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1.0 Description of the Procedure, Product, or Services

Outpatient specialized therapies include evaluations, re-evaluations, and/or multidisciplinary evaluations as well as therapeutic physical, occupational, speech, and audiologic services provided by all provider types and in all settings except hospital/rehabilitation inpatient settings.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NC Health Choice (NCHC) recipients shall be enrolled on the date of service.

NCHC recipients with a need for specialized therapy services confirmed by a licensed Medical Doctor, MD, Doctor of Podiatric Medicine, DPM, Doctor of Osteopathic Medicine, DO, Physician Assistant, PA, Nurse Practitioner, NP or Certified Nurse Midwife, CNM are eligible to receive specialized therapies. This policy does not supersede eligibility restrictions or other governing program policies.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Therapy is rehabilitation concerned with restoration of function and prevention of disability following disease, injury, or loss of body part.

All outpatient specialized therapies must be medically necessary as defined by the policy guidelines (national standards, best practice guidelines, etc.) recommended by the authoritative bodies for each discipline.

Prior approval is required for all treatment services.

3.2.1 Physical Therapy

NCHC accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in their most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns*.

Exception: A specific “treatable” functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific “reversible” functional impairment that impedes ability to participate in productive activities.

3.2.2 Occupational Therapy

NCHC accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in their most recent edition of *Occupational Therapy Practice Guidelines Series*.

Exception: A specific “treatable” functional impairment that impedes ability to participate in productive activities needs to be identified as the basis for beginning treatment rather than a specific “reversible” functional impairment that impedes ability to participate in productive activities.

3.2.3 Speech/Language-Audiology Therapy

NCHC accepts the medical necessity criteria for Speech/Language-Audiology therapy treatment as follows:

- a. CMS Publication 100-3 Medicare National Coverage Determinations Manual 170.3-Speech Language Pathology Services for the Treatment of Dysphagia (Rev.55, Issued: 05-05-06, Effective :10-01-06, Implementation: 10-2-06) and Publication 100-2 The Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, Sections 220 and 230.3 (Rev 36, Issued:06-24-05, Effective: 06-06-05, Implementation:06-06-05) These publications can be found at <http://www.cms.hhs.gov/manuals/IOM/list.asp> **and**
- b. ASHA guidelines regarding bilingual services (<http://www.asha.org>) Position Statement *Clinical Management of Communicatively Handicapped Minority Language Populations* **and**
- c. NCHC recipient is age 6 through 18 years of age and meets the following criteria:

