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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, respiratory, 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**

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

**Note:** Refer to **Section 5.0** for specific eligibility limitations.

Medicaid-eligible 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 (ex., as in home health, federal regulations allow only a licensed physician to order a service).

**Note:** Medicare recipients are exempt from prior approval and visit limits in this policy.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

#### **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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient'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**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

**Basic Medicaid Billing Guide:** <http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

### 3.0 When the Procedure, Product, or Service Is Covered

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

#### 3.1 General Criteria

Medicaid 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 statewide; 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

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.

Medically necessary outpatient specialized therapies are covered for recipients under 21 when provided by any allowable outpatient provider and over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and area mental health centers.

Prior approval is required for all treatment services. For LEAs  
The prior approval process is deemed met by the IEP process.

### 3.2.1 Physical Therapy

Medicaid 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

Medicaid 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

Medicaid 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. The following criteria are for recipients under the age of 21 years.

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

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

<b>Language Impairment Classifications</b> <b>School Age – Kindergarten-Eligible to Age 21</b>	
Mild	<ul style="list-style-type: none"> <li>● Standard scores 1 to 1.5 standard deviations below the mean, <b>or</b></li> <li>● Scores in the 7<sup>th</sup> – 15<sup>th</sup> percentile, <b>or</b></li> <li>● A language quotient or standard score of 78 –85, <b>or</b></li> <li>● 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, <b>or</b></li> <li>● 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.</li> </ul>
Moderate	<ul style="list-style-type: none"> <li>● Standard scores 1.5 to 2 standard deviations below the mean, <b>or</b></li> <li>● Scores in the 2<sup>nd</sup> – 6<sup>th</sup> percentile, <b>or</b></li> <li>● A language quotient or standard score of 70 – 77, <b>or</b></li> <li>● 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, <b>or</b></li> <li>● 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.</li> </ul>
Severe	<ul style="list-style-type: none"> <li>● Standard scores more than 2 standard deviations below the mean, <b>or</b></li> <li>● Scores below the 2<sup>nd</sup> percentile, <b>or</b></li> <li>● A language quotient or standard score of 69 or lower, <b>or</b></li> <li>● If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, <b>or</b></li> <li>● 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.</li> </ul>

<b>Articulation/Phonology Impairment Classifications</b> <b>All Ages</b>	
Mild	<ul style="list-style-type: none"> <li>● Standard scores 1 to 1.5 standard deviations below the mean, <b>or</b></li> <li>● Scores in the 7<sup>th</sup> – 15<sup>th</sup> percentile, <b>or</b></li> <li>● One phonological process that is not developmentally appropriate, with a 20% occurrence, <b>or</b></li> <li>● Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc.</li> </ul> <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"> <li>● Standard scores 1.5 to 2 standard deviations below the mean, <b>or</b></li> <li>● Scores in the 2<sup>nd</sup> – 6<sup>th</sup> percentile, <b>or</b></li> <li>● Two or more phonological processes that are not developmentally appropriate, with a 20% occurrence, <b>or</b></li> <li>● At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, <b>or</b></li> <li>● Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc.</li> </ul> <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"> <li>● Standard scores more than 2 standard deviations below the mean, <b>or</b></li> <li>● Scores below the 2<sup>nd</sup> percentile, <b>or</b></li> <li>● Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, <b>or</b></li> <li>● At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, <b>or</b></li> <li>● Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc.</li> </ul> <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>

<b>Articulation Treatment Goals Based on Age of Acquisition</b>	
<b>Age of Acquisition</b>	<b>Treatment Goal(s)</b>
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>	

<b>Phonology Treatment Goals Based on Age of Acquisition of Adult Phonological Rules</b>	
<b>Age of Acquisition</b>	<b>Treatment Goal(s)</b>
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

<b>Eligibility Guidelines for Stuttering</b>	
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.
<b>Note:</b> 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.	

<b>Differential Diagnosis for Stuttering</b>
<p>Characteristics of normally dysfluent children:</p> <ul style="list-style-type: none"> <li>● Nine dysfluencies or less per every 100 words spoken.</li> <li>● Majority types of dysfluencies include: whole-word, phrase repetitions, interjections, and revisions.</li> <li>● No more than two unit repetitions per part-word repetition (e.g., b-b-ball, but not b-b-b ball.).</li> <li>● Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet).</li> <li>● Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.</li> </ul>
<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"> <li>● 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.</li> </ul> <p>Crossover Behaviors</p> <ul style="list-style-type: none"> <li>● 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.</li> </ul> <p>More Unusual (Atypical Dysfluencies)</p> <ul style="list-style-type: none"> <li>● 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.</li> </ul>

- d. **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 person’s 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 individual for functional use of the device
- c. Therapeutic intervention with the individual 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 individuals communicate effectively using their device in all areas pertinent to the individual. 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. Client 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 client.

### **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 client.

### **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 client/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 client, 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 client).
- 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.

