

Policy terminated because it is an administrative policy from BCBS.

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1.0 Description of the Procedure, Product, or Service

Pre-admission certification (PAC) is authorization by DMA's vendor for scheduled admissions to inpatient hospital facilities. Each certification contains an assigned length-of-stay (LOS), which is the number of days deemed by DMA's vendor to be medically necessary and appropriate for the care to be rendered, based on the type of services provided and the condition of the recipient. While approval certification for inpatient admissions is required to be initiated by the admitting physician, the NCHC recipient's parent or guardian shall be responsible for insuring that the required certification is secured.

2.0 Eligible Recipients

2.1 General Provisions

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

Note: Most children will be able to get all the services they need under the core (basic) plan of NC Health Choice. A child who qualifies as having special needs may be able to receive additional services not covered by the core plan.

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

Specific coverage criteria do not apply to this policy. Refer to **Subsection 5.1**.

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

Specific non-coverage criteria do not apply.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Pre-admission Certification (PAC) for scheduled admissions must be requested prior to the admission.
- b. The Analyst will obtain the necessary medical information from the admitting physician's office.
- c. Using clinical criteria, the Analyst will assess each individual case for the medical appropriateness of the setting and timing of the admission.
- d. If the admission criteria are met, the hospital admission will be certified, a certification number will be assigned, and length-of-stay will be approved according to the diagnosis and clinical criteria.
- e. Immediately (within 48 hours or the next business day) following an emergency or unscheduled admission, length of stay certification must be obtained from DMA's vendor.
- f. If the admission criteria are not met, the case will be referred to an appropriate medical director.
- g. If the physician advisor approves the admission, a certification number will be assigned.
- h. If the physician advisor does not agree with the medical appropriateness of the admission, the Analyst will discuss alternatives with the admitting physician.
- i. Notification of the final determination will be made to the admitting physician by telephone.
- j. Written confirmation of the PAC determination will be sent to the admitting physician, recipient's parent or guardian and hospital.
- k. A computer entry is made of all requests and determinations.
- l. The Analyst will obtain discharge dates from the hospital when the number of approved days are exhausted.
- m. The physician may request an extension of the approved length-of-stay and give medical rationale to justify the need for further hospital stay.
- n. If the recipient has not been discharged and additional days have not been requested by the admitting physician, the Analyst will initiate a Length-of-Stay

(LOS) review by obtaining medical justification from either the doctor or the hospital's utilization review department.

- o. Clinical criteria are used to evaluate each admission which exceeds the approved length-of-stay.
- p. If the criteria are not met, the case will be evaluated by a physician advisor as indicated in **5.1.f** above.
- q. If the criteria are met, additional days will be certified and the physician will be notified of the next review date by telephone.
- r. Written confirmation of the total number of approved days will be sent to the physician, recipient's parent or guardian, and hospital when discharge occurs or when an LOS extension is not certified.
- s. Certification for hospital admission and length of stay is not required for those admissions outside of the United States.

5.2 Inpatient Mental Health Admissions

All inpatient mental health admissions require Pre-admission and length of stay certification by the DMA's vendor.

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."
4/30/12	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

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)

There are no specific procedure codes. Refer to **Subsections 3.2 and 5.1**

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

G. Co-payments

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

H. Reimbursement

Providers must bill their usual and customary charges.