Clinical Policy: In Lieu of Services

Reference Number: WNC.CP.259 Coding Implications
Last Review Date: 05/24 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

The purpose of this policy is to ensure that WellCare of North Carolina® complies with Centers for Medicare and Medicaid Services ("CMS") regulations, as well as applicable contractual requirements regarding In Lieu of Services (ILOS).

In Lieu of Services (ILOS)- Such services or settings that the State, in accordance with 42 CFR 438.3(e)(2), determines to be alternative services or settings that are medically appropriate and cost-effective substitutes for a covered service or setting under the Medicaid State plan.
In Lieu of Services (ILOS) is an affordable alternative to a covered service and may help members avoid costly behavioral health treatments such as inpatient hospital stays and emergency department visits.

Policy[1]

I. In accordance with the North Carolina Medicaid contract section *cc. Section V.C. Benefits and Management, 1. Medical and Behavioral Health Benefits Package, g.* - In Lieu of Service, the PHP may use In Lieu of Services (ILOS), or settings that are not covered under the North Carolina Medicaid and NC Health Choice State Plans.

II. It is the policy of WellCare of North Carolina® that the following In Lieu of Services meet criteria for coverage as follows:

A. Institutes for Mental Disease (IMD)

1. **Service Definition**: The PHP may contract and pay for services for members aged twenty-one (21) to sixty-four (64) who are admitted to an IMD as an alternative placement for acute psychiatric care in another covered setting for no more than fifteen (15) calendar days within a calendar month.
2. **Purpose**: Service allows eligible members to have their mental health and substance use disorder inpatient treatment needs addressed within or closer to their home community increasing the likelihood of engaging paid and natural supports throughout the treatment process. Medical, surgical, and hospital emergency departments (ED) will also benefit by a reduction in psychiatric ED wait times when IMD providers are available to provide this service.

Criteria

Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders
ASAM Level 4WM: Medically Managed Intensive Inpatient Withdrawal Management Service is an organized service delivered by medical and nursing professionals that provides 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols. This is an American Society of Addiction Medicine (ASAM) Level 4-WM for adult members whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care, 24-hour observation, monitoring, and withdrawal management services in a medically monitored inpatient setting. The intended outcome of this level of care is to sufficiently resolve the signs and symptoms of withdrawal so the Member can be safely managed at a less intensive level of care. This level of care must be capable of initiating or continuing any MAT that supports the Member in their recovery from substance use.

A service order for Medically Managed Intensive Inpatient Withdrawal Management Services must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice before or on the day that the services are to be provided.

I. Entrance Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders - The following criteria are to be utilized for review for psychiatric treatment of a Member aged 18 and older with a substance use disorder:

A. Any DSM-5, or any subsequent editions of this reference material, diagnosis of a substance use:

B. Meets American Society of Addiction Medicine (ASAM) Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management Services.

II. Continued Stay Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders

A. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the member's Treatment Plan **OR**

B. The member continues to be at risk for relapse based on history or the tenuous nature of the functional gains **or**

C. Any **ONE** of the following apply:

1. Member has achieved initial Treatment Plan goals and these services are needed to meet additional goals.
2. Member is making satisfactory progress toward meeting goals.
3. Member is making some progress, but the Treatment Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the member's premorbid level of functioning, are possible or can be achieved.
4. Member is not making progress or regressing; the treatment Plan must be modified to identify more effective interventions.

III. Medically Managed Intensive Inpatient Services (ASAM Level 4)

A. Medically Managed Intensive Inpatient Service is an organized service delivered in an acute care inpatient setting. This service encompasses a regimen of medically directed evaluation and treatment services, provided in a 24-hour treatment setting, under a defined set of policies, procedures, and individualized clinical protocols. This is an American Society of Addiction Medicine (ASAM) Level 4 for adolescent and adult members whose acute biomedical, emotional, behavioral and cognitive problems are so severe that they require primary medical and nursing care. The outcome of this level of care is stabilization of acute signs and symptoms of substance use, and a primary focus of the treatment plan should be coordination of care to ensure a smooth transition to the next clinically appropriate level of care. This level of care must be capable of initiating or continuing any MAT that supports the Member in their recovery from substance use.

