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 Definitions 1
1.1.1 Hospital Providers of Long-Term Care Services (Swing Beds) 1
1.1.2 Critical Access Hospitals 1
1.1.3 Inpatient Rehabilitation Hospitals 1
1.1.4 Specialty Hospitals 2
1.1.5 Long-Term Care Hospitals (LTCH) 2
1.1.6 Inpatient Readmission Review 2

2.0 Eligibility Requirements 2
2.1 Provisions 2
2.1.1 General 2
2.1.2 Specific 2
2.2 Special Provisions 3
2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age 3

3.0 When the Procedure, Product, or Service Is Covered 4
3.1 General Criteria Covered 4
3.2 Specific Criteria Covered 4
3.2.1 Specific criteria covered by Medicaid 4

4.0 When the Procedure, Product, or Service Is Not Covered 5
4.1 General Criteria Not Covered 5
4.2 Specific Criteria Not Covered 6
4.2.1 Specific Criteria Not Covered by Medicaid 6
4.2.2 Medicaid Additional Criteria Not Covered 6
4.2.3 Out-of-State Services 6

5.0 Requirements for and Limitations on Coverage 6
5.1 Prior Approval 6
5.2 Prior Approval Requirements 6
5.2.1 General 6
5.2.2 Specific 6
5.3 Acute Inpatient Hospital Services Requiring Prior Approval 6
5.4 Acute Inpatient Hospital Tests 7
5.5 Take-Home Supplies 7
5.6 Routine Newborn Care 7
5.7 Behavioral Health 7
5.8 Transplants 7
5.9 Inpatient Cardiac Recovery Services 7

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service 7

6.1 Provider Qualifications and Occupational Licensing Entity Regulations....8
6.2 Provider Certifications....8
6.3 Hospital Privileges....8

7.0 Additional Requirements....8
7.1 Compliance....8
7.2 Physician's Certification of Need for Acute Inpatient Hospital Services....8
Certification of Need....8
Recertification....8

8.0 Policy Implementation/Revision Information....9

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....14
I Inpatient Readmission Review....14

Attachment B: Claims Submission....16
A. Acute Inpatient Claims....16
B. Lower Level of Care Claims....17
C. Behavioral Health Claims....18
D. Reporting of Never Events and Hospital-Acquired Conditions....18
E. Procedures to Follow for Reporting Avoidable Errors (Never Events)....19
F. Procedures to Follow for Reporting POA and HAC Indicators....19
G. Medicare Part A and Part B....20
H. Routine Newborn Care for a Medicaid Beneficiary....20
I. Long-Term Care for a Medicaid Beneficiary....20
J. Hospice Services....20
K. Teleconsults....20
L. Abortion Procedures....20
M. Sterilization and Hysterectomy Procedures....20
N. Interim Claims for a Medicaid Beneficiary....20
O. Replacement Claims....21
P. DRG Claims....21
Q. Filing Claims....21
R. Time Limits....21
S. Adjustments....21

Attachment C: Utilization Review Requirements for Eligible Hospital Providers....22

Related Clinical Coverage Policies

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

1H, Telemedicine and Telepsychiatry
1E-2, Therapeutic and Non-therapeutic Abortions
1E-1, Hysterectomy
1E-3, Sterilization Procedure
IR-1, Phase II Outpatient Cardiac Rehabilitation Programs
2A-2, Long Term Care Hospital Services
2A-3, Out-of-State Services
2B-1, Nursing Facilities
3D, Hospice Services
8B, Inpatient Behavioral Health Service

1.0 Description of the Procedure, Product, or Service

This policy describes covered services, restrictions, and exclusions in the acute inpatient hospital services category of the NC Medicaid (Medicaid) program.

Inpatient Services are medical services provided to a beneficiary admitted to an acute inpatient hospital. For information about inpatient services for behavioral health, refer to clinical coverage policy 8B, *Inpatient Behavioral Health Services*, at https://medicaid.ncdhhs.gov/, and the North Carolina State Medicaid Plan, at: https://medicaid.ncdhhs.gov/.

1.1 Definitions

1.1.1 Hospital Providers of Long-Term Care Services (Swing Beds)

A hospital that has a Medicare provider agreement must meet the requirements found in 42 CFR 482.58 in order to be granted an approval from CMS to provide post-hospital extended care services.

1.1.2 Critical Access Hospitals

A critical access hospital (CAH) is a hospital that is certified to receive cost-based reimbursement from Medicare. CAHs are located in rural areas and meet certain criteria. CAHs may have a maximum of 25 beds. CAHs that have swing bed agreements (refer to **Subsection 1.1.1,** above) may use beds for either inpatient acute care or swing bed services according to 42 CFR 485.620(a).

