

# Clinical Policy: Nerve Blocks and Neurolysis for Pain Management.

Reference Number: WNC.CP.148  
Last Review Date: 01/23

[Coding Implications](#)  
[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

Nerve blocks are the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks created by the injection of local anesthetic solutions. They can be used to identify the source of pain or to treat pain.

## Policy/Criteria

It is the policy of WellCare of North Carolina® that invasive pain management procedures performed by a physician are **medically necessary** when *the relevant criteria are met and the patient receives only one procedure per visit, with or without radiographic guidance.*

### A. I. Occipital Nerve Block

1. An *initial injection* of a local anesthetic for the diagnosis of suspected occipital neuralgia is **medically necessary** when **all** of the following are met:
  - a. Patient has unilateral or bilateral pain located in the distribution of the greater, lesser and/or third occipital nerves;
  - b. Pain has **two** of the following three characteristics:
    - i. recurring in paroxysmal attacks lasting from a few seconds to minutes;
    - ii. severe intensity;
    - iii. shooting, stabbing, or sharp in quality;
  - c. Pain is associated with dysaesthesia and/or allodynia apparent during innocuous stimulation of the scalp and/or hair, and at least **one** of the following:
    - i. tenderness over the affected nerve branches;
    - ii. trigger point at the emergence of the greater occipital nerve or in the distribution of C2.
2. *Therapeutic occipital nerve blocks* are **medically necessary** when **all** of the following are met:
  - a. There was temporary relief from the initial/previous injection;
  - b. The member has failed **3 months** of conservative treatment including **all** of the following:
    - i. heat, rest and/or physical therapy, including massage;
    - ii. NSAIDS, unless contraindicated or not tolerated;
    - iii. oral anticonvulsant medications (e.g., carbamazepine, gabapentin, pregabalin) or tricyclic antidepressants;
    - iv. activity modification to address triggers;
  - c. No more than **4** injections are to be given within **12** months (includes diagnostic injection).

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3. *Occipital nerve block* for the diagnosis or treatment of other types of headaches, including migraine and cervicogenic headaches, is considered **not medically necessary**.

#### B. Celiac Plexus Nerve Block/Neurolysis

1. Celiac plexus nerve block/neurolysis is **medically necessary** for either of the following indications:
  - a. Chronic neuralgic pain secondary to pancreatic cancer, all of the following:
    - i. Diagnosis of pancreatic cancer with severe visceral abdominal/back pain;
    - ii. Strong analgesics such as opioids are no longer effective or their side effects decrease quality of life;
    - iii. No malignancy in an area of somatic innervation such as the peritoneum or diaphragm.
  - b. Refractory pain due to chronic pancreatitis with non-dilated pancreatic duct.
2. A repeat celiac plexus nerve block for refractory pain from chronic pancreatitis with nondilated pancreatic duct is medically necessary when both of the following are met:
  - a. At least three months have passed since previous injection;
  - b. There was a clinical benefit from the initial celiac block.
3. Repeat celiac plexus nerve blocks or neurolysis, for any indication other than those noted above, are **not medically necessary** as there is a lack of evidence to support effectiveness.

#### C. Intercostal Nerve Block/Neurolysis

1. Intercostal nerve block/neurolysis is **medically necessary** for chronic neuralgic pain secondary to an injured intercostal nerve as a result of a rib fracture, a thoracotomy incision or chronic pain due to post herpetic neuralgia, or other neuropathic process when **all** of the following are met:
  - a. Suspected organic problem;
  - b. Non-responsiveness to conservative modalities of treatment;
  - c. Pain and disability of moderate to severe degree;
  - d. No evidence of contraindications such as infection or pain of predominately psychogenic origin.

#### D. Genicular Nerve Blocks, Neurolysis and Genicular Nerve Radiofrequency Neurotomy

1. There is insufficient evidence to determine safety and efficacy of genicular nerve blocks, neurolysis and radiofrequency neurotomy of the articular nerves.

#### E. Peripheral/Ganglion Nerve Blocks

**Note:** If administered as part of a surgery or other procedure, coding for peripheral/ganglion nerve blocks should follow proper coding practices and would not be subject to prior authorization or payment separately from the procedure.