IV. Entrance Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders - The following are entrance criteria for psychiatric treatment of adult substance use disorders:

A. Members shall meet all the criteria below to be approved for admission:

1. The Member shall meet criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), or any subsequent editions of this reference material, substance use disorder diagnosis, **AND**
2. The Member shall meet the criteria for ASAM level 4- Medically Managed Intensive Inpatient Services and shall meet the specifications in at least one of Dimensions 1, 2, or 3.

V. Continued Stay Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders

A. The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Member's treatment plan or the Member continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

1. Member has achieved initial treatment plan goals and these services are needed to meet additional goals,
2. Member is making satisfactory progress toward meeting goals,
3. Member is making some progress, but the treatment plan (specific interventions) needs to be modified so that greater gains, which are consistent with the Member's premorbid level of functioning, are possible or can be achieved, **OR**
4. The Member is not making progress or regressing; the treatment plan must be modified to identify more effective interventions.

VI. Entrance Criteria for Non-Substance Use Disorders for Medicaid Members Ages 21–64 only - The following are entrance criteria for psychiatric treatment of adult non-substance use disorders **AND** all other conditions:

A. any DSM-5, or any subsequent editions of this reference material, diagnosis **AND ONE** of the following:

1. Impaired reality testing (e.g., delusions, hallucinations), disordered behavior or other acute disabling symptoms not manageable by alternative treatment
2. Potential danger to self or others and not manageable by alternative treatment
3. Concomitant severe medical illness or substance use disorder necessitating inpatient treatment
4. Severely impaired social, familial, occupational or developmental functioning that cannot be effectively evaluated or treated by alternative treatment
5. Failure of or inability to benefit from alternative treatment, in the presence of severe disabling psychiatric illness
6. Need for skilled observation, special diagnostic or therapeutic procedures or therapeutic milieu necessitating inpatient treatment.
7. Symptoms are not due solely to intellectual disability.

VII. Continued Stay Criteria for Non-Substance Use Disorders for Medicaid Members Ages 21-64 only

A. The criteria for continued stay in an acute inpatient psychiatric facility are summarized below:

1. The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the treatment plan **AND**
2. The Member continues to be at risk of harming self or others as evidenced by direct threats or clear and reasonable inference of serious harm to self-violent, unpredictable or uncontrollable behavior which represents potential for serious harm to the person or property of others;
3. Demonstrating inability to adequately care for own physical needs; **OR**
4. Requires treatment which is not available **OR**
5. Is unsafe on an outpatient basis.
6. The Member's condition must require psychiatric and nursing interventions on a 24-hour basis.

B. **Service Exclusions/Limitations**

The non-duplicative components, for example case management, of the following services can be provided to members being admitted to or discharged from Inpatient Hospital Psychiatric Treatment for adults:

1. Community Support Team;
2. Assertive Community Treatment;
3. Substance Abuse Intensive Outpatient;
4. Substance Abuse Comprehensive Outpatient;

Services must be delivered in coordination with the Inpatient Hospital Psychiatric provider and be documented in the treatment plan. Discharge Planning shall begin upon admission to this service.

VIII. Mental Health Intensive Outpatient Services

A. **Service Definition** - Mental Health Intensive Outpatient Program means structured individual and group psychiatric activities and services that are provided at an outpatient program designed to assist adult and adolescent members to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a

day, at least 3 days a week. The Member must be in attendance for a minimum of 3 hours a day in order to bill this service.

