

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

1.1 Cardiac Rehabilitation

Phase II outpatient cardiac rehabilitation is a comprehensive program of medical evaluation designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to active and productive lives. A cardiac rehabilitation program includes prescribed exercise; cardiac risk factor modification; education; and counseling, which includes diet instruction and disease management. It is used to assist beneficiaries 8 years of age and older in dealing with active heart disease and must be performed in a participating facility that has current certification under the Division of Health Service Regulation in accordance with 10A NCAC 14F.1100 through 14F.2106.

1.2 Risk Stratification

Risk stratification is usually documented as high risk, intermediate risk, or low risk and is used to identify beneficiaries at risk for death by infarction or re-infarction to provide guidelines for the rehabilitative process. Risk stratification includes the degree of limitation of exercise during a treadmill electrocardiogram (ECG) stress test performed within three weeks of the program's initiation. Measurement of risk stratification is determined by applying the metabolic equivalents (METs) achieved in the qualifying formal treadmill exercise test or the cycle ergometer exercise test that was performed prior to the patient's participation. A MET or work metabolic rate/resting metabolic rate is a multiple of the resting rate of oxygen consumption during physical activity. One MET represents the approximate rate of oxygen consumption of a seated adult at rest or 3.5 ml of oxygen consumed each minute per kilogram of body weight. For beneficiaries 8-18 years of age with congenital heart defects, risk stratification may include baseline oxygen saturation, state of palliated physiology, the specific nature of the defect, and history of associated arrhythmias. Measurement of risk stratification may be determined by applying the METs in beneficiaries 8 years of age and older who have undergone treadmill or cycle ergometer testing or may also include a statement by the beneficiary's cardiologist that takes into account the current hemodynamic status, the specific nature of the defect, and the expected response to exercise.

1.3 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 policies)

- a. An eligible beneficiary shall be enrolled in 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 Medicaid Beneficiaries 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 medically necessary phase II outpatient cardiac rehabilitation program is covered when it is initiated within six months of any of the following conditions:

- a. Acute myocardial infarction (MI).
- b. Coronary artery bypass grafting (CABG).
- c. Percutaneous transluminal coronary angioplasty or coronary artery stenting.
- d. Heart or heart–lung transplant.
- e. Heart valve repair or replacement.
- f. Diagnosis of stable angina pectoris.
- g. Surgery to palliate a congenital heart defect.
- h. Repaired or unrepaired congenital heart disease with functional limitations.
- i. Diagnosis of cardiomyopathy with stable ventricular function.

- j. Beneficiaries shall meet the minimum age requirements of eight years of age as deemed an appropriate candidate at the physician's discretion using the guidelines referenced in **Subsection 1.2, Risk Stratification**.
- k. **And** the beneficiary meets the criteria in one of the following risk categories:
 - 1. **High-risk** patients are defined as having any one of the following:
 - A. Exercise capacity limited to less than or equal to 5 METs.
 - B. Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more ST depression by ECG, or symptoms such as shortness of breath related to cardiac ischemia.
 - C. Severely depressed left ventricular function, such as an ejection fraction less than or equal to 30%.
 - D. Resting complex ventricular arrhythmia.
 - E. Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing.
 - F. Decrease in systolic blood pressure of 15 to 20 mmHg or more with exercise.
 - G. Recent (within the last six months) MI that was complicated by serious ventricular arrhythmia.
 - H. Recent sudden cardiac arrest.
 - I. Shock or congestive heart failure (CHF) during an MI occurring less than three months previously.
 - 2. **Intermediate-risk** patients are defined as having any one of the following:
 - A. Exercise capacity limited to 6 to 9 METs.
 - B. Ischemic ECG response to exercise of less than 2 mm of ST depression.
 - C. Uncomplicated MI, CABG, or angioplasty and a post-cardiac event maximal functional capacity of 8 METs or less on ECG exercise test.
 - D. Congenital heart disease with palliated biventricular physiology.
 - E. Congenital heart disease assessed as intermediate risk by beneficiary's cardiologist.
 - 3. **Low-risk** patients are defined as having any one of the following:
 - A. Exercise capacity of greater than 9 METs.
 - B. Biventricular congenital heart disease that has been successfully repaired.
 - C. Congenital heart disease assessed as low risk by beneficiary's cardiologist.

3.2.2 Medicaid 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 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

A phase II outpatient cardiac rehabilitation program is not covered when continuous ECG monitoring is not performed for high-risk beneficiaries.