1.1.3 Inpatient Rehabilitation Hospitals

Inpatient rehabilitation hospitals (IRH) can be either free-standing rehabilitation hospitals or rehabilitation units in acute care hospitals. They provide an intensive rehabilitation program and patients who are admitted must be able to tolerate three hours of intense rehabilitation services per day. The CMS admission criteria does not address specific diagnoses, but rather the beneficiary's need for rehabilitation and the ability to benefit from it. Inpatient rehabilitation hospitals shall provide daily access to a rehabilitation physician and 24-hour nursing.

Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics

CPT codes, descriptors, and other data only are copyright 2025 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

therapy) per day at least five days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15

hours of intensive rehabilitation therapy within a seven consecutive-day period, beginning with the date of admission to the IRH. In order for an IRH claim to be considered reasonable and necessary, there must be a reasonable expectation that the beneficiary meets all of the requirements in 42 CFR 412.622 (a)(3).

1.1.4 Specialty Hospitals

A specialty hospital is a hospital that is exclusively engaged in the care and treatment of beneficiaries who:

a. have cardiac or orthopedic conditions;
b. are receiving a surgical procedure; or
c. need any other specialized category of services designated by CMS.

1.1.5 Long-Term Care Hospitals (LTCH)

Hospitals qualifying as long-term acute care hospitals meet the conditions of participation for long- term care hospitals and have an average Medicare length of stay described in 42 CFR 412.23(e)(2).

Refer to clinical coverage policy 2A-2, *Long Term Care Hospital Services,* at https://medicaid.ncdhhs.gov/.

1.1.6 Inpatient Readmission Review

North Carolina Medicaid defines hospital readmission as an unplanned admission to the same facility within 30 days of being discharged as an acute hospital inpatient and the readmission is for the same or related conditions as the index admission.

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. Acute Inpatient Hospital Admission

The provider shall comply with 10A NCAC 25A .0201 (Medical Services). Hospitals may use any recognized system of medical practice standards, including evidence-based criteria and technology solutions to determine medical necessity.

1. Medicaid shall cover acute inpatient hospital services for a beneficiary who:
   A. is admitted as an inpatient;
   B. stays past midnight in an acute inpatient bed; and
   C. meets the criteria in **Section 3.0** of this policy.

2. Acute inpatient hospital services consist of any of the following:
   A. Bed and board in semiprivate room, except when private accommodations are medically necessary or when only private rooms are available;
   B. Nursing services and other related services that are ordinarily furnished by the hospital for the care and treatment of inpatients;
   C. Use of hospital facilities;
   D. Drugs and biologicals from the preferred drug list, for use in the hospital, excluding investigational or trial drugs or biological;
   E. Approved supplies, appliances, and equipment for use in the hospital; and
   F. Other diagnostic or therapeutic items or services not specifically listed but that are ordinarily furnished to inpatients.

b. Hospital Observation Status
A beneficiary who is admitted to a hospital for observation by a physician order does not qualify as an inpatient, even if he or she stays past midnight. For the purposes of this policy, a beneficiary in hospital observation status for more than 30 hours shall either be discharged by the attending physician or converted to inpatient status by written order of the physician to receive continued Medicaid reimbursement beyond the 30 hours.

c. Outpatient Hospital Services
Services for beneficiaries who are admitted and discharged on the same day, and who are discharged to home or to a non–acute care facility, must be billed as outpatient hospital services. Outpatient hospital services provided by a hospital to a beneficiary within the 24 hours immediately preceding an inpatient admission to the same hospital, and that are related to the inpatient admission, must be reported with the inpatient billing.

All claims for outpatient hospital services must be submitted according to UB-04 guidelines.

Note: The only exceptions to these requirements are beneficiaries who are admitted as inpatients and either dies or are transferred to another acute care hospital on the day of admission. Acute hospital admissions prior to 30 days after a previous acute inpatient hospital discharge for the same or related diagnosis are subject to review by DHHS.

d. Transfers
A beneficiary who has medical or surgical needs that cannot be met at the admitting hospital may be transferred to a hospital that is able to provide the appropriate care.

For Medicaid transportation issues refer to clinical coverage policy 15, *Ambulance Services*, at https://medicaid.ncdhhs.gov/.

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 the services and items listed below: For additional information, contact DHHS's designated contractor.

a. Birth certificates, baby bracelets, layettes;
b. Shrouds, morgue boxes;
c. Sitters or attendants;
d. Private duty nurses;
e. Leave days (overnight leave of absence);
f. Late discharge for convenience of the beneficiary or physician; and
g. Private accommodations when the conditions listed in **Section 3.0** are not applicable.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 Out-of-State Services

For Services Out of State more than 40 miles beyond the North Carolina state border, refer to clinical coverage policy 2A-3, *Out-of-State Services*, at https://medicaid.ncdhhs.gov/.

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

Medicaid shall not require prior approval for an acute inpatient hospital admission.

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

5.2.2 Specific

None Apply.