B. Services shall include a structured program consisting of, but not limited to, the following services:
1. Individual counseling and support
2. Group counseling and support
3. Family counseling, training or support
4. Life skills
5. Crisis contingency planning
6. Treatment support activities that have been adapted or specifically designed for Member with physical disabilities, or Member with co-occurring disorders of mental illness and substance use; or an intellectual and developmental disability

Intensive outpatient treatment can be designed for homogenous groups of Member e.g., pregnant women, and women and their children; individuals with co-occurring mental health and substance use disorders; individuals with human immunodeficiency virus (HIV); or individuals with similar cognitive levels of functioning. Member may be residents of their own home, a substitute home, or a group care setting; however, the intensive outpatient treatment must be provided in a setting separate from the Member's residence. The program is provided over a period of several weeks or months. An authorization request form must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

C. **Criteria** - In order to meet medical necessity criteria for this level of care, documentation submitted by providers must demonstrate that ***InterQual Guidelines*** for admission to an Intensive Outpatient Program are met for initial and continued stay requests.

Authorization timeframe for initial requests should not exceed 30 calendar days; reauthorization requests may not exceed 60 calendar days.

IX. Behavioral Health Urgent Care

A. **Service Definition** - Behavioral Health Urgent Care (BHUC) is a designated service for individuals four (4) years or older experiencing a behavioral health crisis related to a substance use disorder, mental health disorder, and/or I/DD diagnosis or any combination of the above. A BHUC is designed to provide triage, crisis risk assessment, evaluation and intervention to individuals whose crisis response needs are deemed to be urgent or emergent. A BHUC is an alternative, but not a replacement, to a community hospital Emergency Department (ED). Individuals receiving this service will be evaluated, then stabilized and/or referred to the most appropriate level of care.

B. **Purpose of Service -** BHUC offers a safe alternative and diversion from the use of hospital emergency departments to address the needs of individuals experiencing behavioral health crises. A BHUC is a service containing Triage, Crisis Assessment, Interventions, Disposition and Discharge Planning.

C. **Treatment Program Philosophy, Goals and Objectives** - Triage consists of an intensity of needs screening to be initiated within 15 minutes of arrival. During the triage process releases of information will be completed to obtain any needed information from supports and/or community providers. This screening will result in a behavioral health urgency determination status of routine, urgent or emergent and may determine the need for emergency medical attention. Only those meeting criteria for urgent or emergent are eligible for this BHUC service. If an individual is screened and is determined to be routine, they will be referred to a community-based service provider for follow up.
   1. A BHUC urgent determination status is defined in instances where the individual presents with moderate risk for incapacitation in one or more areas of safety or physical, cognitive, or behavioral functioning related to a MH/IDD/SU diagnosis; moderate symptoms and distress that may quickly escalate without prompt intervention; thoughts of harm to self or others, acute stressors and symptoms which may include impaired reality testing, self-care, intoxication or withdrawal.
   2. A BHUC emergent determination status is defined as imminent danger to harm self or others due to symptoms of mental illness or substance use or any related medical complications; risk to self or others related to behavioral health distress; risk related to safety and supervision; severe incapacitation which may include impaired reality testing, self-care, intoxication or withdrawal.

D. **Assessment -** The Crisis/Risk Assessment is designed to determine nature of crisis and risks associated with presenting concern. The Crisis/Risk assessment should be initiated within 2 hours of arrival at the BHUC. Components of the assessment can be gathered through interactions with all BHUC staff including but not limited to licensed professionals, nursing staff, and psychiatric prescribing professionals, peers, and qualified professionals (peers and QP's within their scope of practice). A licensed clinical professional is required to observe and interview the individual, establish a diagnosis, and compile an evaluation that will drive the services. The following elements must be addressed as part of the crisis assessment:
   1. Description of presenting illness/problem including source of distress, precipitating events and associated problems and symptoms;
   2. Demographic information;
   3. Behavioral health and medical treatment history;
   4. Access LME/MCO and Care Coordination information;
   5. Reason for referral;
   6. Comprehensive Risk assessment/status;
   7. Current medications;
   8. Medical Screening including biometric data (vitals: pulse, blood pressure, height and weight);
   9. Current medical status and any need for emergency medical treatment;
   10. Breathalyzer or urine drug screen as indicated;
   11. Biopsychosocial information;
   12. Mental Status Exam;
   13. Level of Care Determination including ASAM level of care;

14. Establishment of a Diagnosis that will be the subject of treatment (may be Provisional or Differential Diagnosis);
15. Use of specialty assessments using validated, standardized instruments (i.e., Suicide Risk Assessment, Clinical Institute Withdrawal Assessment for Alcohol/CIWA-A rev., etc.) within the scope of practice for the individual conducting the assessment;
16. Initial disposition.

