

**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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**Related Clinical Coverage Policies**

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

2A-1, *Acute Inpatient Hospital Services*

2B-1, *Nursing Facilities*

8B, *Inpatient Behavioral Health Services*

8D-2, *Residential Treatment Services*

15, *Ambulance Services*

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

Out-of-state (OOS) services are limited to the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands as defined in 42 CFR 400.203.

Out-of-State services is determined medically necessary care and services that is provided within 40 miles of the NC border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia are covered to the same extent and under the same conditions as medical care and services provided in NC, except for **the services found in Subsection 4.2** of this policy.

For a list of NC border zip codes:

<https://www.nctracks.nc.gov/content/public/providers/provider-enrollment/supporting-information/zip-codes.html>.

### **1.1 Definitions**

#### **1.1.1 Emergency Medical Condition (42CFR§489.24(b))**

- a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:
  1. serious impairment to bodily functions; or
  2. serious dysfunction of any body organ or part.
- b. **For Medicaid beneficiaries only**, with regard to pregnant women having contractions:
  1. that there is inadequate time to affect a safe transfer to another hospital before delivery; or
  2. that the transfer may pose a threat to the health or safety of the woman or her unborn child.

#### **1.1.2 Out-of-State providers: Providers located outside the NC border.**

- a. **Contiguous area providers:** Providers located within 40 miles of the NC border are reimbursed to the same extent and under the same conditions as medical care and services provided in NC.
- b. **Non-Contiguous area providers:** Providers located more than 40 miles from the NC border.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

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

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

- a. are more reasonably available than can be provided by an enrolled in-state provider and have been prior approved by NC Medicaid or NC Medicaid's designee prior to rendering the services;

- b. are provided in any ONE of the following situations:
  - 1. emergency medical condition as defined in **Subsection 1.1(a)**;
  - 2. when the health of the beneficiary would be endangered if the care and services were postponed until the beneficiary returns to North Carolina;
  - 3. where the health of the beneficiary would be endangered if travel were undertaken to return to North Carolina; or
- c. the care and services needed by the beneficiary are not available in North Carolina.

**Note:** As soon as medically appropriate, the beneficiary shall return to North Carolina, as no services are covered unless those services meet the specific criteria above in **Subsection 3.2.1**.

### **3.2.2 Medicaid Additional Covered Criteria**

Medicaid shall cover out-of-state services for a foster child who is a ward of the State of North Carolina and living in a foster home more than 40 miles from the NC border without prior approval.

### **3.2.3 Ambulance Services**

Refer to clinical coverage policy 15, Ambulance Services, at <https://medicaid.ncdhhs.gov/>, for prior approval information.

## **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**

Medicaid shall not cover acute inpatient hospital services when the criteria in **Section 3.0** of this policy are not met.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

Medicaid shall not cover the following services when provided in non-contiguous states by out of state providers outside of the 40-mile radius:

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

## 5.0 Requirements for and Limitations on Coverage

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

### 5.1 Prior Approval (PA)

The North Carolina (NC) referring provider shall obtain prior approval for all non-emergency out-of-state services (except for services provided to Medicaid beneficiaries who are foster children (Refer to **Subsection 3.2.2.**)).

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

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

Prior approval for non-emergency care limitations do not apply to foster children who are Medicaid beneficiaries and have been placed in homes outside North Carolina, **except** if the procedure or service specifically requires prior approval as part of its Medicaid coverage in any location.

NC physicians shall request reauthorization of a service and provide a Letter of Medical Necessity (LOMN) before the end of the current authorization period for services to continue. Any subsequent treatment options, or inpatient treatment are requested separately via the NC Tracks provider portal with the submission of clinical information and the LOMN prior to any treatment.

**In the event that the beneficiary becomes eligible for other health coverage, Medicaid is the payer of last resort.** Medicaid shall not grant prior approval for a beneficiary when NC Medicaid is not the primary payer.

