

**Policy terminated because coverage is provided under equivalent Medicaid
Policies 8A – 8N**

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definition.....	1
2.0	Eligible Recipients.....	1
2.1	General Provisions.....	1
3.0	When the Procedure, Product, or Service Is Covered.....	1
3.1	General Criteria.....	1
3.2	Specific Criteria.....	2
4.0	When the Procedure, Product, or Service Is Not Covered.....	2
4.1	General Criteria.....	2
4.2	Specific Criteria.....	3
5.0	Requirements for and Limitations on Coverage.....	3
5.1	Prior Approval.....	3
6.0	Providers Eligible to Bill for the Procedure, Product, or Service.....	3
7.0	Additional Requirements.....	4
7.1	Compliance.....	4
8.0	Policy Implementation/Revision Information.....	4
	Attachment A: Claims-Related Information.....	5
A.	Claim Type.....	5
B.	Diagnosis Codes.....	5
C.	Procedure Code(s).....	5
D.	Modifiers.....	5
E.	Billing Units.....	5
F.	Place of Service.....	5
G.	Co-payments.....	5
H.	Reimbursement.....	5

1.0 Description of the Procedure, Product, or Service

1.1 Definition

Children with special health care needs (CSHCN) are children or youth enrolled in the North Carolina Health Choice program who have been diagnosed as having one or more of the following conditions which in the opinion of the diagnosing physician is likely to continue indefinitely, interferes with daily routine, and requires extensive medical intervention and extensive family management:

- a. Birth defect, including genetic, or congenital
- b. Developmental disability as defined under N.C.G.S.122C-3(12a)
- c. Mental or behavioral disorder
- d. Chronic and complex illnesses
- e. Acquired disorders

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled in the program on the date of service and meet the definition of CSHCN in **Section 1.0**. There is no entitlement for these services. Medical necessity criteria will be individually considered by DMA's vendor to determine whether additional benefits are available.

Children or youth covered by NC Health Choice with special health care needs are eligible for the same benefits as authorized for Medicaid recipients except for long-term care and respite care which shall be provided only under emergency circumstances. Special needs benefits are services not ordinarily covered under core benefits of the NC Health Choice Program. Refer to **Attachment B** of this policy for a list of current services comprising the special needs benefits.

Benefits for these services are paid from funds which have been allocated specifically for the NC Health Choice program..

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are 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 recipient'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; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. In order for a service to be covered under the benefits for CSHCN, the service must be determined to be one which is not ordinarily covered by NC Health Choice Program through the core benefits, and medical necessity criteria for the service must be met.
- b. The services listed in 1 through 8 below are considered special needs benefits. Such special needs benefits are covered as defined by the Division of Medical Assistance and require prior approval by DMA's vendor prior to the start of the service unless otherwise indicated:
 - 1. Diagnostic Assessment (Only one diagnostic assessment is allowed per enrollment year without prior approval)
 - 2. Community Support (Case Management Component only)
 - 3. Intensive In-Home Services
 - 4. Multi-Systemic Therapy
 - 5. Day Treatment
 - 6. Mobile Crisis (Only the first 32 units of Mobile Crisis services are allowed without prior approval.)
 - 7. Residential Treatment Services (all bed capacities)
 - (a) Residential Treatment Level II, Family Type (Therapeutic Foster Care)
 - (b) Residential Treatment Level II, Program Type
 - (c) Residential Treatment Level III (Residential Treatment High)
 - (d) Residential Treatment Level IV (Residential Treatment Secure);
 - 8. Targeted Case Management (Only for sole diagnosis of developmental disability.)
- c. Coverage will be considered by the DMA's vendor only when requests for prior approval are submitted as specified in **Subsection 5.1**.
- d. Coverage for respite care may be authorized by the DMA's vendor only in emergency circumstances in accordance with procedures developed by the Department of Health and Human Services, Division of Public Health.

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

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. Benefits are not available for services under the NC Health Choice special needs plan if any of the criteria outlined under **Subsection 3.2** are not met.
- b. Non-emergency respite care and long term care are not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. All services must be prior approved by the DMA's vendor prior to the start of the service unless indicated differently in **Subsection 3.2**.
- b. Continuing treatment must also be prior approved by DMA's vendor prior to the end of any previously approved period, regardless of whether or not the previously approved units have been exhausted.
- c. Requests for prior approval must be made to DMA's vendor, NC Health Choice team, only via the designated NC Health Choice fax number or the designated toll-free number
- d. When there is a change in eligibility from Medicaid or any other insurance carrier to Health Choice, requests for authorization must be made to DMA's vendor, NC Health Choice team, within 60 days of the date of Health Choice eligibility determination by the State of North Carolina.

Note: In instances where there is a change in eligibility, the Division of Public Health allows the Mental Health Case Manager to retrospectively review services already delivered when the request for Health Choice prior approval is submitted within 60 calendar days from the date of the Health Choice eligibility determination by the State of North Carolina. Otherwise, retrospective reviews are not allowed.

- e. The DMA vendor Web site provides additional information regarding the prior approval process, NC Health Choice-specific phone and fax numbers, and any necessary documents required to request prior approval. Go to <http://www.valueoptions.com>; choose "providers/browse" choose "network specific" then choose "NC Health Choice."

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

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **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.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Codes				
H0019 (For Level 3 and 4 Group homes)				
H0036 HA	H0036 HQ	H0045	H2011	H2012 HA
H2022	H2020	H2033	S5145	S5150
T1005 TD	T1005 TE	T1017 HI	T1023	

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Office, Recipient's Home and School

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.