5.3 Acute Inpatient Hospital Services Requiring Prior Approval

For services or procedures that require prior approval, hospital personnel shall determine if the physician has completed the necessary prior approval (PA) forms before admitting Medicaid beneficiaries. The primary surgeon is responsible for obtaining written PA from DHHS or its designated contractor.

Retroactive PA is considered when a beneficiary, who does not have Medicaid at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Refer to *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

5.4 Acute Inpatient Hospital Tests

Acute inpatient hospital tests are specifically ordered by the attending physician or by a non-physician practitioner, who is responsible for the diagnosis or treatment of a particular beneficiary's condition.

In a teaching situation, a test may initially be ordered by an intern, resident, or medical student; however, the supervising physician shall certify the medical necessity for the test by countersigning the medical record according to hospital policy, rules and regulations. DHHS does not require any additional written information from the supervising physician.

5.5 Take-Home Supplies

Take-home drugs, medical supplies, equipment, and appliances are not covered, except for small quantities of medical supplies, legend drugs, or insulin needed by the beneficiary until such time as he or she can reasonably obtain a continuing supply.

Note: "Small quantities" shall not exceed a four days' supply or one container of a prepackaged product (such as insulin or eye drops).

5.6 Routine Newborn Care

Routine newborn care is limited to care while the infant is in the hospital. Refer to **Subsection 4.2.3 (a).**

5.7 Behavioral Health

Refer to clinical coverage policy 8B, *Inpatient Behavioral Health Services,* at https://medicaid.ncdhhs.gov/, for coverage criteria and billing information.

5.8 Transplants

For information relating to transplants refer to *Transplants and Transplant-Related Services* at https://medicaid.ncdhhs.gov/.

5.9 Inpatient Cardiac Recovery Services

Refer to clinical coverage policy IR-1, *Phase II Outpatient Cardiac Rehabilitation Programs,* at https://medicaid.ncdhhs.gov/. For purposes of this policy, Medicaid covers these services on an inpatient basis, and includes them in the appropriate DRG reimbursement or per diem rate.

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.

6.3 Hospital Privileges

A hospital shall have a current valid license issued by the Division of Health Service Regulation (DHSR) and shall meet the requirements for participation in Medicare for a hospital. The hospital shall have in effect a utilization review plan according to 42 CFR 440.10(a)(3)(iv).

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).

7.2 Physician's Certification of Need for Acute Inpatient Hospital Services

Certification of Need

Title 42 CFR 456.60 states, "(a) Certification, (1) A physician must certify for each applicant or beneficiary that inpatient services in a hospital are or were needed. (2) The certification must be made at the time of admission or, if an individual applies for assistance while in the hospital, before the Medicaid agency authorizes payment."

The physician shall certify the need for acute inpatient hospital services in the beneficiary's health record at the time of admission as either a handwritten or a stamped statement, signed and dated by the physician.

Note: DHHS Program Integrity post-payment review monitors the inclusion of this certification statement in the beneficiary's medical record.

Recertification

Title 42 CFR 456.60 states, "(b) Recertification. (1) A physician, or physician assistant or nurse practitioner (as defined in §491.2 of this chapter) acting within the scope of practice as defined by State law and under the supervision of a physician, must recertify for each applicant or beneficiary that inpatient services in a hospital are needed. (2) Recertifications must be made at least every 60 days after certification."

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1970

Revision Information:

Date	Section Revised	Change
03/01/2011	All sections and attachment(s)	Medicaid: Initial promulgation of current coverage.
03/12/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 2A-1 under Session Law 2011-145, § 10.41.(b)
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
12/01/2012	All sections and attachment(s)	Changed patient and recipient to beneficiary(ies) where appropriate.
12/01/2012	Section 1.0	Reference to NCHC State plan website location moved to Subsection 6.1
12/01/2012	Section 1.0, 2.0 & 3.0	Moved to Subsection 6.1
12/01/2012	Subsection 1.1.3	Moved to Subsection 6.1
12/01/2012	Subsection 1.1.5	Emergency definition removed from policy
12/01/2012	Subsections 1.1.6, 3.2, & 3.3.1	Removed from Policy. Belongs in Orthotics and Prosthetics policy and Out of State (OOS) Policy.
12/01/2012	Subsection 3.3.4	Transfers- This was a repetitive statement in several sections of policy and has been combined into one statement in Subsection 6.1
12/01/2012	Subsection 3.5	Moved to Subsection 3.2.3 reference to new OOS policy. Referred to ambulance manual.
12/01/2012	Subsection 3.6	Referred to New Out of State (OOS) Policy.
12/01/2012	Subsection 4.3	NCHC Non-cover Criteria added.
12/01/2012	Attachment A	Lower Level Of Care Claims described.
12/01/2012	Attachment A	The process for reporting of Never Events and Present on Admission vs Hospital Acquired Conditions is defined and explained.
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.
04/01/2018	Subsection 7.2	Amended policy to comply with 42 CFR 456.60
04/11/2018	All Sections and Attachments	Policy posted on this date, with an Amended Date of April 1, 2018.
09/01/2018	All Sections and Attachments	Policy title changed from Acute Inpatient Hospital to Acute Inpatient Hospital Services
09/01/2018	Table of Contents Attachment B: C.	Behavioral Health Claims page 17 added
09/01/2018	Section 1.0	Inpatient Services defined
09/01/2018	Section 1.0	Mental disease replaced with behavioral health