1. Peripheral nerve blocks *for diagnosis and treatment of malignant pain* are considered **medically necessary** as part of a comprehensive pain management program.
2. Peripheral nerve blocks *for diagnosis or treatment of post-herniorrhaphy pain* are considered **medically necessary** when **all** of the following criteria are met:
  - a. A *first diagnostic* peripheral nerve block when **all** of the following are met:
    - i. diagnosis of post-herniorrhaphy neuralgia;
    - ii. groin pain has persisted for three months after surgical hernia repair;

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- iii. less invasive pain management methods such as NSAIDs and/or opiates have not relieved the pain;
  - iv. imaging studies have ruled out non-neuropathic causes of pain;
  - v. documentation indicates that pain is not attributable to any other cause;
  - b. *Therapeutic* peripheral nerve block(s) for treatment of post-herniorrhapy pain when **all** of the following are met:
    - i. there was temporary relief from the initial/previous injection;
    - ii. injections are given at least a week apart.
3. Peripheral nerve blocks for *prevention or treatment of headaches*, including, but not limited to: migraine headaches, treatment-refractory migraines in pregnancy, and shortlasting unilateral neuralgiform headaches, are considered **not medically necessary** as effectiveness has not been established.
  4. There is insufficient evidence in the published peer-reviewed literature to support the use of peripheral nerve blocks for the treatment of trigeminal neuralgia.
  5. There is insufficient evidence in the published peer reviewed literature to support the use of peripheral/ganglion nerve blocks or neurolysis *for any condition not indicated elsewhere in this policy*, including chronic pain. There is ongoing research but insufficient evidence to establish efficacy.
- F. Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve  
There is insufficient evidence to determine the safety and effectiveness of intraosseous radiofrequency nerve ablation of the basivertebral nerve (e.g. Intracept® Intraosseous Nerve Ablation System.) for the treatment of chronic low back pain.

#### Background

##### *Local Injections for Cervicogenic and Occipital Neuralgia*

Greater occipital nerve blocks have been advocated as a diagnostic test for cervicogenic headache and occipital neuralgia. The effectiveness of greater occipital nerve block in patients with primary headache syndromes is controversial.<sup>25</sup> The International Headache Society (IHS) defines occipital neuralgia as unilateral or bilateral paroxysmal, shooting or stabbing pain in the posterior part of the scalp, in the distribution of the greater, lesser or third occipital nerves, sometimes accompanied by diminished sensation or dysaesthesia in the affected area and commonly associated with tenderness over the involved nerve(s).<sup>1</sup> The IHS includes relief of pain following a local anesthetic block of the affected nerve as part of their diagnostic criteria for occipital neuralgia.<sup>1</sup> Thus, the principal indication for occipital block is diagnosis. Another indication is the treatment of chronic occipital neuralgia, often with a series of therapeutic blocks combining local anesthetic and corticosteroid. Pain relief is typically prompt and may last several weeks or even months. At that time the injection may be repeated.<sup>19,25</sup>

##### *Celiac Plexus Nerve Block/Neurolysis for Pancreatic Cancer*

Although its analgesic effectiveness is similar to analgesic drugs, celiac plexus neurolysis offers pain reduction without the significant adverse effects of opiates.<sup>2</sup> A multidisciplinary, international guideline issued a strong recommendation based on moderate quality evidence for celiac plexus neurolysis as a treatment for pain associated with advanced pancreatic cancer.<sup>2</sup> Furthermore, a 2011 Cochrane review stated that celiac plexus block (neurolysis) significantly reduced opiate use and lowered pain compared to the control group.<sup>3</sup>

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The optimal timing of celiac plexus neurolysis for pain due to pancreatic cancer is not known.<sup>2</sup> Advocates of an earlier approach argue that pain is more effectively addressed by neurolysis when treated earlier, and opiate-related side effects may also be reduced compared to later treatment. However, the effects of celiac plexus neurolysis diminish over time, which would leave a patient with fewer options as the cancer progresses and pain becomes more severe. Repeat celiac plexus neurolysis for pain due to pancreatic cancer is effective only about 30% of the time and is not recommended.<sup>2, 17</sup>

#### *Celiac Plexus Nerve Block/Neurolysis for Chronic Pancreatitis*

Celiac plexus blockade is an option for pain relief in patients with refractory pain due to chronic pancreatitis and a non-dilated pancreatic duct. Advantages of celiac plexus blockade include that a single treatment can potentially provide pain reduction or relief, may reduce or eliminate the need for oral analgesia, and can be performed quickly and repeated as needed. However, it is unclear which patients will derive the most benefit and the pain relief is transient, lasting for three to six months.<sup>24</sup>

The American College of Gastroenterology suggests considering celiac plexus block for treatment of pain in chronic pancreatitis (conditional recommendation, very low quality of evidence) noting that celiac plexus blockade represents a relatively low-risk, opioid-free method to reduce refractory pain in certain patients with chronic pancreatitis.<sup>41</sup>

#### *Intercostal Nerve Blocks*

Intermittent intercostal nerve blocks can be used to control pain in the chest and upper abdomen, such as pain associated with rib fractures or chronic pain due to post herpetic neuralgia. Intercostal nerve blocks can be performed using anatomic landmarks or with ultrasound guidance, which can be used to minimize the chance of intravascular injection and pneumothorax and to increase reliable dermatomal coverage.<sup>4, 8</sup>