### **3.2.5 Respiratory Therapy**

Refer to Clinical Coverage Policy No.: 10-D

#### **Asthma Guidelines**

Medical necessity is determined by a diagnosis and treatment of asthma that is consistent with the most current National Institutes of Health (NIH) Guidelines for the Diagnosis and Management of Asthma at:

<http://www.nhlbi.nih.gov/guidelines/asthma/>.

Service delivery requires the following elements.

#### **Evaluation**

Evaluate in concert with the PCP/MD and as appropriate the following through interview, observation, and clinical testing:

- a. Recipient's history of episodic symptoms and how treated including allergic rhinitis
- b. Need for oral steroids more than once in a 6 month period
- c. Missed school, caregivers missed work or interruption in routine
- d. Family history of asthma or allergies

- e. History of eczema, nasal allergies, food allergies
- f. Physical assessment [heart rate (HR), respiratory rate (RR), bilateral breath sounds (BBS)], skin color and tone, accessory muscle use
- g. SA 02 Oximetry
- h. Peak expiratory flow (PEF) measurement
- i. Medication regimen and history if available
- j. Medication/treatment compliance
- k. Inhaler technique
- l. Perception of symptoms
- m. Lifestyle (such as days missed from school or day care) and limitations to normal activities
- n. Recipient-provider communication and recipient satisfaction
- o. Environmental Factors (e.g., exposure to tobacco smoke)
- p. Exposure to Animals
- q. Home Heating Systems (e.g., exposure to wood burning stoves, fireplaces, kerosene heaters)
- r. Other triggers i.e. allergic rhinitis, viral infections
- s. Colds, exercise, change in temperature, change in seasons,
- t. Strong emotional response
- u. Menstrual cycle
- v. Idling cars or bus

Evaluation outcomes should include both ICD-9-CM code(s) and specific functional limitation(s), which must be measurable and quantified. Criteria can be found in the NIH Guidelines.

### **Care Plan**

Characteristics of the care plan must have a focus of educating the recipient and caregiver along with an anticipated discharge date. The characteristics of the care plan include:

- a. The development of the care plan with the recipient, family, and PCP/MD to determine severity level and pharmacological treatment along with the discharge date.
- b. The short-term goals: for example, “improve respiratory status as defined in functional limitations.” Educate recipient and caregiver. Amelioration of symptoms. No authorization is given without PCP/MD participation.
- c. All care plans must be reviewed and signed off by the recipient’s PCP/MD.

### **Discharge**

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

- a. Recipient/ is able to follow prescribed therapy program independently or with assistance
- b. A physician orders discharge
- c. Recipient reaches age 21

**Follow-up**

At discharge, the respiratory therapist should identify indicators for potential follow-up care, such as changes in functional status, living situation, childcare, or caregiver and shared with the recipient’s PCP/MD. Any case reopened after a period of 12 consecutive months requires assessment of condition by PCP/MD

**3.2.6 Chronic Respiratory Condition Guidelines**

The following guidelines are for chronic respiratory conditions other than asthma (such as recipients who are ventilator dependent or have a tracheostomy).

Level and Action	Characteristics
Level I—Assessment	<ul style="list-style-type: none"> <li>● Occasional day and/or night symptoms</li> <li>● Ability to clear secretions</li> <li>● Clear breath sounds</li> <li>● Mildly limited physical activity</li> </ul>
Level II—Assessment and Treatment	<ul style="list-style-type: none"> <li>● Daily and nightly symptoms</li> <li>● Ability to clear secretions</li> <li>● Clear breath sounds</li> <li>● Limited physical activity</li> </ul>
Level III—Assessment and Treatment	<ul style="list-style-type: none"> <li>● Daily and nightly symptoms</li> <li>● On-going use of inhaled short-acting beta<sub>2</sub>-agonist</li> <li>● Exacerbations affect activity</li> <li>● Exacerbations &gt;2 times a week; may last days</li> <li>● Limited physical activity or bedridden</li> </ul>
Level IV—Assessment and Treatment	<ul style="list-style-type: none"> <li>● Continual symptoms</li> <li>● Daily and nightly symptoms</li> <li>● Limited physical activity/bedridden/house-confined</li> <li>● Frequent exacerbations</li> <li>● Limited physical activity or bedridden</li> </ul>

Service delivery requires the following elements.

**Evaluation**

Evaluate the following through the review of history, interview, observation, and clinical testing:

- a. Recipient’s history
- b. Physical assessment (HR, RR, BBS)
- c. Pulmonary assessment
- d. Oximetry
- e. Pulmonary function test (PFT) (if applicable)

- f. ABG (if applicable)
- g. Radiological findings

Evaluation outcomes should include both ICD-9-CM code(s) and specific functional limitation(s), which must be measurable and quantified. Examples include the following:

- a. Inability to remove secretions by means of spontaneous cough/suctioning technique
- b. PFTs below acceptable levels for 2 weeks
- c. Inability to clean and maintain tracheostomy
- d. Inability to maintain oxygen (O<sub>2</sub>) saturation at 94% or better
- e. Inability to exert without shortness of breath
- f. Inability to perform pursed-lip and diaphragmatic breathing
- g. Inability to wean from mechanical life support

### Care Plan

Characteristics of the care plan include the following:

- a. Development with the recipient, family, and medical provider (PCP/MD) or Respiratory Physician Specialist to determine treatment goals and outcomes
- b. Education and training of caregivers and other professional staff
- c. Short-term goals: for example, “improve respiratory status as defined in functional limitations”
- d. Long-term goals: for example, “decrease or eliminate functional deficit”

All care plans must be reviewed and signed off by the recipient’s PCP/MD.

