Clinical Policy: Nursing Facility Services

Reference Number: WNC.CP.234
Last Review Date: 07/22

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[1]

A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the NC Medicaid (Medicaid) program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services.
A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Nursing Facility Services when prior approval is obtained **and** the following medical necessity is met:

A. Nursing Facility Level of Care Criteria
   1. The following criteria are not intended to be the only determinants of the resident's or beneficiary's need for nursing facility level of care. Professional judgment and a thorough evaluation of the resident's or beneficiary's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for nursing facility care and other health care alternatives. All professional services that are provided to the resident or beneficiary to maintain, monitor, or enhance the resident's or beneficiary's level of health must be addressed in the health records.

B. Qualifying Conditions - Conditions that are considered when assessing a beneficiary for nursing facility level of care include the following:
   1. Need for services that, by physician judgment, require:
      a. a Registered Nurse for a minimum of 8 hours daily; **and**
      b. other personnel working under the supervision of a licensed nurse.
   2. Need for 24-hour observation and assessment of resident needs by a registered nurse or a licensed practical nurse.
   3. Need for administration and control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 13O.0202, 21 NCAC 36.0401 and 21 NCAC 36.0403, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for teaching, supervision and evaluation).

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4. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities; such measures may include the following:
   a. encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transferring, and ambulation);
   b. using preventive measures and devices, such as positioning and alignment, range of motion, handrolls, and positioning pillows, to prevent or retard the development of contractures; **or**
   c. training in ambulation and gait, with or without assistive devices.
5. Special therapeutic diets: nutritional needs under the supervision and monitoring by a registered dietician.
6. Nasogastric and gastrostomy tubes requiring monitoring and observation:
   a. tube with flushes;
   b. medications administered through the tube;
   c. supplemental bolus feedings.
7. Respiratory therapy: oxygen as a temporary or intermittent therapy or for residents who receive oxygen therapy continuously as a component of a stable treatment plan:
   a. nebulizer usage;
   b. pulse oximetry;
   c. oral suctioning.
8. Wounds and care of decubitus ulcers or open areas.
9. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan.
10. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan.
11. Diabetes, when daily observation of dietary intake and medication administration is required for proper physiological control.
12. Cognitive disabilities impacting the ability of a resident to independently perform activities of daily living, resulting in the need for hands on assistance.

C. Conditions When in Combination May Justify Nursing Facility Level of Care - The following conditions when in combination may justify nursing facility level of care:
   1. Need for teaching and counseling related to a disease process, disability, diet, or medication.
   2. Adaptive programs: training the resident to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must incorporate the purpose of the resident’s participation in the program and the resident’s progress.
   3. Ancillary therapies: supervision of resident performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of casts.
   4. Injections: requiring administration and professional judgment by a licensed nurse.
   5. Treatments: temporary cast, braces, splint, hot applications, cold applications, or other applications requiring nursing care and direction.
   6. Psychosocial considerations: psychosocial condition of each resident is evaluated in relation to his or her medical condition when determining the need for nursing facility level of care. Factors to consider along with the resident’s medical needs are:

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a. acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes or by nursing or therapy notes);
b. age;
c. length of stay in current placement;
d. location and condition of spouse;
e. proximity of social support; **and**
f. effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning will help alleviate the fear and worry of transfer).

7. Blindness.
8. Cognitive and Behavioral symptoms,
   a. wandering;
   b. verbal disruptiveness;
   c. physical aggression;
   d. verbal aggression; **or**
   e. inappropriate behavior (when it can be properly managed at the nursing facility level of care).
9. Frequent falls.
10. Chronic, recurrent medical problems that require daily observation by licensed personnel for prevention and/or treatment.

D. Ventilator Level of Care
   1. To qualify as ventilator level of care, a resident must be dependent upon mechanical ventilation at least 10 hours per day and in stable condition without unstable or progressive infections or extreme changes in ventilator settings or duration (such as increase in respiratory rate by five breaths per minute, increase in fraction of inspired oxygen (FIO2) of 25% or more or increase in tidal volume of 200 milliliters or more).

E. Non-Emergency Medically Necessary Ambulance Transportation
   1. Non-emergency medically necessary ambulance transportation to receive medical services that cannot be provided in the nursing facility when any other means of transportation would endanger the resident's health and it is medically necessary that the resident be transported via stretcher due to a medical or physical condition is covered **only** if they are furnished to a resident whose medical condition is such that other means of transportation would be contraindicated.

F. Non-Ambulance Transportation
   1. Non-ambulance transportation of Medicaid-eligible residents to receive medical care that cannot be provided in the facility is covered in the per diem that is reimbursed to the facility.

