

**Refer to Section 8.0
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Refer to Section 8.0

1.0 Description of the Procedure, Product, or Service

Hyperbaric oxygen (HBO) therapy consists of the exposure of the entire body to 100% oxygen at pressures greater than one atmosphere absolute (ATA) in accordance with accepted clinical protocols for duration and pressure in a mono- or multi-place pressurized chamber.

1.1 Definitions

None Apply

2.0 Eligible Beneficiaries

2.1 Provisions

2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC 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.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

- a. **Medicaid**
None Apply
- b. **NCHC**
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

- a. 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.
- b. **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: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid and NCHC 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 both Medicaid and NCHC

Medicaid and NCHC shall cover Hyperbaric Oxygenation Therapy when the beneficiary meets the following specific criteria:

- a. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment;
- b. Acute carbon monoxide intoxication;
- c. Acute peripheral arterial insufficiency; including central retinal artery occlusion;
- d. Chronic peripheral vascular insufficiency is only covered when the following conditions are met: (a) investigation of arterial inflow indicates no lesions amenable to either bypass or stenting (b) transcutaneous PO₂ in the region of the wound less than 40 mmHG breathing air and a response to oxygen breathing (either at 1 atmosphere or during hyperbaric exposure).
- e. Acute traumatic peripheral ischemia. HBO therapy is an adjunctive treatment to be used in combination with accepted standard therapeutic measures, when loss of function, limb or life is threatened;
- f. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;

- g. Crush injuries and suturing of severed limbs. HBO therapy as an adjunctive treatment when loss of function, limb, or life is threatened;
- h. Cyanide poisoning;
- i. Decompression illness;
- j. Gas embolism;
- k. Gas gangrene;
- l. Meleney ulcers;

Note: The use of hyperbaric oxygen in any other type of cutaneous ulcer is not covered;

- m. Necrotizing soft tissue infections of subcutaneous tissue, muscle, or fascia in conjunction with standard medical and surgical procedures when loss of function, limb, or life is threatened;
- n. Osteoradionecrosis as an adjunct to conventional treatment;
- o. Pre-treatment and post-treatment for patients undergoing dental surgery (non-implant related) of an irradiated jaw which has received a total dose threshold of radiation greater than 5000cGY;
- p. Preparation and preservation of compromised skin grafts;
- q. Soft tissue radionecrosis as an adjunct to conventional treatment; or
- r. Lower extremity wound due to diabetes when the wound is classified as a Wagner Grade III or higher and has failed an adequate course of wound therapy.

Note: The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 calendar days of treatment with standard wound therapy, and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible; optimization of nutritional status; optimization of glucose control; debridement by any means to remove devitalized tissue; maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; appropriate off-loading; and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

Note: Evidence based treatments will be permitted as noted in **Subsection 3.2** above. The treatment of multiple sclerosis, brain injury (which includes autism, cerebral palsy, stroke) are not approved due to lack of evidence based medicine at this time.

3.2.2 Medicaid Additional Criteria Covered

None Apply

3.2.3 NCHC Additional Criteria Covered

None Apply

4.0 When the Procedure, Product, or Service Is Not Covered

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

4.1 General Criteria Not Covered

Medicaid and NCHC 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 Non-Covered Criteria

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

- a. Medicaid and NCHC shall not cover Hyperbaric Oxygenation Therapy for the following conditions:
 1. acute cerebral edema;
 2. acute or chronic cerebral vascular insufficiency;
 3. acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency);
 4. aerobic septicemia;
 5. anaerobic septicemia and infection other than clostridial;
 6. arthritic diseases;
 7. cardiogenic shock;
 8. chronic peripheral vascular insufficiency, except as noted in **Subsection 3.2**;
 9. congenital conditions, e.g., cerebral palsy, autism, mental retardation;
 10. cutaneous, decubitus, and stasis ulcers;
 11. exceptional blood loss anemia;
 12. hepatic necrosis;
 13. multiple sclerosis;
 14. myocardial infarction;
 15. nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease);
 16. organ storage;
 17. organ transplantation;
 18. pulmonary emphysema;
 19. senility;
 20. sickle cell crisis;

21. skin burns (thermal);
 22. systemic aerobic infection;
 23. tetanus; and
 24. traumatic brain injury.
- b. Topical Application
Topical application of oxygen does not meet the definition of HBO therapy and is not covered.
- c. Replacement Therapy
HBO therapy is not covered as a replacement for other standard successful therapeutic measures.