For isolated injuries, such as single rib fracture, nonsteroidal anti-inflammatory drugs with or without opioids would be the initial treatment. For more severe injuries, particularly if ventilation is compromised, intercostal nerve blocks may be needed. For patients with multiple rib fractures, there is a need to perform the procedure at multiple intercostal levels. Repeated blockade may be needed for prolonged relief upon return of pain and/or deterioration in functional status. For repeat blocks or other interventions, the patient must have been responsive to prior interventions with improvement in physical and functional status.<sup>5, 8</sup>

Regional anesthesia plays an important role in thoracic surgery, particularly with regard to postoperative pain control. The first choice of regional anesthesia for thoracic surgery is epidural analgesia or thoracic paravertebral block. In general, the analgesic efficiencies of both these types of anesthesia are equivalent; however, thoracic paravertebral block has some advantages over epidural analgesia, including fewer complications. When these two blocks are contraindicated, intercostal nerve block or interpleural block should be considered.<sup>6, 7</sup>

#### *Genicular Nerve Blocks and Radiofrequency Neurotomy*

The genicular nerve is a sensory nerve that surrounds the knee and provides innervation for the joint. Genicular nerve blocks, neurolysis and radiofrequency neurotomy are emerging interventions for knee pain. The limited evidence regarding genicular nerve blocks for determining appropriateness of treatment with genicular radiofrequency ablation has reached conflicting results.<sup>9, 10, 41</sup> A few small studies suggest that genicular radiofrequency neurotomy

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may be effective for relief of pain, but further research is needed to establish safety and efficacy.  
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#### *Peripheral/Ganglion Nerve Block*

Peripheral nerve blocks (PNB) are widely-used for surgical anesthesia as well as for both postoperative and nonsurgical analgesia. Indications for PNBs are diverse and vary widely. Blocks are often used to avoid the effects of alternative anesthetics or analgesics. The most common rationale for their use is to avoid side effects and complications of general anesthesia, particularly respiratory-related effects, and to provide analgesia while minimizing opioid use.<sup>37</sup> Chronic pain can be treated with a number of pharmacologic and nonpharmacologic therapies which generally fall into six major categories: pharmacologic, physical medicine, behavioral medicine neuromodulation, interventional and surgical approaches.<sup>33</sup> Optimal outcomes result from multiple approaches.<sup>33,50</sup> Interventional approaches, which typically attempt to target the presumed pain generators, may play a complementary role to other strategies (e.g., rehabilitation and appropriate pharmacotherapy.) The best candidates for interventional management have persistent focal pain of shorter duration, appropriate expectations, and well-managed psychosocial distress.<sup>33</sup>

Cancer pain can be caused by complex interactions among cancer cells, the peripheral and central nervous systems, and the immune system. Peripheral pain receptors may become activated, sensitized or injured with certain cancers. Neuropathic pain may arise from nerve tissue damage and cancer patients may experience mild to severe pain. At least 15% will experience no relief or have severe adverse effects from interventions to address their pain. Nerve blocks or other interventional procedures may be appropriate as part of a comprehensive pain management program.<sup>34, 35</sup>

#### *Peripheral Nerve Blocks for Prevention or Treatment of Headaches*

Peripheral nerve blocks have been proposed as a treatment for migraines in pregnancy and refractory migraines. However, evidence is limited to support this indication. In a series of 13 pregnant women with migraine refractory to medication, injection of local anesthetic into one or more peripheral nerve resulted in elimination of pain in seven women, pain reduction in two and no response in four women. Larger studies are necessary to better define the efficacy of this approach.<sup>31</sup>

#### *Peripheral Nerve Blocks for Diagnosis and Treatment of Post-Herniorrhaphy Groin Pain*

Persistent pain following inguinal hernia surgery is relatively common and a comprehensive pain management program is recommended. A prospective study, including elective primary open hernia repairs, found persistent pain occurred in 16.5-16.1 percent of patients at six months and five years.<sup>36</sup> Acute pain persisting more than eight weeks is most likely neuropathic due to primary or secondary nerve injuries. Post-herniorrhaphy neuralgia should be suspected if pain persists beyond six to eight weeks. These patients should undergo imaging to exclude nonneuropathic causes. Patients with positive response to initial nerve block can be treated every 1-3 weeks until pain relief is sustained. Those who have a positive response initially, but the pain returns, may require groin nerve sacrifice via percutaneous nerve ablation or surgical neurectomy.<sup>36</sup>