   Note: The facility cannot charge the family or the resident's funds for the cost of this transportation. The facility may contract with a service (such as county-coordinated transportation systems) to provide transportation or may provide transportation services using its own vehicles if this is more cost effective.

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II. WellCare of North Carolina® **shall not** cover Nursing Facility Services when **ONE** of the following are met:

A. The beneficiary (age 65 and older) is entitled to Medicare benefits and does not apply for Medicare;
B. A preadmission screening resident review (PASRR) was not completed prior to admission as required by 42 CFR 483 Subpart C.
C. Non-Covered Resident Care Items
   1. Telephone, such as a cellular phone;
   2. Television, radio, personal computer or other electronic device for personal use;
   3. Personal reading matter, such as a newspaper and a magazine;
   4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
   5. Non-covered special care services such as privately hired nurses or aides;
   6. Personal comfort items, including smoking materials, notions, novelties, and confections;
   7. Gifts purchased on behalf of a resident;
   8. Flowers and plants;
   9. Cost to participate in social events and entertainment offered outside the scope of the activities program;
   10. Specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, unless ordered by the resident's physician, physician assistant, nurse practitioner or clinical nurse specialist;
   11. Personal clothing;
   12. Private rooms, unless the beneficiary's attending physician orders a private room based on medical necessity or when therapeutically required (such as, isolation for infection control) or if the only room available within the facility is a private room;
   13. Guest meal tray; **or**
   14. Morgue boxes, shrouds, or burial wrappings.

   Note: This list is not all inclusive.
D. Bed Hold Days
E. Non-Covered Ambulance Transportation Services
   1. Non-emergency transportation when it is not medically necessary to transport a resident by ambulance;
   2. Transportation from the nursing facility to the emergency room or to the outpatient department of a hospital for medical services that can be rendered at the nursing facility;
   3. Transportation of a deceased resident, if the resident was pronounced dead prior to the call for pick-up; **or**
   4. Transportation from a nursing facility to a site for therapeutic leave.

Limitations / Requirements[1]

An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility.

I. Preadmission Screening Resident Review

A. The Preadmission Screening Resident Review (PASRR) program is a federal statutory requirement (refer to 42 CFR 483 Subpart C) that mandates the review of every

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individual who applies to or resides in a Medicaid-certified nursing facility, regardless of the source of payment for nursing facility services.

B. In accordance with 42 CFR 483.106, all applicants to and residents of Medicaid-certified nursing facilities shall be screened through the Level I and, if appropriate, the Level II process.
   1. Level I Screens
      a. Federal law (42 CFR 483.128) mandates that states provide a Level I screen for all applicants to Medicaid-certified nursing facilities to identify residents with serious mental illness (SMI), intellectual and developmental disabilities (IDD), or a related condition (RC). For residents with no evidence or diagnosis of SMI, IDD, or RC, the initial Level I screen remains valid unless there is a significant change in status.
   2. Level II Screens
      a. Any applicant to a Medicaid-certified nursing facility whose Level I screen indicates the possible presence of SMI, IDD, or RC must undergo a Level II screen. Level II screens are federally mandated (42 CFR 483.128) to be performed on-site and prior to admission to the nursing facility.
      b. After a resident receives a Level II evaluation, the resident no longer needs to receive an Annual Resident Review (ARR) to evaluate the resident's continuing need for nursing facility care or specialized SMI, IDD, or RC services. Congress repealed the Federal requirement for annual reviews in 1996.

C. Nursing facilities are responsible for identifying significant changes in the resident's status. The following applies:
   1. A significant change shall require referral for a PASRR evaluation if a mental illness, intellectual and developmental disability, or related condition is present or is suspected to be present. Nursing facilities are responsible to notify the DHHS designated contractor for PASRR within seven (7) business days of the significant change so that either a PASRR I or PASRR II evaluation can be arranged, whichever is indicated by the change. The process then follows the same steps as for the initial Level I PASRR evaluation process.
   2. Once the PASRR II is completed, communication of changes in service needs must occur with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), who is responsible to arrange and assure Mental Health (MH) and IDD services for residents who are appropriate for additional services.

D. Level II Screen Postponements
   1. Federal regulations (42 CFR 483.130) allow short-term nursing facility admissions for some applicants with SMI, IDD, or RC. These **time-limited** approvals are authorized during the Level I screen process when any of the following six (6) circumstances are applicable:
      a. *Convalescent care* (30-calendar-day approval): applies to admissions to nursing facilities directly from acute care hospitals;
         Note: A beneficiary shall need 30 calendar days or less of nursing facility care for the hospitalization condition for this approval to be granted. The attending physician shall provide certification that the nursing facility stay is not expected to exceed 30 calendar days. (42 CFR 483.106);

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b. *Emergency* (7-calendar day approval): applies when the beneficiary needs emergency protective service placement;
c. *Delirium* (7-calendar day approval): applies to a beneficiary suspected of having SMI, IDD, or RC but whose delirium state prevents accurate completion of the Level I or Level II processes;
d. *Respite* (7-calendar-day approval): applies to a beneficiary whose in-home caregivers need temporary respite;
e. *Terminal illness* (1-calendar-year approval): applies to a beneficiary under the care of hospice; **or**
f. *Severe physical illness* (1-calendar-year approval): applies when a beneficiary has a diagnosis which results in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services.