Contraindications to an outpatient cardiac rehabilitation program include, but are not limited to, the following:

- a. Marked progressive worsening of exercise tolerance, suggesting an acute pathologic process.
- b. Worsening of dyspnea during exercise over the previous three to five days.
- c. Acute systemic illness or fever.
- d. Acute pericarditis.
- e. Moderate to severe aortic stenosis.
- f. New onset of atrial fibrillation.
- g. Recent embolism.
- h. Acute thrombophlebitis.
- i. Unstable ischemia.
- j. Uncontrolled arrhythmias.
- k. Decompensated congestive heart failure.
- l. Uncontrolled diabetes.
- m. MI within two weeks.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

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 shall not require prior approval for Phase II Outpatient Cardiac Rehabilitation Programs.

5.2 Program Requirements

5.2.1 High-Risk Patients

Up to 36 sessions (three times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring are covered. The sessions shall include the following:

- a. An educational program for risk factor/stress reduction.
- b. An individualized outpatient exercise program that can be self-monitored and maintained.
- c. Oxygen saturation monitoring for patients with congenital heart disease.

5.2.2 Intermediate-Risk Patients

Up to 24 sessions (three times per week for eight weeks) of supervised exercise with continuous telemetry monitoring available, if needed, are covered. The sessions shall include the following:

- a. Exercise with supervision, but without continuous monitoring, at a controlled rate prescribed during an exercise treadmill test.
- b. An individualized outpatient exercise program that can be self-monitored and maintained.

5.2.3 Low-Risk Patients

A program of up to six 1-hour sessions (three times per week for two weeks) involving risk factor reduction education and the creation of a self-administered exercise program for home use is covered. Low-risk patients may be candidates for an unmonitored exercise program and do not require continuous telemetry monitoring.

5.3 Service Provisions

Phase II outpatient cardiac rehabilitation programs must be comprehensive and include, at a minimum, a medical evaluation; a patient assessment; risk stratification; care planning with follow-up evaluations; procedures to modify cardiac risk factors, (see **Section 5.7**) (such as nutritional counseling, prescribed counseling, exercise, education, and a discharge plan.) The program design must be provided in accordance with the policies and procedures adopted by the program as indicated in 10A NCAC 14F.1302.

As indicated in 10A NCAC 14F.1801, at least one Advanced Cardiac Life Support (ACLS)–trained staff member who has the appropriate licensure to administer advanced cardiac life support and one other staff member must be present at the site during all program hours. For facilities that are not located within a hospital, or where a hospital resuscitation team is not available to respond in an emergency, a supervising physician, physician’s assistant, or nurse practitioner or must be on-site during all program hours. For facilities providing rehabilitation care to children, at least one Pediatric Advanced Life Support (PALS)–trained staff member who has the appropriate certification to administer pediatric life support must be present at the site at all times when pediatric patients are scheduled.

5.4 Program Admission

As indicated in 10A NCAC 14F.1501, an individual order, which may be in the form of a prescription, from the patient’s treating provider is required prior to rendering service.

5.5 Assessments

Within five weeks of the patient's admission to the program, the interdisciplinary team must complete and document a cardiac rehabilitation assessment to include, at a minimum, the following components as specified in 10A NCAC 14F.1601.

5.5.1 Medical Assessment

As documented in 10A NCAC 14F.1601(b), the assessment must include the following:

- a. cardiovascular evaluation as to present diagnosis, therapy, and a discharge summary of the patient's last hospitalization; or
- b. statement by referring physician as to present diagnosis and therapy;
- c. resting 12-lead ECG;
- d. medical record documentation prior to or during the first exercise session of ECG, hemodynamic data, oxygen saturation (for beneficiaries with congenital heart disease), and the presence or absence of symptoms, preferably determined by a graded exercise test. A graded exercise test shall not be required when deemed unnecessary by the beneficiary's attending or personal physician or the program's medical director;
- e. fasting blood chemistry, as indicated, to include total cholesterol, high density lipoprotein (HDL) cholesterol, low density lipoprotein (LDL) cholesterol, triglycerides, and other comparable measures;
- f. simple spirometry, if clinically indicated; and
- g. resting oxygen saturation (for beneficiaries with congenital heart disease).

5.5.2 Physical Assessment

As documented in 10A NCAC 14F.1601(c), the assessment must include the following:

- a. Functional capacity as determined by measured or predicted (METs).
- b. Height, weight, or other anthropometric measures (for example, body mass index, percent body fat, waist-to-hip ratio, girth measurements).
- c. Current and past exercise history.
- d. Physical limitations and disabilities that may impact rehabilitation.