Language Impairment Classifications Infant/Toddler – Birth to 3 Years	
Mild	<ul style="list-style-type: none"> ● Standard scores 1 to 1.5 standard deviations below the mean, or ● Scores in the 7th –15th percentile, or ● A language quotient or standard score of 78 – 85, or ● A 20% - 24% delay on instruments that determine scores in months, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	<ul style="list-style-type: none"> ● Standard scores 1.5 to 2 standard deviations below the mean, or ● Scores in the 2nd – 6th percentile, or ● A language quotient or standard score of 70 – 77, or ● A 25% - 29% delay on instruments which determine scores in months, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	<ul style="list-style-type: none"> ● Standard scores more than 2 standard deviations below the mean, or ● Scores below the 2nd percentile, or ● A language quotient or standard score of 69 or lower, or ● A 30% or more delay on instruments that determine scores in months, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Preschool – Age 3 Years to Kindergarten-Eligible Language Impairment Classifications	
Mild	<ul style="list-style-type: none"> ● Standard scores 1 to 1.5 standard deviations below the mean, or ● Scores in the 7th – 15th percentile, or ● A language quotient or standard score of 78 – 85, or ● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12 month delay, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	<ul style="list-style-type: none"> ● Standard scores 1.5 to 2 standard deviations below the mean, or ● Scores in the 2nd – 6th percentile, or ● A language quotient or standard score of 70 – 77, or ● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13 to 18 month delay, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	<ul style="list-style-type: none"> ● Standard scores more than 2 standard deviations below the mean, or ● Scores below the 2nd percentile, or ● A language quotient or standard score of 69 or lower, or ● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 19 month or more delay, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications School Age – Kindergarten-Eligible to Age 18	
Mild	<ul style="list-style-type: none"> ● Standard scores 1 to 1.5 standard deviations below the mean, or ● Scores in the 7th – 15th percentile, or ● A language quotient or standard score of 78 –85, or ● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrate a 1 year to 1 year, 6 month delay, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics, or pragmatics.
Moderate	<ul style="list-style-type: none"> ● Standard scores 1.5 to 2 standard deviations below the mean, or ● Scores in the 2nd – 6th percentile, or ● A language quotient or standard score of 70 – 77, or ● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1 year, 7 month to 2 year delay, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	<ul style="list-style-type: none"> ● Standard scores more than 2 standard deviations below the mean, or ● Scores below the 2nd percentile, or ● A language quotient or standard score of 69 or lower, or ● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, or ● Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation/Phonology Impairment Classifications All Ages	
Mild	<ul style="list-style-type: none"> ● Standard scores 1 to 1.5 standard deviations below the mean, or ● Scores in the 7th – 15th percentile, or ● One phonological process that is not developmentally appropriate, with a 20% occurrence, or ● Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. <p>Child is expected to have few articulation errors, generally characterized by typical substitutions, omissions, and/or distortions. Intelligibility not greatly affected but errors are noticeable.</p>
Moderate	<ul style="list-style-type: none"> ● Standard scores 1.5 to 2 standard deviations below the mean, or ● Scores in the 2nd – 6th percentile, or ● Two or more phonological processes that are not developmentally appropriate, with a 20% occurrence, or ● At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, or ● Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. <p>Child typically has 3 - 5 sounds in error, which are one year below expected development. Error patterns may be atypical. Intelligibility is affected and conversational speech is occasionally unintelligible.</p>
Severe	<ul style="list-style-type: none"> ● Standard scores more than 2 standard deviations below the mean, or ● Scores below the 2nd percentile, or ● Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, or ● At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, or ● Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. <p>Child typically has more than five sounds in error with a combination of error types. Inconsistent errors and lack of stimulability is evident. Conversational speech is generally unintelligible.</p>

Articulation Treatment Goals Based on Age of Acquisition	
Age of Acquisition	Treatment Goal(s)
Before Age 2	Vowel sounds
After Age 2, 0 months	/m/, /n/, /h/, /w/, /p/, /b/
After Age 3, 0 months	/f/, /k/, /g/, /t/, /d/
After Age 4, 0 months	/n/, /j/
After Age 5, 0 months	voiced th, sh, ch, /l/, /v/, j
After Age 6, 0 months	/s/, /r/, /z/, /s/ blends, /r/ blends, vowelized /r/, voiceless th, /l/ blends
<p>In using these guidelines for determining eligibility, total number of errors and intelligibility should be considered. A 90% criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5% - 10% of performances on a standardized instrument to be outside the normal range.</p>	

Phonology Treatment Goals Based on Age of Acquisition	
Age of Acquisition	Treatment Goal(s)
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
<p>When children develop idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and should be addressed in therapy.</p> <p>Minor processes, or secondary patterns such as glottal replacement, apicalization and palatalization typically occur in conjunction with other major processes. These minor processes frequently correct on their own as those major processes are being targeted.</p>	
After age 4 years, 0 months	Deaffrication, vowelization/vocalization, cluster reduction, gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: When the percentage of stuttered words fall in a lower severity rating and duration and/or presence of physical characteristics falls in a higher severity rating, the service delivery may be raised to the higher level.	