E. Continued Stays
1. If residence in the facility is expected to extend beyond the end date shown on the initial Level I screen, further approval and evaluation, as authorized by 42 CFR 483.130(e), must be obtained before the authorized period ends. The admitting facility is responsible for initiating further assessment through an updated Level I evaluation.
a. Within 5 calendar days of the resident's date of admission for 7-calendar-day approvals;
b. Within 25 calendar days for 30-calendar-day approvals; **and**
c. Within 50 calendar days for 60-calendar-day approvals.

II. Provision of Services

A. All services must be provided according to 42 CFR 483 Subpart B. A Medicaid-certified nursing facility shall provide or arrange for the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment and plan of care. A licensed nurse shall provide daily observation and assess the total needs of the resident, plan and manage treatment according to the plan of care approved by the physician and render direct services to the resident.

B. Services and Items Covered in the Per Diem - The following items and services must be provided by a nursing facility as part of the per diem that is reimbursed to the facility. **This list is not all inclusive** – please refer to **https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/facility-services-clinical-coverage-policies** for additional covered items.
1. Room and board;
2. All general nursing services, including restorative nursing;
3. Personal hygiene and laundry care items;
4. Dressing and skin care items;
5. Medical supplies and equipment;
6. Non-prescription (over-the-counter) drugs, biologicals, and emergency drugs;
7. Dietary services, such as therapeutic diets and special dietary supplements used for oral or tube feeding;
8. Rehabilitative services, such as physical, speech, and occupational therapies;
9. Social services;
10. Activity services;

11. Therapeutic leave;
12. Non-ambulance transportation of Medicaid-eligible residents to receive medical care that cannot be provided in the facility; **and**
13. Miscellaneous items:
    a. Items furnished on a routine basis to all residents;
    b. Items stocked in gross supply and distributed or used individually in small quantities; **and**
    c. Items used by individual residents but reusable and expected to be available.

C. Therapeutic Leave - Therapeutic leave must be provided as follows:
1. Each Medicaid eligible resident who is occupying a nursing facility bed for which the N.C. Medicaid program is then paying reimbursement shall be entitled to take up to 60 days of therapeutic leave in any calendar year from any such bed, without the facility's suffering any loss of reimbursement during the period of leave.
2. The taking of such leave must be for therapeutic purposes only, and must be ordered by the resident's attending physician. The necessity for such leave shall be documented in the resident's plan of care and therapeutic justification for each instance of such leave shall be entered into the resident's health record.
3. Facilities shall reserve a therapeutically absent resident's bed for him or her, and are prohibited from deriving any Medicaid revenue for that resident other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken that exceed the legal limit.
4. No more than 15 consecutive therapeutic leave days may be taken without approval of NC Medicaid.
   Note: The facility shall request prior approval on behalf of the beneficiary through NC Medicaid's fiscal agent for therapeutic leave that exceeds 15 consecutive days.
5. The therapeutic justification for such absence is subject to review by the State or its agent during scheduled on-site medical reviews.
6. For reference and audit purposes, facilities shall keep a cumulative record of therapeutic leave days taken by each resident. In addition, residents on therapeutic leave must be noted as such on the facility's midnight census. Facilities bill Medicaid for approved therapeutic leave days as regular residence days.
7. The official record of therapeutic leave days taken for each resident must be maintained by the State or its agent.
8. Entitlement to therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving either inpatient or nursing services provided either elsewhere or at a different level of care in the current facility when such services are paid for by Medicaid.
9. Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose is not reimbursed by Medicaid.

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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

2019, 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
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.
99307	Subsequent nursing facility care, per day for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity.
99315	Nursing facility discharge day management; 30 minutes or less
99316	Nursing facility discharge day management; more than 30 minutes
99318	Evaluation and management of patient involving an annual nursing facility assessment, which requires these 3 key components: A detailed interval history; A comprehensive examination; and medical decision making that is of low to moderate complexity.

HCPCS ®* Codes	Description
No applicable codes.	

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ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
No applicable codes.	

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	04/21	06/21
Removed LOC criteria.	07/22	

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 2B-1 Nursing Facility Services. https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies. Published April 15, 2022. Accessed July 20, 2022.

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.

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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.

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

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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:
   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/.

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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 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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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