Date	Section Revised	Change
09/01/2018	Section 1.1.1	Hospital Providers of Long-Term Care Services (Swing Beds) must meet requirements found in 42 CFR 482.58.
09/01/2018	Section 1.1.1	42 CFR 482.66 replaced with 42 CFR 482.58
09/01/2018	All Sections and Attachments	Text additions, deletions and corrections to improve readability.
09/01/2018	Section 1.1.3	Replaced definition of Inpatient Rehabilitation Hospitals
09/01/2018	Section 1.1.3	Replaced 42 CFR 485.58. with 42 CFR 412.622 (a)(3)
09/01/2018	Section 3.2.1 (a)	Deleted Interqual or Milliman and Robertson**,** added: including evidence based criteria and technology solutions
09/01/2018	Section 3.2 (d)	Deleted the forthcoming Ambulance policy, added clinical coverage policy 15, *Ambulance Services*, on NC Medicaid's website at https://medicaid.ncdhhs.gov/
09/01/2018	Section 5.2.1	Deleted The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following: the prior approval request; and all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy. Added none apply.
09/01/2018	Section 5.6	Added reference to subsection 4.2.3 (a).
09/01/2018	Attachment B. A. 1.	Added and Critical Access
09/01/2018	Attachment B. A. 2.	Changed transfer to discharge
09/01/2018	Attachment B. A. 8.	Replaced Unless inpatient hospital tests are specifically ordered by the attending physician or other non-physician practitioner, payments for the tests are subject to recoupment. These tests shall be medically necessary, with Testing and procedures are required to be medically necessary and are subject to review and recoupment and
09/01/2018	Attachment B. B.	Deleted the FL2 form is also available in electronic format. Added: prior approval (PA) requests for nursing facility level of care (LOC) are initiated by submitting the FL-2 form, DMA 372-124, electronically through the website of the DHHS utilization review contractor.
09/01/2018	Attachment B. B.	Added X to 28.
09/01/2018	Attachment B. B.	Deleted all verbiage in the paragraph following **Note:** regarding FL2 form submission
09/01/2018	Attachment B. C. (added)	Added Section C. Behavioral Health Claims; For Medicaid beneficiaries who are receiving psychiatric care in a general hospital, with a psychiatric Diagnosis Related Group (DRG), while waiting for an inpatient psychiatric bed, submit claims to the Prepaid Inpatient Health Plan (PIHP) for reimbursement.
09/01/2018	Attachment B. F.	Replaced list of hospitals exempt from POA/HAC indicator from a. Critical access hospitals b. Long-term care hospitals c. Rural health clinics d. Federally qualified health centers e. Indian health centers f. Inpatient psychiatric hospitals to 1. Critical Access

Date	Section Revised	Change
		Hospitals (CAHs) 2. Long-term Care Hospitals (LTCHs) 3. Maryland Waiver Hospitals* 4. Cancer Hospitals 5. Children's Inpatient Facilities 6. Religious Non-Medical Health Care Institutions 7. Inpatient Psychiatric Hospitals 8. Inpatient Rehabilitation Facilities 9. Veterans Administration/Department of Defense Hospitals *Maryland Waiver Hospitals must report the POA indicator on all claims.
09/01/2018	Attachment B. G.	Deleted Refer to *Medicare Part B Billing* (Special Bulletin V for 2004, published in August 2004 and effective September 6, 2004) for detailed billing instructions. Refer to Medicaid's website at https://medicaid.ncdhhs.gov/. The NC Health Check Program Guide and the TPL Medicaid and NCHC Billing Guide are located at: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
09/01/2018	Attachment B. L.	Deleted Abortion procedures are billed on paper. An abortion statement is required for therapeutic abortions and shall be submitted with a paper claim.
09/01/2018	Attachment B. M.	Deleted Sterilization and hysterectomy claims may be filed electronically. The consent or statement shall be mailed on the same date.
09/01/2018	Attachment B. P.	42 CFR 433.51 (b) replaced with 42 CFR 412.60
09/01/2018	Attachment B. R.	Added calendar
09/01/2018	Attachment C.	Inserted licensed by the State of North Carolina
09/01/2018	Attachment C.	Replaced http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr456_06.html. Or http://ecfr.gpoaccess.gov/ with https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42tab_02.tpl
09/01/2018	Attachment C.	Added **License Number assigned by the Department of Health and Human Services-Division of Health Service Regulation**
09/01/2018	Attachment C.	Replaced NA with-The UR plan must be signed by hospital administration or authorized committee members
09/01/2018	All Sections and Attachments	Medical record changed to health record
09/01/2018	All Sections and Attachments	Updated policy template language. Changed Division of Medical Assistance (DMA) or DMA, to NC Medicaid, as needed.
09/07/2018	All Sections and Attachments	Policy posted 09/07/2018 with an Amended Date of 09/01/2018
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services

