement using ultrasound densitometry, quantitative computed tomography, or dual x-ray absorptiometry of peripheral sites. Screening individuals who are at low risk for osteoporosis is considered not medically necessary.
- b. Pulse-Echo Ultrasound Density Measurement.
- c. Dual x-ray absorptiometry (DXA) body composition studies.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover BMM for female beneficiaries under the age of 65 or male beneficiaries under the age of 70 who do not meet medical necessity criteria listed in **Subsection 3.2.1**

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

5.1.1 Prior Approval Requirements for Medicaid Beneficiaries

Medicaid shall require prior approval only for the following BMM services: computed tomography, bone mineral density study, one or more sites: axial skeleton or appendicular skeleton (peripheral). The provider shall obtain prior approval before rendering these BMM services.

Medicaid shall not require prior approval for other BMM procedure codes

- a. Refer to **Attachment A, Section C** for the applicable CPT codes.
- b. Refer to clinical coverage policy 1K-7, *Prior Approval for Imaging Services* at: <https://medicaid.ncdhhs.gov/>.

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 Additional Limitations or Requirements

- a. BMM is limited to one test every two years for a Medicaid beneficiary at risk for low bone mass (at least 23 months must have passed since the month the last covered BMM was performed).
- b. An additional BMM may be covered more frequently than every 23 months for one of the following conditions:
 1. Long-term glucocorticoid (steroid) therapy of 5.0 mg of prednisone or more per day of more than three months' duration;
 2. Long-term anticonvulsant therapy of more than three months' duration; or
 3. Monitoring with uncorrected primary hyperparathyroidism.

Note: Refer to **Attachment A, Section B** for the diagnosis codes.

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 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 a Medicaid Beneficiary 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: January 1, 1987

Revision Information:

Date	Section Revised	Change
02/01/2009	Throughout	Initial promulgation of current coverage.
07/01/2010	Throughout	Policy Conversion: Implementation of Session Law (SL) 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the DMA in the NC Department of Health and Human Services.”
12/01/2011	Throughout	Title of policy changed from Bone Mineral Density Studies to Bone Mass Measurement.
12/01/2011	Section 1.0	Added description of Bone mass measurement (BMM). Added information related to diagnosing low bone mineral content in children and adolescents. Deleted description of Bone mineral density (BMD) studies.
12/01/2011	Subsection 3.2	Added NCHC specific coverage criteria for BMM which includes policy guidelines. Deleted specific criteria regarding BMD studies.
12/01/2011	Subsection 3.3	Added NCHC coverage limits for drug therapy monitoring of low bone mineral content. Deleted Policy Guidelines.
12/01/2011	Subsection 4.2	Added specific noncoverage criteria for BMM including CPT codes not covered. Deleted BMD studies noncoverage criteria.
12/01/2011	Subsection 5.1	Added requirement for Prior Approval for Bone Mass Measurement procedures.
12/01/2011	Subsection 5.2	Added specific documentation required to obtain Prior Approval. Deleted documentation requirements regarding requesting BMM more frequently than every two years.
12/01/2011	Subsection 5.3	Added limitations for BMM procedures.
12/01/2011	Subsection 5.4	Added Dual Energy X-ray absorptiometry (DXA) interpretation and reporting in children and adolescents.
12/01/2011	Subsection 5.5	Added baseline DXA report requirements.
12/01/2011	Attachment A, B.	Added the ICD-9-CM codes which permit BMM to be performed more than every 23 months.
12/01/2011	Attachment A, C.	Added descriptions for covered CPT codes 77078, 77079, 77080, 77081 and 76977. Deleted CPT codes 77083, 78350, and 78351. Added Hospital revenue codes.
12/01/2011	Attachment A, F.	Deleted beneficiary’s home, Intermediate Care Facility, Skilled Nursing Facility for NCHC.