5.5.3 Nursing Assessment

As documented in 10A NCAC 14F.1601(d), the assessment must include the following:

- a. Coronary risk profile.
- b. Current symptoms such as angina or dyspnea, and recovery from recent cardiac events.
- c. Presence of co-morbidities.
- d. Assessment of medications.
- e. Educational needs.

5.5.4 Nutrition Assessment

As documented in 10A NCAC 14F.1601(e), the assessment must include the following:

- a. Review of medical history.
- b. Eating patterns as measured by a food diary or food frequency questionnaire.
- c. Fasting blood work.
- d. Anthropometric measures.
- e. Behavioral patterns.
- f. Identification of nutritional goals.

5.5.5 Mental Health Assessment

As documented in 10A NCAC 14F.1601(f), the assessment must include the following:

- a. Past history of mental illness, including depression, anxiety, or hostility or anger.
- b. Present mental health functioning and need for referral to a mental health professional.

5.5.6 Vocational Assessment

As documented in 10A NCAC 14F.1601(g), the assessment must include the following:

- a. Vocational questionnaire to determine current vocational status, description of physical requirements of job, working conditions, and psychological demands as perceived by the patient.
- b. Need for vocational rehabilitation services.

5.6 Care Planning

In accordance with 10A NCAC 14F.1701, within five weeks of a beneficiary's admission to the program, the interdisciplinary team must develop a cardiac rehabilitation care plan for the beneficiary, and must address, at a minimum, the following services components:

- a. Exercise therapy.
- b. Nutrition services, if indicated.
- c. Mental health services, if indicated.
- d. Vocational services, if indicated.
- e. Educational counseling.
- f. Cardiac rehabilitation goals.
- g. Discharge planning.

Note: Where it is applicable, phase II outpatient cardiac rehabilitation programs are required to provide an assessment and refer the patient to the appropriate vocational rehabilitation service.

5.7 Service Components

Services must be provided in accordance with 10A NCAC 14F.1800.

5.7.1 Exercise Therapy

Unless contraindicated by medical and laboratory assessments or the cardiac rehabilitation care plan, each beneficiary's exercise therapy must include, as required by 10A NCAC 14F.1802, the following:

- a. Mode of exercise therapy: including, but not limited to, walking or jogging, aquatic activity, cycle ergometry, arm ergometry, resistance training, stair climbing, rowing, aerobics.
- b. Intensity:
 1. up to 85percent of symptom-limited heart rate reserve.
 2. up to 80 percent of measured maximal oxygen consumption.
 3. rating of perceived exertion (RPE) of 11 to 13 if a graded exercise test is not performed.
 4. for MI beneficiaries, heart rate not to exceed 20 beats per minute above standing resting heart rate if a graded exercise test is not performed; for post-CABG beneficiaries, heart rate not to exceed 30 beats per minute above standing resting heart rate if a graded exercise test is not performed.
 5. for beneficiaries with congenital heart disease, the intensity shall be determined in consultation with patient's cardiologist.
- c. Duration: up to 60 minutes, as tolerated, including a minimum of 5 minutes each for warm-up and cool-down.
- d. Frequency: minimum of three days per week.

The beneficiary must be monitored through the use of electrocardiography (and oxygen saturation for patients with congenital heart disease) during each exercise therapy session. The frequency of the monitoring—continuous or intermittent—must be based on medical acuity and risk stratification.

5.7.2 Nutrition Services

If indicated, based on the nutrition assessment and cardiac rehabilitation care plan, each beneficiary's program shall include, as required by 10A NCAC 14F.1803, the following nutrition services:

- a. Interpretation and feedback on the beneficiary's eating patterns, blood chemistries, anthropometric measures, and behavioral patterns.
- b. Identification of a therapeutic diet plan to determine, at a minimum, a reasonable body weight and caloric and fat intake.
- c. Patient counseling or behavior modification based on the therapeutic diet plan and goals.

5.7.3 Mental Health Services

If indicated, based on the mental health assessment and cardiac rehabilitation care plan, each beneficiary's program shall include, as required by 10A NCAC 14F.1804, the following mental health services:

- a. Feedback from mental health assessment to the patient.
- b. Present mental health functioning and need for referral to a mental health professional for evaluation or treatment.

