

**Policy is terminated because coverage is provided under the combined
Medicaid and Health Choice 2A-3, Out of State Services**

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Date of Termination: 03.31.2013

1.0 Description of the Procedure, Product, or Service

Out-of-state services are defined as more than 40 miles from the North Carolina (NC) border. Medically necessary care and services provided within 40 miles of the NC border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia will be covered to the same extent and under the same conditions as medical care and services provided in NC, with the **exception of the following services:**

- a. Critical Access Behavioral Health Agency (CABHA);
- b. Home Health;
- c. Home Infusion Therapy (HIT);
- d. Hospice;

1.1 Definitions

Emergency Medical Condition [42CFR§489.24(b)]

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:

- a. placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or
- b. serious impairment to bodily functions; or
- c. serious dysfunction of any body organ or part.

Out-of-State providers:

Providers located outside the NC border.

Contiguous area providers: Providers located within 40 miles of the NC border will be reimbursed to the same extent and under the same conditions as medical care and services provided in NC

Non-Contiguous area providers: Providers located more than 40 miles from the NC border. Eligible Recipients

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

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

Medically necessary care and services may be provided more than 40 miles from the NC border if 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 DMA or DMA's designee prior to rendering the services; or
- b. the care and services are provided in an emergency situation as noted below in **Subsection 3.2.1**.

3.2.1 Emergency Services

Emergency services provided for emergency medical conditions as defined in **Subsection 1.1** and those noted below are exempt from prior approval:

- a. where the health of the recipient would be endangered if the care and services were postponed until the recipient returns to North Carolina;
- b. where the health of the recipient would be endangered if travel were undertaken to return to North Carolina;

Note: As soon as medically appropriate the recipient shall return to North Carolina. Refer to **Subsection 4.2**.

3.2.2 Acute Inpatient Hospital Services and Outpatient Specialty Care

Contiguous hospitals providing acute inpatient hospital services *within* 40 miles of the N.C. border for the following states of Georgia, South Carolina, Tennessee, and Virginia will be covered to the same extent and under the same conditions as services provided in North Carolina. Refer to **Section 6.0**.

Acute inpatient hospital services and outpatient specialty care hospital services provided more than 40 miles from the border will not be covered without prior approval except in the following situation:

An emergency arises from an accident or illness (refer to **Subsection 1.1, Definitions, Emergency Medical Condition**).

3.2.3 Ambulance Services/Transportation

Services provided by non-contiguous providers (hospitals, acute medical care, and ambulance services) are considered out-of-state services when provided more than 40 miles from the N.C. border.

Contiguous hospitals, acute medical care, and ambulance services provided within 40 miles of the N.C. border for the following states of Georgia, South Carolina, Tennessee, and Virginia will be covered to the same extent and under the same conditions as services provided in North Carolina. Refer to **Section 6.0**.

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

As soon as medically appropriate the recipient shall return to North Carolina, as no services are covered unless those services can be provided more reasonably than in-state. Refer to **Subsections 1.1 and 5.3**.

4.2.1 Emergency Services

As soon as medically appropriate the recipient shall return to North Carolina. Refer to **Subsection 5.3**.

4.2.2 Acute Inpatient Hospital Services

Except for emergencies (refer to **Subsections 1.1 and 5.3**), no services are covered out-of-state (more than 40 miles from the border) unless those services can be provided more reasonably than in-state.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is required for all non-emergency out-of-state medical care and services. Providers who have questions about a particular service shall refer to DMA's policies at <http://www.ncdhhs.gov/dma/healthchoice/index.htm>. If the service or procedure that will be provided requires prior approval for NC residents, the provider shall request that prior approval when requesting approval for out-of-state services.

- a. Prior approval is granted only for the specific facility requested. Prior approval cannot be transferred to another facility nor may a resident be transferred from one out-of-state facility to another without obtaining additional prior approval for the new facility.
- b. Claims are denied if service dates are after the prior approval grant date.

Note: Referral for treatment by the recipient'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

The provider(s) shall submit to DMA's designee the following:

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

5.3 Emergency Services

The provider shall contact DMA's designee within 72 hours (or the next business day) of the emergency service or emergency admission. Payment for services may be affected if DMA's designee is not notified by the next business day.

5.4 Observation Services

Recipients who are admitted to outpatient hospital observation status shall either be discharged within 30 hours or converted to inpatient status.

5.5 Emergency Treatment Follow-Up Care

Providers rendering out-of-state emergency treatment shall refer recipients to a North Carolina provider for follow-up care. If DMA determines that follow-up care is more reasonably available out-of-state, the out-of-state provider shall obtain PA. The written PA request shall be made to DMA's designee, and the guidelines for other out-of-state services shall be followed. Recipients who are being sent out-of-state shall be informed by the provider that follow-up for services will occur in NC facilities.

5.6 Ambulance Services

Refer to the applicable clinical coverage policy, <http://www.ncdhhs.gov/dma/hcmp/>, for prior approval information.

5.7 Transplants

Refer to the applicable clinical coverage policy, <http://www.ncdhhs.gov/dma/hcmp/>, for prior approval information.

5.8 Inpatient Behavioral Health Services

Refer to the applicable clinical coverage policy, <http://www.ncdhhs.gov/dma/hcmp/>, for prior approval information.

5.9 Residential Children Services

Refer to the applicable clinical coverage policy, <http://www.ncdhhs.gov/dma/hcmp/>, for prior approval information.

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.

Note: Refer to DMA Provider Services (<http://www.ncdhhs.gov/dma/provenroll/>) for information on obtaining a N.C. Medicaid Provider number.

7.0 Additional Requirements

7.1 Compliance

Providers shall 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:

Revision Information:

Date	Section Revised	Change
03/12/2012	All sections and attachment(s)	NC Health Choice Program Clinical Coverage Policy NCHC Out-of-State Services (OOS) revised to be equivalent to NC Medicaid Program Clinical Coverage Policy Number 2A-3, Out-of-State Services, pursuant to SL2011-145, Section 10.41.(b).
03/31/2013	All sections and attachment(s)	Termination of NCHC policy which will be superseded by the Combined Template policy to comply with S.L. 2011-145, § 10.41.(b).

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)

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. Diagnosis Codes

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

C. Procedure Code(s)

Refer to the applicable clinical coverage policy or manual linked from <http://www.ncdhhs.gov/dma/healthchoice/index.htm>.

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, Outpatient, Office, Ambulance.

G. Co-payments

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

H. Reimbursement

Providers shall bill their usual and customary charges.

Providers are required to bill applicable revenue codes.

I. Provider Fee Schedules

Provider specific fee schedules can be linked from <http://www.ncdhhs.gov/dma/fee/>.