Date	Section Revised	Change
		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.
12/15/2023	Section 3.2.1 and Attachment B: A.15	Removed "outpatient" language. Posting and amended date not changed.
06/01/2024	Attachment B.A.5	Changed timeframe for readmission review from 72 hours to 30 days.
06/01/2024	Section 3.2.1.C	Changed timeframe for readmission review from 72 hours to 30 days
07/15/2024		Corrected typographical error in section 8.0 for amended date for the Attachment B.A.5 change and corrected date back to 06/01/2024. Amended date not changed
09/23/2024	Attachment B.A.5	Changed timeframe for readmission review from 30 days to 72 hours with effective date of 06/01/2024 with an amended date of 09/23/2024.
09/23/2024	Section 3.2.1.C	Changed timeframe for readmission review from 30 days to 72 hours with effective date of 06/01/2024 with an amended date of 09/23/2024.
01/01/2026	Section 1.1.6	Added definition for inpatient readmission review.
01/01/2026	Section 3.2.1.C	Changed timeframe for readmission review from 72 hours to 30 days
01/01/2026	Attachment A.I	Added 30-day inpatient readmission review exclusion criteria
01/01/2026	Attachment B.A.5	Changed timeframe for readmission review from 72 hours to 30 days.

Attachment A: Claims-Related Information

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

A. Claim Type

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.

Hospital providers shall bill Revenue Center (RC) codes from the most current UB-04 Data Specification Manual on the detail lines and shall bill ICD-10-PCS codes (to the greatest specification possible) for all procedures and treatments performed during hospitalization.

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 Codebook 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

Inpatient.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

I Inpatient Readmission Review

As a means to encourage hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans, and in turn, reduce avoidable readmissions, claims may be subject to quality review by DHHS or its designee for medical necessity and quality of care.

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

The quality review assesses care during the index admission and the patient's post discharge care and services recommended and delivered for appropriate communication, care coordination, patient and caregiver engagement, and discharge planning for elements of care by the hospital, primary care provider, and care manager. The review shall analyze the stay at the first hospital and post discharge services to determine the cause(s) and extent of any problem(s) (e.g., incomplete or substandard treatment). Information available to the attending physician who discharged the patient will be considered. Determinations of a premature discharge will not be based on information the physician or provider could not have known or events that could not have been anticipated at the time of discharge.

Readmissions found to not be medically necessary, a circumvention of the payment system for inpatient services, or resulting from a premature discharge from the same facility may be denied. Specific clinical reasons, including how the readmission was reasonably preventable, and the offer of a peer-to-peer discussion, must be provided to the provider within the denial letter. When indicated, provider recoupments may be made. Adverse determinations are subject to appeal review if requested by the hospital.

Inpatient readmission review does not apply to cancer hospitals, critical access hospitals, planned hospital transfers, and inpatient rehabilitation centers. The following claims, if no administrative or clerical errors are present on the claim, shall be exempt from utilization review measures based solely on occurring within 30 days of an inpatient index stay for the same or similar diagnosis:

1. Medical treatment of cancer
2. Psychiatric illness
3. Rehabilitation
4. Planned readmission
5. Age less than 2 years
6. Discharge against medical advice during index stay
7. Pregnancy, childbirth, and puerperium
8. Organ or tissue transplant inclusive of patients under active evaluation for transplant, listed for transplant, or post transplant
9. Sickle cell anemia
10. Cystic fibrosis
11. Authorization denial for inpatient, continued stay, or post-acute care for the patient at the index admission, visit, or stay.

Attachment B: Claims Submission

The preferred method for claims submission is one claim for the beneficiary's entire stay using the currently applied UB code for "admit through discharge."

The Diagnosis Related Group (DRG) DRG-allowable is calculated and day or cost outliers are added to represent the DRG maximum allowable.

Any applicable Medicaid beneficiary liability, deductible balance, and third-party liabilities are then applied.