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

### 5.2 Prior Approval Requirements

#### 5.2.1 General

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

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

### 5.2.2 Specific

In addition to **Subsection 5.2.1** above, **ALL** of the following requirements must be met:

- a. The OOS prior approval request must be submitted by the NC referring provider;
- b. The OOS facility and rendering provider(s) must be enrolled in NC Medicaid at the time of the prior approval submission. If the National Provider Identifier (NPI) of the rendering provider or facility is not active in NC Tracks, the prior approval request cannot be submitted; and
- c. The NC referring provider (s) shall submit via the NC Tracks Provider Portal the following:
  1. The prior approval request with the LOMN, signed by the NC referring physician which contains ALL the following information:
    - A. The name of the NC Medicaid beneficiary;
    - B. The beneficiary's NC Medicaid number;
    - C. The beneficiary's date of birth;
    - D. The beneficiary's current clinical status with diagnosis(es);
    - E. The description of the beneficiary's medical treatment rendered in NC;
    - F. The name of the OOS physician(s) and facility, that is to treat the beneficiary with their National Provider Identification (NPI) number(s);
    - G. Reason(s) why the beneficiary cannot be treated medically in NC; and
    - H. The anticipated treatment plan, documenting CPT, HCPCS and revenue codes that are to be billed, and the inpatient or outpatient length of stay at the OOS facility.

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

Refer to clinical coverage policy 2A-1, *Acute Inpatient Hospital Services*, at <https://medicaid.ncdhhs.gov/>, for prior approval information.

### 5.4 Emergency Treatment Follow-Up Care for Medicaid Beneficiaries

Providers rendering out-of-state emergency treatment shall refer the beneficiary to a North Carolina provider for follow-up care. If NC Medicaid determines that follow-up care is more reasonably available out-of-state, the NC provider shall obtain PA. The written PA request must be submitted to NC Medicaid's designee, and the guidelines for out-of-state services must be followed. A beneficiary who is being sent out-of-state shall be informed by the referring NC provider that follow-up for services is to occur in a NC facility.

Refer to clinical coverage policy 2A-1, *Acute Inpatient Hospital Services*, at <https://medicaid.ncdhhs.gov/>, for prior approval information.

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

A PA for transportation is required for nonemergent air or ground transport for OOS services and a separate PA for transportation is required for air or ground transport for a return to a NC Medicaid facility. A separate **medical** PA is not required for a beneficiary to return to a NC Medicaid facility. The NC provider must request the PA through the NCTracks provider portal.

**Note:** Emergent transportation does not require prior approval.

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

Refer to clinical coverage policy 2B -1, *Nursing Facilities*, at <https://medicaid.ncdhhs.gov/>, for prior approval information.

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

Refer to clinical coverage policy 8B, *Inpatient Behavioral Health Services*, at <https://medicaid.ncdhhs.gov/>, for prior approval information.

### **5.8 Residential Treatment Services**

Refer to clinical 8D-2, *Residential Treatment Services*, at <https://medicaid.ncdhhs.gov/>, for prior approval information.

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

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

- a. meet Medicaid 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 Enrollment**

- a. Out-of-state providers, including border area providers, must be enrolled in Medicare or their home state Medicaid program to enroll in NC Medicaid. If Medicare participation cannot be verified, the DHHS Fiscal Contractor shall contact the home state Medicaid program for verification. If Medicare participation is required based on taxonomy, it is verified, and if verified, home state Medicaid participation is not required.
- b. Attending, rendering, ordering, prescribing, and referring providers are required to be enrolled in NC Medicaid, for the date of service in which services were rendered. Providers who render emergent services where prior approval was not obtained, may

retroactively enroll in NC Medicaid. This requirement applies to all providers or facilities who render out-of-state services in non-contiguous states outside of the 40-mile radius.

