Clinical Policy: Out-of-State Services

Reference Number: WNC.CP.196 Coding Implications
Last Review Date: 11/24 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]

- Out-of-state (OOS) services are limited to the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands as defined in 42 CFR 400.203.
- Out-of-State services are determined to be medically necessary, and care and services that are provided within 40 miles of the NC border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia are covered to the same extent and under the same conditions as medical care and services provided in NC, except for the services found in this policy.
- For Out-of-State services requested more than 40 miles from the NC border, the Policy/Criteria below must be applied.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover Out–of–Services (OOS) when the member meets the following specific criteria:
- **A.** Services not available in NC;
- **B.** The member is out of state and requires one or more of the following situations:
  1. Emergency medical condition as defined below, in Background I.;
  2. When the health of the member would be endangered if the care and services were postponed until the member returns to North Carolina; OR
  3. Where the health of the member would be endangered if travel were undertaken to return to North Carolina; **or**

***Note**: As soon as medically appropriate, the member shall return to North Carolina, as no services are covered unless those services meet the specific criteria above.*

II. **In addition to the covered section above, Criteria I** of this policy, WellCare of North Carolina® shall cover out-of-state services for a foster child who is a ward of the State of North Carolina and living in a foster home more than 40 miles from the NC border without prior approval.

III. WellCare of North Carolina® shall not cover out-of-state services rendered by a provider or facility that is not enrolled in NC Medicaid.

IV. WellCare of North Carolina® **shall not** cover the following services when provided by out of state providers:
- **A.** Children's Developmental Service Agency (CDSA);
- **B.** Community Alternatives Program (CAP);
- **C.** Program of All-Inclusive Care for the Elderly (PACE);
- **D.** Private Duty Nursing (PDN); **and**
- **E.** Durable Medical Equipment (DME);
- **F.** Services rendered outside of an emergency department or inpatient stay resulting from an evaluation in the emergency department without prior approval.

V. Reimbursement
- **A.** Out-of-state treatment provided to a NC Medicaid member shall require prior approval with the exception of treatment received in an emergency department that results in a discharge or admission.
- **B.** In-state and out-of-state providers must be currently enrolled in NC Medicaid to bill for services rendered to a NC Medicaid member. A member may not be billed when the NC Medicaid enrolled provider submits a claim and receives no or partial reimbursement from NC Medicaid.
- **C.** Services rendered by a provider, not enrolled in NC Medicaid, may be billed to the member or their legal guardian.

Background[1]

I. Definitions

A. Emergency Medical Condition

1. 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. Serious impairment to bodily functions; **or**
   b. Serious dysfunction of any body organ or part.
2. ***With regard to pregnant women having contractions***:
   a. That there is inadequate time to affect a safe transfer to another hospital before delivery; **or**
   b. That the transfer may pose a threat to the health or safety of the woman or her unborn child.

B. Out-of-State providers: Providers located outside the NC border.

1. Border **Providers**: Providers located within 40 miles of the NC border are reimbursed to the same extent and under the same conditions as medical care and services provided in NC.
2. Out-of-State **Providers**: Providers located more than 40 miles from the NC border.

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 2024, 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
No applicable codes.	

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	06/21
Annual Review	09/21	11/21
Annual Review	08/22	09/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Updated link for NC adjacent Zip codes.	05/23	05/23
Annual Update. Removed Criteria II.f,g,h,I,(Critical Access Behavioral Health Agency, Home Health, Home Infusion Therapy, Hospice). ICD-10-CMS and HCPCS code tables removed.	05/24	05/24
Annual Review. Description regarding state locations was moved from Background with no effect on criteria. Removed the list of NC border zip codes. Background I.B.1 and 2. Changed Non/Contiguous Area to Border & Out-of-State. Updated the language in Criteria I.A and B and deleted C. with no effect on criteria. Added Criteria II. Foster child coverage. Added Criteria III. Shall not cover OOS rendered by provider or facility not enrolled in NC Medicaid. Added Criteria IV.F. "Medicaid shall not cover services rendered outside of an emergency department or inpatient stay resulting from an evaluation in the emergency department without prior approval." Added Criteria V. Reimbursement: Added 'Out-of-state treatment provided to a NC Medicaid member shall require prior approval with the exception of treatment received in an emergency department that results in a discharge or admission' "In-state and out-of-state providers must be currently enrolled in NC Medicaid to bill for services rendered to a NC Medicaid member. A member may not be billed when the NC Medicaid enrolled provider submits a claim and receives no or partial reimbursement from NC Medicaid.' and that 'services rendered by a provider, not enrolled in NC Medicaid, may be billed to the member or their legal guardian.' Under Background I.B. 1.and 2. Changed	11/24	11/24

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
non/contiguous to Out of State and Border with no effect on criteria. Removed Medicaid and health choice verbiage from References.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 2A-3 Out-of-State Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published September 1, 2024. Accessed September 12, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid 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.

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.
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/

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 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:

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

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 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.