A. Acute Inpatient Claims

1. Acute Inpatient hospital services for general acute care hospitals (excluding Inpatient Psychiatric, Rehabilitation, Specialty, and Critical Access Hospital services) are reimbursed by DRG methodology. Generally, claims submission guidelines parallel those for inpatient Medicare claims submission. The DRG reimbursement system does not alter the UB-04 claim form requirements, nor does it prevent electronic claims submission with the 837I transaction. Omission of required UB-04/837I fields may cause denial of payment. Payment is based on beneficiary diagnoses, surgical procedures, and DRG rate setting methodology as described in 10A NCAC 22G .0202. Inpatient Psychiatric, Rehabilitation and Specialty Hospitals claims are paid on a per-diem rate methodology.
2. When a beneficiary shall be transferred from one acute care facility to another, both the transferring facility and the receiving facility are paid. Beneficiary status on the claim form shall reflect the appropriate discharge status code as defined by the national UB committee. The transferring facility is entitled to a prorated DRG amount, not to exceed the full DRG amount. If the required days of the acute care stay are greater than or equal to the average length of stay assigned for the DRG, the transferring facility is eligible for the entire amount. The receiving facility receives the usual DRG payment unless the beneficiary is transferred again.
3. If the hospital requires a beneficiary to return home for a short period after being admitted as an inpatient, the beneficiary should not be discharged and readmitted upon his or her return. The claim is billed as a continuous stay. A leave of absence, revenue code 180, is billed for each day the beneficiary was away from the facility. The claim reflects charges for the entire stay. The admit date should equal the From Date of service and is billed through the discharge date. Leave of absence days are included in this span of dates.
4. When a beneficiary continues to occupy his or her accommodations beyond the checkout time for personal reasons, Medicaid will not pay for the continued stay. However, it is expected that institutions will not impose late charges on a beneficiary unless he has been given reasonable notice, such as 24 hours, of impending discharge.
5. If a beneficiary is readmitted to the same facility within 30 days of being discharged as an acute hospital inpatient and the readmission is for the same or related conditions as the original admission, the claim is subject to review by DHHS or its designee for medical necessity and quality of care. When indicated, provider recoupments are made.
6. If an inpatient beneficiary needs a medically necessary outpatient diagnostic or treatment service that cannot be performed at that facility, and the service is performed at a different facility, each facility can be paid for the actual services it rendered.

7. If an outpatient diagnostic or treatment service is performed at the same facility while the beneficiary is an inpatient, the outpatient charges should be included in the inpatient bill. The DRG payment is considered payment in full for all procedures and services rendered during the inpatient stay.
8. Testing and procedures are required to be medically necessary and are subject to review and recoupment and reimbursement is included in the DRG or per diem rate.
9. If outpatient services are provided by a hospital to a beneficiary within the 24-hour period prior to an inpatient admission in the same hospital and the outpatient services are related to the inpatient admission, the provider shall include the outpatient services with the inpatient billing.
10. If the inpatient claim is paid first, a subsequent outpatient claim will be denied.

Note: An inpatient replacement claim, bill type 117, may be submitted to reflect the outpatient charges, which are then included in the DRG payment.

11. Hospital claims submitted for a high dollar amount are reviewed by DHHS or its designated contractor for medical necessity, appropriateness of services, and quality of care. When indicated, claims may be denied or recouped.
12. All claims are subject to post-payment review by DHHS or its designated contractor. Any claims determined to be inappropriately paid are subject to recoupment of payment. The provider is responsible for reporting any inappropriately paid claims.
13. Admission and discharge hours are required fields on the UB-04 or 837I.
14. Services for beneficiaries who are admitted and discharged on the same day, either to home or to a non–acute care facility, shall be billed as outpatient services.
15. Claims reporting observation in excess of 30 hours are subject to recoupment upon post-payment review.

B. Lower Level of Care Claims

When a Medicaid beneficiary no longer meets acute care requirements and is approved for a nursing facility, but has not yet been released to a nursing facility, the hospital shall bill for a lower level of care while the beneficiary is still in the hospital.

Prior approval must be obtained by filing an approved DHHS screening FL2 form before billing for the lower level of care. Prior approval (PA) requests for nursing facility level of care (LOC) are initiated by submitting the FL-2 form, electronically through the website of the DHHS utilization review contractor.

To receive per diem for a lower level of care, the facility shall submit a claim showing discharge from the acute level. A separate claim must be submitted for the admission to a lower level of care.

If the beneficiary's condition changes to an acute level of care, a claim must be submitted showing discharge from the lower level.

A separate claim must be submitted showing the readmission to acute care. Bill Type 66X is used for billing lower level of care and Bill Type 28X is used for billing ventilator care.

Days for lower-than-acute level of care for ventilator-dependent beneficiaries in swing-bed hospitals or in hospitals that have been downgraded through the utilization review (UR) process

may be paid up to 180 calendar days at a lower-level ventilator-dependent rate if the hospital is unable to place the beneficiary in a lower-level facility. An extension may be granted by DHHS. DHHS may make a retrospective review of any transfers to a lower level of care prior to the expiration of the average length of stay for the applicable DRG (Refer to Medicaid State Plan attachment 4.19A).