Differential Diagnosis for Stuttering
<p>Characteristics of normally dysfluent children:</p> <ul style="list-style-type: none"> ● Nine dysfluencies or less per every 100 words spoken. ● Majority types of dysfluencies include: whole-word, phrase repetitions, interjections, and revisions. ● No more than two unit repetitions per part-word repetition (e.g., b-b-ball, but not b-b-b ball.). ● Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet). ● Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.
<p>The following information may be helpful in monitoring children for fluency disorders. This information indicates dysfluencies that are considered typical in children, crossover behaviors that may be early indicators of true stuttering and what characteristics are typical of true stutterers.</p> <p>More Usual (Typical Dysfluencies)</p> <ul style="list-style-type: none"> ● Silent pauses; interjections of sounds, syllables or words; revisions of phrases or sentences; monosyllabic word repetitions or syllable repetitions with relatively even rhythm and stress; three or less repetitions per instance; phrase repetitions. <p>Crossover Behaviors</p> <ul style="list-style-type: none"> ● Monosyllabic word repetitions or syllable repetitions with relatively even stress and rhythm but four or more repetitions per instance, monosyllabic word repetitions or syllable repetitions with relatively uneven rhythm and stress with two or more repetitions per instance. <p>More Unusual (Atypical Dysfluencies)</p> <ul style="list-style-type: none"> ● Syllable repetitions ending in prolongations; sound, syllable or word prolongations; or prolongations ending in fixed postures of speech mechanism, increased tension noted in the act.

- a. **Augmentative and Alternative Communication (AAC)** standards for treatment from ASHA *Augmentative Communication Strategies*, volume II, 1988:

Note:

- a. These criteria define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment.
- b. These criteria are not intended to override or replace existing limits on coverage for services, either as dollar amounts or as acceptable billing codes.

“The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each persons preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual’s initiative, independence, and sense of personal responsibility and self-worth.”

AAC treatment programs are developed in accordance with Preferred Practices approved by ASHA. These services include:

- a. Counseling
- b. Product Dispensing
- c. Product Repair/Modification
- d. AAC System and/or Device Treatment/Orientation
- e. Prosthetic/Adaptive Device Treatment/Orientation
- f. Speech/Language Instruction

AAC treatment codes are used for the following:

- a. Therapeutic intervention for device programming and development
- b. Intervention with family members/caregivers/support workers, and recipient for functional use of the device
- c. Therapeutic intervention with the recipient in discourse with communication partner using his/her device

The above areas of treatment need to be performed by a licensed Speech-Language Pathologist with education and experience in augmentative communication to provide therapeutic intervention to help recipients communicate effectively using their device in all areas pertinent to the recipient. Treatment will be authorized when the results of an authorized AAC assessment recommend either a low-tech or a high-tech system.

Possible reasons for additional treatment include:

- a. Update of device
- b. Replacement of current device
- c. Significant revisions to the device and/or vocabulary
- d. Medical changes

3.2.4 **Audiology Therapy (Aural Rehabilitation) Practice Guidelines**

The basis for audiology referral is the presence of any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation assessment or presence of impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.

Examples of deficits for initiating therapy may include, **but are not limited to**, the following:

- a. Hearing loss (any type) >25 dBHL at 2 or more frequencies in either ear
- b. Standard Score more than 1 SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing
- c. Impaired or compromised auditory processing abilities as documented on the basis of the results of a central auditory test battery
- d. Less than 1-year gain in skills (auditory, language, speech, processing) during a 12-month period of time

Underlying Referral Premise

Aural rehabilitation will:

- a. facilitate receptive and expressive communication of recipients with hearing loss, and/or
- b. achieve improved, augmented or compensated communication processes, and/or
- c. improve auditory processing, listening, spoken language processing, overall communication process, and/or
- d. benefit learning and daily activities.

Evaluation—Audiologic (Aural) Rehabilitation

Service delivery requires the following elements:

Note: Functioning of hearing aids, assistive listening systems/devices, and sensory aids must be checked prior to the assessment.

Through interview, observation, and clinical testing, evaluate (in both clinical and natural environments):

- a. Recipient history
- b. Reception, comprehension, and production of language in oral, signed or written modalities
- c. Speech and voice production
- d. Perception of speech and non-speech stimuli in multiple modalities
- e. Listening skills
- f. Speechreading
- g. Communication strategies

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for recipient.

Evaluation—Central Auditory Processing Disorders (CAPD)

Note: CAPD assessment is to be interdisciplinary (involving audiologist, speech/language pathologist, and neuropsychologist) and is to include tests to evaluate the overall communication behavior, including spoken language processing and production, and educational achievement of individuals.