5.7.4 Patient Education

Each beneficiary's cardiac rehabilitation care plan must include participation in the program's basic education plan. At a minimum, the education plan must include, as required by 10A NCAC 14F.1806, the following topics:

- a. Basic anatomy, physiology, and pathophysiology of the cardiovascular system.
- b. Risk factor reductions, including smoking cessation and management of blood pressure, lipids, diabetes, and obesity.
- c. Principles of behavior modification, including nutrition, exercise, stress management, and other lifestyle changes.
- d. Relaxation training offered at least once per week by staff trained in relaxation techniques.
- e. Cardiovascular medications, including compliance, interactions, and side effects.
- f. Basic principles of exercise physiology, guidelines for safe and effective exercise therapy, and guidelines for vocational/recreational exertional activities.
- g. Recognition of cardiovascular signs, symptoms, and management.
- h. Environmental considerations such as exercise in hot or cold climates.

5.8 Follow-up Evaluations

In accordance with 10A NCAC 14F.1702, providers are required to meet on a monthly basis to re-evaluate the beneficiary's progress. Changes to the beneficiary's care plan must be based on the follow-up evaluations.

5.9 Discharge

In accordance with 10A NCAC 14F.1500, a discharge plan must be developed and must include instructions for the beneficiary on how to achieve and maintain the goals established in the care plan. A copy of the discharge summary must be provided to the beneficiary's attending physician.

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 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 Staff Requirements

In accordance with 10A NCAC 14F.1301, phase II outpatient cardiac rehabilitation programs must be conducted utilizing an interdisciplinary team composed of a program director, medical director, nurse, exercise specialist, mental health professional, dietician or nutritionist, supervising physician, physician assistant or nurse practitioner, and a Division of Vocational Rehabilitation Services or other vocational rehabilitation counselor.

6.2 Staff Qualifications

It is the responsibility of the provider to ensure that staff meets the required qualifications for the functions they provide.

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).

7.2 Medical Record Documentation

In addition to documenting the risk stratification/exercise tolerance, in accordance with 10A NCAC 14F.2002, the patient's medical record must include, at a minimum, the following:

- a. Beneficiary identification data.
- b. Medical history and, when applicable, hospital discharge summary.
- c. Graded exercise data, if available.
- d. Resting 12-lead ECG.
- e. Signed physician referral.
- f. Records of blood chemistry analyses.
- g. Signed informed consent to participate in the program.
- h. Progress notes and response to the cardiac rehabilitation care plan.
- i. All records of each discipline's participation in the patient's cardiac rehabilitation care plan.
- j. A discharge summary, which describes the patient's progress while in the program, reason(s) for discharge, the post-discharge plan, and follow-up as indicated.
- k. Miscellaneous clinical records developed pursuant to the patient's course of treatment.

Note: Documentation must be made available to the Division of Medical Assistance or its agents upon request.

7.3 Emergency Equipment

Phase II outpatient cardiac rehabilitation programs must comply with the regulations pertaining to emergency plans and equipment in 10A NCAC 14F.1902.

The facility must have available for immediate use the necessary cardiopulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary, including, but not limited to, portable suction equipment, oxygen tank supply, regulator and mask for nasal cannula, intubation

equipment, other appropriate cardiopulmonary resuscitation equipment including medications, and a portable defibrillator.

The facility also must have a communication system to access emergency services and a written plan approved and signed by the medical director establishing the procedures to use to handle any emergencies occurring on site while cardiac rehabilitation services are being provided. All equipment must be serviced and maintained according to manufacturers' instructions and recommendations. Facilities providing care to children eight years of age and older must have age/size-appropriate life-saving equipment available for immediate use.

8.0 Policy Implementation/Revision Information

Original Effective Date: April 1, 2008

Revision Information:

Date	Section Revised	Change
4/1/08	Throughout	Initial promulgation of new service.
7/1/10	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
3/1/12	Throughout	To be equivalent where applicable to NC DMA’s Clinical Coverage Policy # 1R-1 under Session Law 2011-145 § 10.41.(b)
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2012	Subsections 1.1, 1.2	Correction to restore wording. Changed “8-18 years of age” to “8 years of age and older”
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.
01/03/2020	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.”
01/03/2020	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”.
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 6/1/2023 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)

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.

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.

Codes(s)
93797
93798

Revenue Code(s)

Hospital outpatient clinics bill for services using RC 943.

The service components (**Sections 5.0** through **7.0**) are not separately reimbursable.

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).
One unit = 1 session.

F. Place of Service

Hospital outpatient clinics, Physicians' offices, and Medical diagnostic clinics.

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/>