When a hospital UR committee performs an inpatient concurrent review or the beneficiary's attending physician review determines acute care is no longer necessary, UR shall note that date and indicate that nursing facility or ventilator care is appropriate.

In order to bill for the lower level of care rate:

a. The beneficiary must first be discharged from acute care and then admitted as a lower level of care patient.
b. File a Hospital Claim using Bill Type 11X to discharge the beneficiary from the acute hospital inpatient level of care.
c. Providers must then file a Hospital Claim for billing the appropriate lower level of care services under the appropriate Bill Type indicated below:
    1. Bill Type 66X must be used for billing the Nursing Facility level of care.
    2. Bill Type 28X must be used for billing the Ventilator level of care.

The hospital must continue to actively seek appropriate level of care facility placement for beneficiaries in lower level of care beds. Prepayment and post payment reviews may be performed by DHHS or its designated contractor with denial or recoupment of payments when appropriate.

The hospital billing office uses the UR notice to correctly bill for approved acute-care days only. For those days indicated as nursing facility level of care, the hospital should bill the appropriate lower level of care or lower level of care ventilator rate. The hospital cannot bill Medicaid for days the beneficiary is awaiting other discharge arrangements, such as home or adult care home.

If a hospital consistently fails to bill Medicaid properly, resulting overpayments will be subject to recoupment.

C. Behavioral Health Claims

For behavioral health coverage criteria and billing information for inpatient services in an inpatient psychiatric facility, or in a psychiatric unit of a general hospital for Medicaid beneficiaries, refer to clinical coverage policy 8B, *Inpatient Behavioral Health Services*, at https://medicaid.ncdhhs.gov/. For Medicaid beneficiaries who are receiving psychiatric care in a general hospital, with a psychiatric Diagnosis Related Group (DRG), while waiting for an inpatient psychiatric bed, submit claims to the Prepaid Inpatient Health Plan (PIHP) for reimbursement.

D. Reporting of Never Events and Hospital-Acquired Conditions

In compliance with CMS billing guidelines and N.C. budget mandates 2010, requests for claims payment for dates of service on or after October 1, 2010, that are processed beginning on May 1, 2011, using DRGs that are attributed to the list that Medicare maintains related to hospital-acquired conditions (HACs) or never events are not approved by the Peer Review Organization (PRO) and are not reimbursable. This policy refers to all reimbursement provisions documented in Title XIX of the Social Security Act Section 1902, 1903 and 42 CFR 434, 42 CFR 438 and 42

CFR 447 including supplemental or enhanced payments and disproportionate share hospital payments to **in-state** as well as **out-of-state** providers and complies with Medicare billing guidelines for HACs, never events, and present on admission (POA).

E. Procedures to Follow for Reporting Avoidable Errors (Never Events)

Avoidable errors that fall under this policy are:
1. Wrong surgical or other invasive procedure performed on a patient;
2. Surgery or other invasive procedure on the wrong body part; and
3. Surgical or other invasive procedure performed on the wrong patient;

Inpatient hospital claims that report avoidable errors must be submitted on a UB-04 claim form or the 837I claim transaction with type of bill (TOB) 110 indicated on the claim. Outpatient hospital claims for avoidable errors should use TOB 130. The non-covered claim must have one of the following ICD-10-CM diagnosis codes reported:
a. Y65.51– Performance of wrong procedure (operation) on correct patient
b. Y65.52 – Performance of procedure (operation) on patient not scheduled for surgery
c. Y65.53– Performance of correct procedure (operation) on wrong side or body part

Ambulatory surgical centers and practitioners using the CMS 1500 claim form or 837P claim transaction must include the appropriate modifier appended to all lines that relate to the erroneous surgery(ies) or procedure(s) using one of the following applicable National Coverage Determination modifiers:
a. **PA –** Surgery wrong body part
b. **PB –**Surgery wrong patient
c. **PC –**Wrong surgery on patient

F. Procedures to Follow for Reporting POA and HAC Indicators

Effective with date of processing May 1, 2011, any claim for dates of service October 1, 2010, and after, involving inpatient admissions to general acute care hospitals using the UB-04 claim form or 837I claim transaction must file their discharge claims with POA/HAC indicators for all primary and secondary diagnoses. The POA/HAC indicator is placed adjacent to the principle and secondary diagnoses after the ICD-10-CM diagnosis code.
The codes that are acceptable as POA/HAC indicators are:
Y = Yes – Present at the time of inpatient admission.
N = No – Not present at the time of inpatient admission.
U = Unknown – The documentation is insufficient to determine if the condition was present at the time of inpatient admission.
W = Clinically Undetermined – The provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not.