Date	Section Revised	Change
12/01/2011	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1K-2 under Session Law 2011-145 § 10.41.(b)
08/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
08/01/2012	Throughout	Replaced "recipient" with "beneficiary."
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.
03/15/2019	Table of Contents	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."
03/15/2019	All Sections and Attachments	Updated policy template language.
05/01/2019	Subsection 1.1	Updated according to International Society for Clinical Densitometry Skeletal Health Adults 2015 Official Positions. Added "The categories for diagnosis are: <ul style="list-style-type: none"> a. Normal (T-score – 1.0 and above) b. Low bone mass, referred to as osteopenia (T-score between – 1.0 and – 2.5) c. Osteoporosis (T-score – 2.5 and below) d. Severe osteoporosis (T -score – 2.5 and below with history of a fracture).
05/01/2019	Subsection 1.2	Updated according to current International Society for Clinical Densitometry Pediatric 2013 Official Positions. Removed "According to 2007 International Society for Densitometry (ISCD) Pediatric Official Positions," removed "patients" added "beneficiaries".
05/01/2019	Subsection 1.3	Added definitions for: T-score – a standardized score comparing bone marrow density to average values to young, healthy women. Z-score – a measure of how many standard deviations below or above the population mean a raw score is. Areal BMD – bone mineral content, measured by DXA, divided by the bone area in square centimeters.
05/01/2019	Subsection 3.2.1 (a)	Added CMS guideline for general supervision
05/01/2019	Subsection 3.2.1(b).6	Changed sentence to read "A beneficiary with non-traumatic (fragility) or pathologic fracture: or from "a beneficiary with a history of low trauma fracture.

Date	Section Revised	Change
05/01/2019	Subsection 3.2.1(b).7	Added “anorexia nervosa”.
05/01/2019	Subsection 3.2.1.8	Added “Peripheral measurement of BMD will be considered medically necessary: a. If the hip-spine or hip-hip cannot be done or the patient is over the table limit for weight, or b. for hyperparathyroidism, where the forearm is essential for diagnosis
05/01/2019	Subsection 4.2.1	Added to specific criteria not covered: Bone mineral density measurement using ultrasound densitometry, quantitative computed tomography, or dual x-ray absorptiometry of peripheral sites is considered investigational. Pulse-Echo Ultrasound Density Measurement is considered experimental, investigational and or unproven.
05/01/2019	Subsection 4.2.2	Added Medicaid shall not cover BMM for female beneficiaries under the age of 65 or male beneficiaries under the age of 70 who do not meet medical necessity criteria listed in Subsection 3.2.1
05/01/2019	Subsection 5.1.1	Rearranged wording in the paragraph.
05/01/2019	Subsection 5.1.2	Rearranged wording in sentence.
05/01/2019	Subsection 5.3	Added “steroid” after the word glucocorticoid.
05/01/2019	Attachment A B	Added ICD 10 does for anorexia nervosa. Removal of end dated and duplicate ICD 10 codes.
05/01/2019	Attachment A C	Added updated CPT codes and removed end dated CPT codes.
05/01/2019	Attachment A F1b	Added the words “primary private residence” and removed “home”. Removed the word “skilled” from skilled nursing home phrase.
05/01/2019	Attachment A F2b	Added the words “primary private residence” and removed “home”.
12/20/2019	Table of Contents	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.”
12/20/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.
8/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 8/15/2023 with an effective date of 4/1/2023.

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:

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Providers are required to bill applicable revenue codes.

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.

ICD-10-CM Code(s)			
E21.0	G40.209	G40.803	G40.A01
E21.2	G40.211	G40.804	G40.A09
E21.3	G40.219	G40.811	G40.A11
F50.0	G40.301	G40.812	G40.A19
F50.01	G40.309	G40.813	G40.B01
F50.02	G40.311	G40.814	G40.B09
G40.001	G40.319	G40.821	G40.B11
G40.009	G40.401	G40.822	G40.B19
G40.011	G40.409	G40.823	R56.9
G40.019	G40.411	G40.824	Z79.3
G40.101	G40.419	G40.89	Z79.51
G40.109	G40.501	G40.901	Z79.52
G40.111	G40.509	G40.909	Z79.891
G40.119	G40.801	G40.911	Z79.899*
G40.201	G40.802	G40.919	

*Use for anticonvulsant therapy of more than three months’ duration; bill with the secondary diagnosis for epilepsy, G40.309 through G40.919, or other convulsions, R56.9.

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.

C.1 CPTs covered are:

CPT Code(s)
77078*
77080
77081
76977

Asterisk * means the Procedure codes require prior approval for Medicaid beneficiaries only – refer to **Subsection 5.1**.

C.2 CPTs not covered are:

CPT Code(s)
77086
78350
78351

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 code(s) used which determines the billing unit(s).

F. Place of Service

F1. Medicaid

- a. Inpatient hospital, Outpatient hospital, Physician’s office; and
- b. In addition to the place of services listed in F.1a, CPT code 76977 can also be provided in: beneficiary’s primary private residence, Intermediate care facility and nursing facility.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>