4.2.2 Medicaid Additional Criteria Not Covered

None apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for Hyperbaric Oxygenation Therapy. The provider shall obtain prior approval before rendering Hyperbaric Oxygenation Therapy.

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

Prior approval is given for an initial period of 30 days. Treatment beyond 30 calendar days requires a second prior approval request.

5.3 Additional Limitations or Requirements

- a. The provider shall submit the completed PA request and the following documentation to DMA's designee:
 1. all of the beneficiary's diagnoses;
 2. date of onset;
 3. conventional treatment history, including duration and outcomes of each treatment;
 4. treatment plan, including the treatment duration.
- b. The prior approval request must indicate the acceptance of the case by the medical director (or designee) of the HBO therapy treatment facility.
- c. In urgent situations, providers must submit a prior approval request within five calendar days of treatment. The first day of treatment is counted as day one. If the request is received within five days, authorization will begin on the first date of treatment if coverage criteria are met. If the request is received six or more days after the initiation of treatment, authorization will begin on the date the service is approved. Requests for urgent situations should be marked as "urgent." DMA's fiscal agent reviews the request to determine if the situation meets Medicaid coverage criteria as listed in the policy and to determine if the services were provided under urgent conditions.

5.4 Technical Requirements

The entire body must be pressurized and 100% oxygen inhaled by one of several methods: the environment (within the chamber), hood tent, face mask, or endotracheal or tracheostomy tube.

5.5 Service Limitation

HBO therapy is limited to two sessions per date of service.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

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

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply

6.2 Provider Certifications

None Apply

7.0 Additional Requirements

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

7.1 Compliance

- Provider(s) shall comply with the following in effect at the time the service is rendered:
- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
 - b. All DMA'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 1, 1988

Revision Information:

Date	Section Updated	Change
12/01/2003	Section 4.0	Titles were added to the subsections.
12/01/2003	Section 4.0	The sentence "HBO therapy is not covered when the medical criteria listed in Section 3.0 are not met." Was added to this section.
12/01/2003	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/2003	Section 6.0	A sentence was added to the section stating that providers must comply with Medicaid guidelines and obtain referrals where appropriate for Managed Care enrollees.
12/01/2003	Section 8.0	Titles were added to the subsections.
09/01/2004	Section 1.0	The word "man rated" was deleted.
09/01/2004	Section 3.0	Coverage criteria was added to include lower extremity wound due to diabetes. The wound is classified as a Wagner Grade III or higher and has failed an adequate course of wound therapy.
09/01/2004	Section 3.0	The word "valuable" was deleted.
09/01/2004	Section 3.0	Text was added to describe wound care in the diabetic patient with a lower extremity wound.
09/01/2004	Section 4.0	Noncovered conditions were expanded to include congenital conditions (e.g., cerebral palsy, autism, mental retardation and traumatic brain injury).
09/01/2004	Section 4.0	A disclaimer statement was added to indicate that the list was not all inclusive.
09/01/2004	Section 5.0	The word "whole" was replaced with the word "entire."
09/01/2004	Section 6.0	Text was added to include facilities that provide service.
09/01/2004	Section 8.0	Text was added to clarify the billing guidelines.