Hospitals will not receive additional payment for cases in which the selected condition was not present on admission. In other words, the DRG will be paid excluding any code that has a character of N or U. An indicator of "1" will be paid as though the secondary diagnosis were not present. Only diagnoses codes with a character of Y will be considered in the DRG calculations.

At this time the following types of providers are **EXEMPT** from POA/HAC indicator reporting:

a. Critical Access Hospitals (CAHs)
b. Long-term Care Hospitals (LTCHs)
c. Maryland Waiver Hospitals*
d. Cancer Hospitals
e. Children's Inpatient Facilities
f. Religious Non-Medical Health Care Institutions
g. Inpatient Psychiatric Hospitals
h. Inpatient Rehabilitation Facilities
i. Veterans Administration/Department of Defense Hospitals

*Maryland Waiver Hospitals must report only the POA indicator on all claims.

G. Medicare Part A and Part B

The NC Health Check Program Guide and the Third Party Liability (TPL) Medicaid Billing Guide are located at: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

H. Routine Newborn Care for a Medicaid Beneficiary

Routine newborn care is billed on a separate claim form under the newborn's Medicaid number, not on the mother's claim form.

I. Long-Term Care for a Medicaid Beneficiary

Refer to clinical coverage policy 2B, *Nursing Facilities,* at https://medicaid.ncdhhs.gov/ for billing instructions and coverage criteria.

J. Hospice Services

Refer to clinical coverage policy 3D, *Hospice Services,* at https://medicaid.ncdhhs.gov/, for billing instructions and coverage criteria.

K. Teleconsults

Refer to clinical coverage policy 1H, *Telemedicine and Telepsychiatry,* at https://medicaid.ncdhhs.gov/, for billing instructions and coverage criteria.

L. Abortion Procedures

Refer to clinical coverage policy 1E-2, *Therapeutic and Non-therapeutic Abortions,* at https://medicaid.ncdhhs.gov/, for billing instructions and coverage criteria.

M. Sterilization and Hysterectomy Procedures

Refer to clinical coverage policies 1E-1, *Hysterectomy,* and 1E-3, *Sterilization Procedure,* at https://medicaid.ncdhhs.gov/, for billing instructions and coverage criteria.

N. Interim Claims for a Medicaid Beneficiary

1. Interim claims are reimbursed only if the covered days span at least 61 calendar days.
2. All first interim claims submitted with an interim bill type that are less than a 61-calendar day span will be denied.
3. All continuing interim claims received after the initial interim claims are treated as replacement claims.

4. The final claim shall be submitted with a Beneficiary Status of discharged, expired, or transferred using the appropriate UB beneficiary status code.

O. Replacement Claims

Any errors made on a previously paid claim can be corrected by submitting a replacement claim.

P. DRG Claims

Information specific to DRG claim methodology according to 42 CFR 412.60.

Q. Filing Claims

DHHS requires all claims to be filed electronically.

R. Time Limits

Hospital inpatient claims shall be filed within 365 calendar days of the *last* date of service on the claim.

For information on time-limit overrides, unless a longer period is allowed, (10A NCA 22B .0104) refer to *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html.

S. Adjustments

Requests for adjustment or reconsideration of a denied claim must be filed within 18 months of the date of payment or denial.

Attachment C: Utilization Review Requirements for Eligible Hospital Providers

Each hospital, licensed by the State of North Carolina, shall have a written Utilization Review (UR) plan that complies with 42 CFR. 456.101 through 456.145. If there is any major change or qualifying event—such as a change in hospital operations, a change in hospital ownership, an increase or decrease in the number of beds, or a change in the hospital's location—the hospital shall submit a new UR plan to NC Medicaid. The new UR plan must be approved at the time of the change. If there is no qualifying event, the hospital shall update and submit its UR plan to NC Medicaid every four years.

Submit all UR plan updates (refer to outline below) to Hospital Nurse Consultant, Division of Medical Assistance, 2501 Mail Service Center, Raleigh NC 27699-2501.

Access to this and other related Federal regulations is available at https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42tab_02.tpl and look for utilization review.

UR outline and authority sources as noted below:

License number assigned by the Department of Health and Human Services-Division of Health Service Regulation

Purpose	**42 CFR 456.105**
Organization	**42 CFR 456.106**
Committee Meetings/Minutes	**42 CFR 456.105 & 106**
Functions of the UR Committee	**42 CFR 456.105, 112, 113**
	42 CFR 456.105, 106, 112, 113
Methods of Review	**42 CFR 456.121, 131**
Pre-Admission Review	**42 CFR 456.127**
Admission Review	**42 CFR 456.60**
	42 CFR 456.111
	42 CFR 456 121, through 126 & 129
Continued Stay Review	**42 CFR 456.128 through 137**
Physician Advisor Role	**42 CFR 456.123, 135**
Medical Care Evaluation Studies	**42 CFR 456.141 through 145**
Signature Page	**The UR plan must be signed by hospital administration or authorized committee members**