E. Disposition and Discharge Planning - Disposition and discharge planning is provided to ensure a person served through BHUC is linked to the least restrictive and most appropriate level of care. Disposition coordination and discharge planning from BHUC includes the use of person-centered strategies and processes that:

1. Provide education and information regarding community services and resources;
2. Facilitate engagement of natural supports;
3. Communicate with care management entities as needed;
4. Communicate with current community providers, including primary care and/or make referrals with written consent;
5. Provide a discharge plan that includes safety and aftercare instructions, including appointments and point of contact with contact information for agencies and medication instructions. A copy of this is to be placed in the individual's record;
6. Arrange admissions to psychiatric hospitals, Facility Based Crisis, emergency departments, or other clinically appropriate services;
7. Assistance with housing and transportation;
8. Provide education and linkage to medication assistance;
9. Develop and revise individual crisis plan;
10. If individual expresses interest, refer her/him to facilitator to develop psychiatric advance directives

F. Additional Information - There is no prior approval requirement for BHUC services. WellCare will monitor utilization through claims analysis to identify overutilization and wait times of members waiting to be assessed to ensure appropriate outcomes.

X. Programs for High-Risk Populations

A. Service Definition - A specialized therapeutic in-home service is a flexible in-home support service designed for children at risk of foster care, ages 5 through 17, who are at risk for or stepping down from inpatient services. Services are delivered by a team led by a licensed clinician and a targeted case manager, a Master's-level therapist and a psychiatric nurse. This is a time-limited, intensive child and family intervention based on the clinical needs of the Member. The service is intended to accomplish the following:

1. Reduce presenting psychiatric or substance use disorder symptoms;
2. Provide first responder intervention to diffuse current crisis;
3. Ensure linkage to community services and resources; **AND**
4. Prevent out of home placement for the Member

B. Purpose of Service - To provide therapeutic support in addition to helping parents in developing parenting skills, specialized therapeutic in-home services are designed to aid in the transition to community-based outpatient services by providing intensive therapeutic services plus 24-hour crisis response services for an anticipated length of stay of up to 120 days.

C. **Eligibility Criteria -** The Member is eligible for this service when **ALL** of the following criteria are met:
   1. There is a mental health or substance use disorder diagnosis (as defined by the DSM-5, or any subsequent editions of this reference material), other than a sole diagnosis of intellectual and developmental disability;
   2. Based on the current comprehensive clinical assessment, this service was indicated, and outpatient treatment services were considered or previously attempted, but were found to be inappropriate or not effective;
   3. The Member has current or past history of symptoms or behaviors indicating the need for a crisis intervention as evidenced by suicidal or homicidal ideation, physical aggression toward others, self-injurious behavior, serious risk-taking behavior (running away, sexual aggression, sexually reactive behavior, or substance use);
   4. The Member's symptoms and behaviors are unmanageable at home, school, or in other community settings due to the deterioration of the Member's mental health or substance use disorder condition, requiring intensive, coordinated clinical interventions;
   5. The Member is at imminent risk of out-of-home placement or inpatient hospitalization based on the Member's current mental health or substance use disorder clinical symptomatology, or is currently in an out-of-home placement and a return home is imminent;
   6. There is no evidence to support that alternative interventions would be equally or more effective.