Through interview, observation, and clinical testing, evaluate:

- a. Communication, medical, educational history.
- b. Central auditory behavioral tests. Types of central auditory behavioral tests include:
 1. Tests of temporal processes
 2. Tests of dichotic listening
 3. Low redundancy monaural speech tests
 4. Tests of binaural interaction
- c. Central auditory electrophysiologic tests include:
 1. Auditory brainstem response (ABR)
 2. Middle latency evoked response (MLR)
 3. N1 and P2 (late potentials) responses and P300
 4. Mismatched negativity (MMN)
 5. Middle ear reflex
 6. Crossed suppression of otoacoustic emissions

Interpretations are derived from multiple tests based on age-appropriate norms. Evaluation may involve a series of tests given over a period of time at one or more clinic appointments. Procedures in a CAPD battery should be viewed as separate entities for purposes of service provision and reimbursement.

Include the ICD-9-CM diagnosis code. Determine specific functional limitation(s) (must be measurable) for recipient.

Examples of Functional Deficits

Examples of functional deficits may include, **but are not limited to**, the following:

- a. Inability to hear normal conversational speech
- b. Inability to hear conversation via the telephone
- c. Inability to identify, by hearing, environmental sounds necessary for safety (i.e., siren, car horn, doorbell, baby crying, etc.)
- d. Inability to understand conversational speech (in person or via telephone)
- e. Inability to hear and/or understand teacher in classroom setting
- f. Inability to hear and/or understand classmates during class discussion
- g. Inability to hear/understand co-workers/supervisors during meetings at work
- h. Inability to read on grade level (as result of auditory processing difficulty)
- i. Inability to localize sound

Treatment Planning

The treatment plan is developed in conjunction with recipient/caregiver and medical provider and considers performance in both clinical and natural

environments. Treatment should be culturally appropriate. Short- and long-term functional communication goals and specific objectives are determined from assessment. The amount of time, place(s), and professional or lay person(s) involved must be designated. Generalization of skills and strategies is enhanced by extending practice to the natural environment through collaboration among key professionals. Goals and objectives are reviewed periodically to determine appropriateness and relevance.

- a. Short-term Goals: Improve the overall communication process as defined in functional limitations.
- b. Long-term Goals: Decrease or eliminate functional deficit.

Note: Rate of improvement varies by recipient, depending on the severity level, compliance with therapy, and the context in which the client lives and performs activities of daily living.

Discharge/Follow-up

Discharge

The therapy will be discontinued when one of the following criteria is met:

- a. Recipient has achieved functional goals and outcomes.
- b. Recipient's performance is within normal limits for chronological age on standardized measures of language, speech, audition, and/or auditory processing (as applicable to the recipient).
- c. Recipient/parent is non-compliant with treatment plan.

At discharge, audiologist will identify indicators for potential follow-up care.

Follow-Up

Readmittance to audiologic (aural) rehabilitation may result from changes in functional status, living situation, school or child care, caregiver, or personal interests.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates that of another provider; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Outpatient specialized therapies are not covered when the policy guidelines are not met. Prior approval is required before the start of any treatment services.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is required at the start of all treatment services.

5.2 Prior Approval Requirements

The provider(s) shall submit to DMA's designee the following:

- a. the prior approval request; and
- b. all health care records and any other records that support the NCHC recipient has met the criteria in **Section 3.0** of this policy

5.3 Treatment Services

The process for providing treatment, regardless of place of service, consists of the following steps and requirements:

- a. Prior approval is required at start of treatment services.
- b. All services must be provided according to a written plan.
- c. The written plan for services must include defined goals for each therapeutic discipline.
- d. Each plan must include a specific content, frequency, and length of visits of services for each therapeutic discipline.
- e. A verbal or a written order must be obtained for services* prior to the start of the services. Backdating is not allowed.
*(*Services are all therapeutic PT/OT/ST/RT activities **beyond** the entry evaluations. This includes recommendations for specific programs, providers, methods, settings, frequency, and length of visits.)*
- f. Service providers must review and renew or revise plans and goals no less often than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than 6 months after the most recent physician order signature date and before the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.
- g. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet.

Detailed information and instructions for registering and submitting requests is available on the Carolinas Center of Medical Excellence (CCME) website <http://www.medicaidprograms.org/nc/therapyservices>.