Date	Section Updated	Change
09/01/2004	Section 8.1	Text was added to indicate that facilities bill using the UB-92 claim form.
09/01/2004	Section 8.2	An ICD-9-CM diagnoses codes table was added.
09/01/2004	Section 8.2	Text was added to the ICD-9-CM table for diabetic, lower extremity wound.
09/01/2004	Section 8.3	The definition of CPT code 99183 was added.
09/01/2004	Section 8.3	Sections 8.3.1 and 8.3.2 were added with specific codes.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
09/01/2005	Section 8.0	The sentence stating that providers must comply with Medicaid guidelines and obtain referral where appropriate for Managed Care enrollees was moved from Section 6.0 to Section 8.0.
12/01/2005	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.
12/01/2006	Sections 2 through 5	A special provision related to EPSDT was added.
12/01/2006	Section 5.1	Instructions about prior approval in urgent situations were added.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
05/01/2007	Section 8	Added UB-04 as an accepted claim form.
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
06/01/2011	Sections 1.0,3.0,4.0,6.0,7.0, Attachment A	Updated to standard DMA policy language
06/01/2011	Subsection 3.2	Added item "n." – "Pre-treatment and post-treatment for patients undergoing dental surgery (non-implant related) of an irradiated jaw which has received a total dose threshold of radiation greater than 5000cGY"
06/01/2011	Section 8.0	Billing Guidelines moved to Attachment A
06/01/2011	Section 9.0	Becomes section 8 due to moving Billing Guidelines to Attachment A
06/01/2011	Attachment A	Changed wording for claim type to standard DMA language in A., F. added place of service, G. copayments
06/01/2011	Attachment A	Actinomyces changes to Actinomycotic infections
03/01/2012	Section 3.2 c.	Added: including central retinal artery occlusion
03/01/2012	Section 3.2	Added 3.2 d
03/01/2012	Section 3.2 Note	Added Note at end of section
03/01/2012	Section 4.2 h	Added: except as noted in 3.2
03/01/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1A-8 under Session Law 2011-145 § 10.41.(b)
3/12/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.

Date	Section Updated	Change
05/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
05/01/2014	Attachment A: C	Removed descriptions from codes
09/30/2015	All Sections and Attachments	This policy contains ICD-9 codes. Due to federally mandated implementation of ICD-10 codes on 10/01/2015, the codes in this policy are not valid after 09/30/2015.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Ninth Revisions, Clinical Modification (ICD-9-CM) Codes

Provider(s) shall report the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-9-CM 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. **Before October 1, 2015**, the provider shall continue to use ICD-9 code sets to report medical diagnoses and procedural codes. **Effective October 1, 2015** the provider shall use ICD-10 code sets for reporting.

Description	ICD-9-CM Code
Actinomycotic infections	039.0 through 039.9
Arterial gas embolism	958.0; 999.0; 999.1
Arterial insufficiency, peripheral acute	444.21 through 444.22; 444.81; 733.40 through 733.49
Carbon monoxide poisoning, acute	986
Crush injuries and suturing of severed limbs	925 through 929.9 885.0-887.7; 895.0-897.7; 996.90-996.99
Cyanide poisoning	989.0; 987.7
Decompression illness	993.3
Diabetic, lower extremity wound	707; 707.1; 707.10; 707.12; 707.13; 707.14; 707.19 These codes must be billed with the appropriate diabetic diagnosis (250.70-250.83).
Gas gangrene	040.0
Ischemia, peripheral traumatic, acute	444.21 through 444.22; 902.53; 903.0 through 904.9
Meleny ulcers	686.01; 686.09
Necrotizing fasciitis, progressive	728.86; 686.0
Osteomyelitis, chronic refractory	730.1 through 730.19; 730.2
Preparation and preservation of compromised skin grafts	996.52; 996.59
Radionecrosis, bone Mandible	733.40 through 733.49 526.89
Soft tissue radionecrosis	909.2; 990

C. Code(s)

Provider(s) shall select 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), ICD-9-CM procedure codes, 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

The following codes are covered by Medicaid and NCHC:

Professional

99183

Facility

RC413

93.59

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

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s). One unit = one session.

F. Place of Service

Inpatient, Outpatient

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

I. ICD-10-CM and Procedural Coding System(PCS) code(s), effective 10/01/2015

Provider(s) shall report the ICD-10 code set(s) 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.

For services provided on or after October 1, 2015, the provider shall bill the applicable ICD-10-CM diagnosis code(s) and procedure code(s).