D. **Continued Service Criteria** - The Member is eligible to continue this service if the desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the Member's PCP; **or** the Member continues to be at risk for out-of-home placement, based on current clinical assessment, history, and the tenuous nature of the functional gains, **AND ONE** of the following applies:
   1. The Member has achieved current PCP goals, and additional goals are indicated as evidenced by documented symptoms;
   2. The Member is making satisfactory progress toward meeting goals and there is documentation that supports that continuation of this service will be effective in addressing the goals outlined in the PCP;
   3. The Member is making some progress, but the specific interventions in the PCP need to be modified so that greater gains, which are consistent with the Member's premorbid level of functioning, are possible; or
   4. The Member fails to make progress, or demonstrates regression, in meeting goals through the interventions outlined in the PCP. The Member's diagnosis should be reassessed to identify any unrecognized co-occurring disorders, and interventions or treatment recommendations shall be revised based on the findings. This includes consideration of alternative or additional services.

E. **Discharge Criteria** - The Member meets the criteria for discharge if any **ONE** of the following applies:
   1. The Member has achieved goals and is no longer in need of IIH services;
   2. The Member's level of functioning has improved with respect to the goals outlined in the PCP, inclusive of a transition plan to step down to a lower level of care;

3. The Member is not making progress or is regressing, and all reasonable strategies and interventions have been exhausted, indicating a need for more intensive services;
4. The Member or legally responsible person no longer wishes to receive IIH services; **OR**
5. The Member, based on presentation and failure to show improvement despite modifications in the PCP, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (for example, National Institute of Drug Abuse, American Psychiatric Association).

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS ®* Codes	Description	Billing Unit
H0046	Programs for High-Risk Populations	1 unit=1 day
RC0160	Institutes for Mental Disease (IMD)	1 unit=1 day
S9480	Mental Health Intensive Outpatient Treatment	1 unit =1 day
T2016 U5	Behavioral Health Urgent Care	1 unit = 1 event

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original Approval date.	06/21	06/21
Revised Urgent Care HCPCS code.	07/21	08/21
Annual Review	06/22	08/22
II.B.2. changed Milliman Care Guidelines to InterQual	12/22	12/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage.	05/23	05/23
Criteria – Added "Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders" Criteria I. Changed title from "Preadmission Review Criteria for Substance Use Disorders" to "Entrance Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders" Also Added ""Meets American Society of Addiction Medicine (ASAM) Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management Services." Criteria II. Changed title from "Continued Stay Criteria for	08/23	08/23

Substance Use Disorders" to "Continued Stay Criteria for Medically Managed Intensive Inpatient Withdrawal Management for Substance Use Disorders" Criteria II. A. and II.C.4. Changed "Person Centered" to "Treatment." Criteria II.C.4. added "or regressing;" Added Criteria III.. "Medically Managed Intensive Inpatient Services (ASAM Level 4)" Added Criteria IV. "Entrance Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders" Added Criteria V. " Continued Stay Criteria for Medically Managed Intensive Inpatient Services for Substance Use Disorders" Criteria VI. Changed "Preadmission Review Criteria for Non-Substance Use Disorders" to "Entrance Criteria for Non-Substance Use Disorders for Medicaid Member Ages 21–64 only." Added VI.A.7. "Symptoms are not due solely to intellectual disability" Criteria VII. Added "Continued Stay Criteria for Non-Substance Use Disorders for Medicaid Member Ages 21-64 only"		
Annual Review. Under Criteria added "A service order for Medically Managed Intensive Inpatient Withdrawal Management Services must be completed by a physician, licensed psychologist, physician assistant or nurse practitioner according to their scope of practice before or on the day that the services are to be provided." Removed CPT code box.	05/24	05/24

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8A Enhanced Mental Health and Substance Abuse Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published March 1, 2024. Accessed March 12, 2024.
2. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8A-2 Facility-Based Crisis Service for Children and Adolescents. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published April 1, 2023. Accessed March 12, 2024.
3. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 8B Inpatient Behavioral Health Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published June 1, 2023. Accessed March 12, 2024.

North Carolina Guidance

Eligibility Requirements

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.

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.

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/

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.

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).

Claims-Related Information

Provider(s) shall comply with the NC Tracks 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 - as applicable to the service provided:
   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.
   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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.