

Out-of-State Services (for North Carolina Only)

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[Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Definitions	3
References	3
Guideline History/Revision Information	3
Instructions for Use	3

Related Policies
None

Application

This Utilization Review Guideline only applies to the state of North Carolina.

Coverage Rationale

Indications for Coverage

Out-of-State Services Coverage Criteria

Elective

Medicaid and North Carolina Health Choice (NCHC) shall cover Medically Necessary care and services when provided more than 40 miles from the North Carolina (NC) border if the out-of-state care and services meet the following criteria:

- Are more reasonably available than can be provided by an enrolled in-state provider and have been prior approved by NC Medicaid or NC Medicaid’s designee prior to rendering the services. Out-of-state services are more reasonably available when all the following are met:
 - The member has an uncommon or ongoing special condition, and requires a medical procedure or a consultation from a specialist; and
 - The clinical expertise of a specialist is required to address the specific health care needs of the member, as determined by UnitedHealthcare; and
 - An in-state specialist provider with the professional training and expertise to treat the member’s condition is not available, as determined by UnitedHealthcare; and
 - The requested service itself is a covered expense and has been determined by UnitedHealthcare to be Medically Necessary; and
 - Equally effective in-state services cannot be provided in a less costly manner.

Non-Elective

Medicaid and North Carolina Health Choice (NCHC) shall cover Medically Necessary care and services when provided more than 40 miles from the NC border if the out-of-state care and services meet any of the following criteria:

- The care and services are provided in any one of the following situations:
 - Emergency Medical Condition;
 - Where the health of the beneficiary would be endangered if the care and services were postponed until the beneficiary returns to North Carolina; or
 - Where the health of the beneficiary would be endangered if travel were undertaken to return to North Carolina

Note: As soon as medically appropriate, the beneficiary shall return to North Carolina, as no services are covered unless those services meet the specific criteria in the [Indications for Coverage](#) section.

Out-of-state services are provided to 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 border.

Coverage Limitations and Exclusions

The following are not covered services:

- Acute inpatient hospital services when the coverage criteria in the Indications for Coverage section have not been met
- The following services when provided in non-contiguous states by out-of-state providers:
 - Private Duty Nursing (PDN); and
 - Durable Medical Equipment (DME)
- Services that do not meet the definition of a covered expense
- Services that are not Medically Necessary, as determined by UnitedHealthcare
- Services that don't meet the criteria in the [Indications for Coverage](#) section above
- Services for which a benefit limit has been exhausted
- Services done solely for the convenience of the member

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

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:

- That is unsafe, ineffective, or experimental or investigational.
- 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

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.

EPSDT does not apply to NCHC beneficiaries.

Definitions

Emergency Medical Condition: 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:

- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part

For Medicaid beneficiaries only, with regard to pregnant women having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery; or
- That the transfer may pose a threat to the health or safety of the woman or her unborn child

Medically Necessary Services and Supplies: Those Covered Services, including professional services or supplies which are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes;
 - Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease, or its symptoms;
 - Within generally accepted standards of medical care in the community; and
 - Not solely for the convenience of the member, the member's family, or provider.
- N.C. Gen. Stat. § 58-50-61

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

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

References

North Carolina Medicaid and Health Choice, Out-of-State Services (OOS) Clinical Coverage Policy, No: 2A-3.
https://files.nc.gov/ncdma/documents/files/2A-3_0.pdf. Accessed April 28, 2021.

Guideline History/Revision Information

Date	Summary of Changes
07/01/2021	<ul style="list-style-type: none">• New Utilization Review Guideline

Instructions for Use

This Utilization Review Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Utilization Review Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.