Submit a request to NCHC vendor to start the approval process. Please note that approval, if granted, is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service

After 52 visits per recipient, per discipline, in a 6-month period approval is required for continued treatment.

Note: Home Health: Physician referral, orders, plan of care, and documentation must adhere to Medicare and NCHC guidelines as outlined in NCHC *Home Health Services*

Policy (not yet finalized). The service must also be in accordance with all other Home Health program guidelines, including the appropriateness of providing service in the home. NCHC policies can be found at <http://www.ncdhhs.gov/dma/hcmp/>.

5.4 Medical Necessity Visit Guidelines for All Recipients

5.4.1 Physical and Occupational Therapy

- a. The maximum of the usual range of visits for a condition as published in the most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns* or *Occupational Therapy Practice Guidelines Series*, **or**
- b. the number of medically necessary visits not to exceed a time limit of 6 months.

5.4.2 Speech/Language-Audiology Therapy

- a. for a recipient with:
 1. Mild Impairment range of visits: 6–26
 2. Moderate Impairment range of visits: Up to 46
 3. Severe Impairment range of visits: Up to 52,**or**
- b. the number of visits not to exceed a time limit of 6 months
- c. Audiology: 30- to 60-minute sessions, 1 to 3 times a week, in increments of 6 months. Length of visit and duration are determined by the recipient's level of severity and rate of change.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **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.

Eligible providers are defined by the following program types: independent practitioners, home health agencies, children's developmental service agencies, health departments, federally qualified health centers, rural health clinics, hospital outpatient services, and physician offices who employ qualified physical therapists, occupational therapists, speech pathologists, or audiologists are eligible to bill for these services. Physical therapists, occupational therapists, speech–language pathologists, and audiologists must meet the qualifications according to 42 CFR 440.110. The provider agency is to verify that their staff are licensed by the appropriate body and that the license is current, active, and unrestricted to practice.

7.0 Additional Requirements

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Documenting Services

Each provider must maintain and allow DMA to access the following documentation for each individual:

- a. The recipient name and NCHC identification number.
- b. A copy of the treatment plan.
- c. A copy of the MD, DO, DPM, CNM, PA, or NP's order for treatment services. Home Health services may only be ordered by an MD or DO.
- d. Description of services (intervention and outcome/client response) performed and dates of service.
- e. The duration of service (length of assessment and/or treatment session must be **in minutes**).
- f. The signature and credentials of the person providing each service.
- g. A copy of each test performed or a summary listing all test results, and the written evaluation report.
- h. Any other documentation relating to the financial, medical, or other records necessary to fully disclose the nature and extent of services billed to NCHC.

7.3 Post-Payment Validation Reviews

DMA or agents acting on behalf of NCHC will perform reviews for monitoring utilization, quality, and appropriateness of all services rendered. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the specialized therapy provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment. Case reviews may also show the need for an educational notification to the provider.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
12/5/11	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 10A under Session Law 2011-145 § 10.41.(b)

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

Note: Separate CMS-1500 claim forms/837P transactions must be filed for assessment/evaluation and treatment services, and for each type of service provided. Because individual and group speech therapy are considered the same type of service, they can be listed on the same claim form.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity. Providers who bill on the CMS-1500 claim form must include one of the discipline-specific ICD-9-CM diagnosis codes listed below as a secondary diagnosis on the claim.

V57.1	Physical Therapy
V57.21	Occupational Therapy
V57.3	Speech Therapy/Audiology

This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. Remember: The primary treatment ICD-9-CM diagnosis code must be entered first on the claim form. The discipline-specific V code should follow the primary treatment code.

C. Procedure Codes

Providers shall use program-specific codes.

D. Modifiers

Providers are required to follow applicable program-specific modifier guidelines.

E. Billing Units

Follow applicable guidelines.

F. Place of Service

Any outpatient setting allowed by the provider's type and specialty

G. Co-Payments

Co-Payment(s) may apply to covered prescription drugs and services.

H. Unit Limitations

Follow program-specific guidelines, if applicable.

I. Reimbursement

Providers shall bill their usual and customary charges.