## 7.0 Additional Requirements

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

### 7.1 Compliance

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

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## 8.0 Policy Implementation/Revision Information

Original Effective Date: July 19, 1988

### Revision Information:

Date	Section Revised	Change
08/01/2011	All Sections and Attachments	New policy documenting current coverage.
03/01/2012	All Sections and Attachments	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 2A-3 under Session Law 2011-145, § 10.41.(b)
01/15/2013	All Sections and Attachments	Technical changes to merge Medicaid and NCHC current coverage into one policy.
01/15/2013	Section 1.0	Changed first sentence to refer to services provided out of state, removed reference to within 40 miles of border here.
01/15/2013	Section 4.3 2 <sup>nd</sup> paragraph	Made wording the same as Subsection 4.4 to read non-coverage in non-contiguous states vs non coverage out of state.
01/15/2013	Section 5.3	Changed from 2 separate references to one reference since Behavioral health policy is now combined policy.
01/15/2013	Attachment A (h)	Added reference to NCHC SPA for reimbursement.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
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.
12/01/2019	Related Clinical Coverage Policy Box	Added new policy 15, Ambulance Services, and removed policy 8D-1, Psychiatric Residential Treatment Facilities for Children under the age of 21. Ambulance Services requires a separate PA.
12/01/2019	Section 1.0	Added services shall be provided to territories and possessions of the United States. Included URL of zip codes for contiguous providers located within 40 miles of the NC border.
12/01/2019	Subsection 3.2.1	Added language to this subsection.
12/01/2019	Subsections 4.2.2 and 4.2.3	Added text outside of the 40-mile radius
12/01/2019	Subsection 5.1	Clarified prior approval is obtained by the NC

Date	Section Revised	Change
		provider for out-of-state (OOS) services. The NC provider must obtain authorization if OOS service needs to continue. Added text that Medicaid is the payer of last resort. Medicaid does not grant prior approval for beneficiaries in which NC Medicaid is not the primary payer.
12/01/2019	Subsection 5.2.2	Added text in 5.2.2.1 regarding criteria required to submit an electronic prior approval request.
12/01/2019	Subsection 5.4	Changed OOS provider to NC provider.
12/01/2019	Subsection 5.5	Text added regarding PA for OOS Transportation
12/01/2019	Subsection 5.8	Deleted reference to clinical policy 8D-1.
12/01/2019	Subsection 6.0	Added language per Federal Regulation 42 CFR 455.410, that all providers must be enrolled in NC Medicaid or NCHC if included on a claim billed to NC Tracks. Clarified enrollment for Out-of-State providers.
12/01/2019	Attachment A, Section F.	Nursing Facilities added to place of service.
12/01/2019	Attachment A, Section H.	Added Professional to providers that shall bill. Added documentation the provider should submit when billing for emergent services. Added text that beneficiaries shall not be billed in the event the provider submits a claim and receives no or partial reimbursement from NC Medicaid
12/01/2019	Attachment A	Updated policy template language “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.
12/01/2019	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.”
01/15/2023	Subsection 5.5	Clarified text in this section that a separate medical PA is not required for a beneficiary to return to a NC facility.
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 4/15/2023 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)

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

### B. International Classification of Diseases 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.

#### Unlisted Procedure or Service

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

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

### D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

### E. Billing Units

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

## F. Place of Service

Inpatient, Outpatient, Office, Ambulance, Nursing Facilities.

## G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

## H. Reimbursement

**Note:** Institutional and professional Provider(s) shall bill their usual and customary charges.

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

Out-of-state Medicaid providers are reimbursed according to the North Carolina Medicaid State Plan Amendments 4.19-A and 4.19-B. A copy of the State Plan can be accessed at:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

When submitting a claim for payment of emergent services, the provider shall submit the beneficiary's face sheet, emergency department record, observation record, admission history and physical, discharge summary, and any other relevant information that demonstrates that the beneficiary's condition met the definition of emergent services as defined by 42CFR 489.24(b).

In-state and out-of-state providers must be currently enrolled in NC Medicaid to bill for services rendered to a NC Medicaid beneficiary. A beneficiary may not be billed when the provider submits a claim and receives no or partial reimbursement from NC Medicaid.

## I. Provider Fee Schedules

For provider-specific fee schedules refer to <https://medicaid.ncdhhs.gov/>.