

## 22/8 VISIT LIMITATION

1. North Carolina legislature passed law 2007-323, changing the policy for the number of allowable visits per SFY (July 1 – June 30) from 24 to 30. Changes are effective 8/1/08. There are 2 categories of limitations defined by the Federal Code of Regulations (42 CFR 440.210/440.220):
  - Mandatory Services – 22 allowable visits. Services that CMS requires state Medicaid programs to cover.
  - Optional Services – 8 allowable visits. CMS allows states to determine which of these services will be covered.Mandatory and optional services must be kept as distinct services and cannot be combined in the visit count.
2. The following people are not subject to the limitations:
  - Recipients under age 21
  - Recipients enrolled in Community Alternatives Program (CAP)
  - Recipients receiving prenatal services
3. Provider types included in the mandatory visit count:
  - Physician (except for physicians enrolled in NC Medicaid as specialists in oncology, radiology, or nuclear medicine.
  - Nurse practitioners
  - Nurse midwives
  - Health departments
  - Rural health clinics
  - Federally qualified health centersProvider Types included in the optional visit counts:
  - Chiropractors
  - Optometrists
  - Podiatrists
4. DMA has created a list of CPT codes that are counted toward the 22/8 visit limitations and a list of ICD-9 codes that do not count toward the limitations. These lists can be found at [http://www.ncdhhs.gov/dma/annual\\_visitlimit.htm](http://www.ncdhhs.gov/dma/annual_visitlimit.htm)) These codes will be reviewed regularly and updated as appropriate.
5. An annual preventive medicine visit (99381-99397) **does not** count toward the 22 visit limitations.
6. Requests to exceed the 22/8 visit limitations can be made when the life of the patient could be in jeopardy without additional treatments. This component of the law is met in part by the use of the diagnoses to bypass the visit count. In addition, a method is being developed so that the treating provider can send a request to the EDS Medical Director and include appropriate supporting documentation. If approved, the override would be effective for the duration of the SFY in which the request was made. Each treating provider must submit their own request for approval to exceed the limitations. Once this process is completed in the claims processing system by EDS, providers will be notified.
7. The CCNC/CA authorization by the primary care provider is not affected by this change. Authorizations are still given according to the referral policy found in the Basic Medicaid Billing Guide found at <http://www.dhhs.state.nc.us/dma/basicmed/Octo8/Section4.pdf>