#### *Peripheral Nerve Blocks for Prevention or Treatment of Trigeminal Neuralgia*

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Compression of the trigeminal nerve root is the main mechanism of trigeminal neuralgia, but brainstem lesions account for a small proportion of cases. Initial treatment of most patients with trigeminal neuralgia is pharmacologic therapy. For patients with TN refractory to medical therapy, it is reasonable to discuss options for surgical therapy (e.g., microvascular decompression, various types of rhizotomy, or gamma knife radiosurgery.) The decision to have surgery and the choice among surgical options will be influenced by individual circumstances including patient preference, adverse effect profile of the available techniques, and expertise of the local center.<sup>42</sup> There is insufficient evidence in the published peer-reviewed literature to support the use of peripheral nerve blocks for the treatment of trigeminal neuralgia.<sup>50</sup>

#### *Intraosseous Radiofrequency Nerve Ablation of Basivertebral Nerve*

Basivertebral nerve radiofrequency ablation has been developed for the treatment of chronic low back pain thought to arise from the vertebral body endplates.<sup>43</sup> The Intrasept Intraosseous Nerve Ablation System, Relieva Medsystems, Inc. is approved by the FDA and intended to be used in conjunction with radiofrequency generators for the ablation of basivertebral nerves of the L3 through S1 vertebrae. Its purpose is to relieve chronic low back pain of at least six months duration that has not responded to at least six months of conservative care, and is also accompanied by features consistent with Type 1 or Type 2 Modic changes on an MRI [e.g., inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypointensive signals (Type 1 Modic change), and changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyperintensive signals (Type 2 Modic change.)]<sup>49</sup>

Studies to date report relief of pain and improvement in function and quality of life after treatment, however, most are company sponsored, limited in size and are of generally poor or fair quality. A review of full-text clinical practice guidelines and position statements offers weak support for the Intrasept Intraosseous Nerve Ablation for chronic low back pain of suspected vertebrogenic origin. Long-term non-industry-funded prospective trials should be pursued to confirm the results of currently published clinical studies.<sup>44</sup>

#### **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 2021, 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.

CPT®* Codes	Description
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve

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CPT® Codes	Description
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve
64447	Injection(s), anesthetic agent(s); femoral nerve
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
64505	Injection, anesthetic agent; sphenopalatine ganglion
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
64620	Destruction by neurolytic agent, intercostal nerve
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64640	Destruction by neurolytic agent; other peripheral nerve or branch
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64999	Unlisted procedure, nervous system

HCPCS® Codes	Description
No applicable codes.	

#### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
C25.0-C25.9	Malignant neoplasm of pancreas
G44.85	Primary stabbing headache
G54.0-G54.9	Nerve root and plexus disorders
G56.40-G56.43	Causalgia of upper limb
G57.70-G57.73	Causalgia of lower limb
G89.22	Chronic post-thoracotomy pain
G89.4	Chronic pain syndrome
G90.50-G90.59	Complex regional pain syndrome I (CRPS I)
K86.0	Alcohol-induced chronic pancreatitis
K86.1	Other chronic pancreatitis
M54.81	Occipital neuralgia
R07.81-R07.89	Other chest pain
R10.10-R10.12	Pain localized to upper abdomen

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ICD-10-CM Code	Description
S22.41X+- S22.49X+	Multiple fractures of rib

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	03/21	06/21
Added Sympathetic Nerve Block criteria, Background information, and CPT codes. Added note to Peripheral/ganglion nerve blocks criteria.	08/21	11/21
Revised policy title from “Nerve Blocks for Pain Management” to “Nerve Blocks and Neurolysis for Pain Management.” Change verbiage C.1. “...either of the following indications...” Added. ” A. Chronic neuralgic pain secondary to pancreatic cancer, all of the following” Added refractory chronic pancreatitis as an indication for celiac plexus block to C1B. Changed verbiage to C.2. and added meeting criteria. Changed verbiage to C.3. Change verbiage E.1. w/no change to criteria. Section F.1.. moved NOTE for visibility and edited verbiage to say “If administered as part of a surgery or other procedure, coding for peripheral/ganglion nerve blocks should follow proper coding practices and would not be subject to prior authorization or payment separately from the procedure.”; F.1. & F.5. Changed “Experimental/investigational” language. F.4. Added insufficient evidence to support peripheral nerve block for treatment of trigeminal neuralgia. Added G. “Added VII. Insufficient evidence to determine the safety and effectiveness of intraosseous radiofrequency nerve ablation of basivertebral nerve. Added ICD -10 codes K86.0 & K86.1 to support coverage criteria. removed G50.0 from list of ICD 10 codes that support coverage criteria updated background and references accordingly.	08/22	08/22
Annual review completed. Added “as effectiveness has not been established” to I. C. Background updated. Reworded some extraneous language with no clinical significance. References reviewed and updated.	01/23	

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#### **North Carolina Guidance**

##### *Eligibility Requirements*

- 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 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.

##### *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.

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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/>  
EPSDT does not apply to NCHC beneficiaries.

#### *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 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.

#### *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 and NCHC:

- a. Claim Type - as applicable to the service provided:

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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>  
For NCHC refer to NCHC 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

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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.

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