### Discharge

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

- a. Recipient has achieved functional goals and outcomes
- b. Recipient or family is able to follow prescribed therapy program independently or with assistance
- c. A physician orders discharge
- d. Recipient reaches age 21

At discharge, the respiratory therapist should identify indicators for potential follow-up care, such as changes in functional status, living situation, school or childcare, or caregiver and share with the recipient’s medical provider (PCP/MD or Respiratory Physician Specialist)

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

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

#### 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

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

#### 5.1 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.

LEAs may review, renew and revise the IEP annually, including obtaining a dated physician order and signature, provided that the IEP requirement of parent notification occurs at regular intervals throughout the year, and such notification details how progress is sufficient to enable the child to achieve the IEP goals by the end of the year.

- 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. Electronic signatures and printed dates are acceptable. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper/unauthorized use, and reconstruction of records in the event of a system breakdown. Stamped signatures are not permitted.

## 5.2 Recipients under the Age of 21 Years

Prior approval is required at the start of all treatment services. For LEAs the prior approval process is deemed met by the IEP process

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 DMA 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.

## 5.3 Visit Limitations for Adults

Prior approval is required at the start of treatment services.

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 DMA 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

Outpatient specialized therapies are covered for recipients over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and area mental health centers.

A recipient 21 years of age or older may have up to 3 combined treatment visits and 1 evaluation visit of all therapies combined (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit

A recipient 21 years of age or older who has had an amputation, joint replacement or post-op hip fracture and is within 3 months post surgery or discharge from inpatient services may have 1 Physical therapy evaluation and/or 1 Occupational therapy evaluation visit and up to 10 therapy treatment combined visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit. A different amputation, joint replacement or hip fracture would trigger a new 10 visit limit segment and 2 evaluations.

A recipient 21 years of age or older who has had a stroke, traumatic brain injury or spinal cord injury and is within 6 months post discharge from inpatient services may have 1 Physical therapy evaluation and/or 1 Occupational therapy evaluation and/or 1 Speech therapy evaluation and up to 30 therapy treatment combined visits (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit. If a recipient receiving these services experiences a documented occurrence of a new stroke, a new cycle of 30 visits may start. A new stroke, TBI or spinal cord injury would trigger a new 30 visit segment and 3 evaluations.

All limits are hard limits.

Therapy services solely for maintenance are not covered.

**Note:** Home Health: Physician referral, orders, plan of care, and documentation must adhere to Medicare and Medicaid guidelines as outlined in Clinical Coverage Policy 3A, *Home Health Services*. The service must also be in accordance with all other Home Health program guidelines, including the appropriateness of providing service in the home. The policy can be found on DMA's Web site, <http://www.ncdhhs.gov/dma/mp/>.

## 5.4 Medical Necessity Visit Guidelines for under 21

### 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 client's level of severity and rate of change.

### 5.4.3 Respiratory Therapy

Functional performance measures and potential for change determine whether the intervention is needed and the frequency with which it will be provided. Length of visit and duration are determined by the client's level of severity and rate of change.

Asthma Guidelines: Refer to Clinical Policy 10D, *Independent Practitioners Respiratory Therapy Services*, on DMA's Website at <http://www.ncdhhs.gov/dma/mp/>.

Chronic Respiratory Guidelines:

Level I

Average Time: 60 minutes face-to-face with client

Maximum Units: 0

Level II

Average Time: 60 minutes face-to-face with client

Average Days: 2 days per week

Average Procedures: 3 procedures

Maximum Units: 156

Level III

Average Time: 60 minutes face-to-face with client

Average Days: 3 days per week

Average Procedures: 4 procedures

Maximum Units: 312

Level IV

Average Time: 60 – 90 minutes face-to-face with client

Average Days: 5 days per week

Average Procedures: 6 procedures

Maximum Units: 780

**Note:** Medicare recipients are exempt from Prior approval and visit limits in this policy.

## 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 Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; 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.

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for procedures, products, and services related to this policy when the procedures, products, or services are within the scope of their practice.

Eligible providers are defined by the following program types. Medicaid-enrolled local education agencies, 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, respiratory 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. **Only** therapy assistants may work under the direction of the licensed therapist. Speech language pathologists in their clinical fellowship year may work under the supervision of the licensed therapist. The Supervising Therapist is the biller of the service. Respiratory therapists must follow 42 CFR 440.185. The provider agency is to verify that their staff is licensed by the appropriate body and that the license is current, active, and unrestricted to practice.

## 7.0 Additional Requirements

**IMPORTANT NOTE:** EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient'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 DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED.** For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.2** of this policy.

### 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: The recipient name and Medicaid identification number.

- a. A copy of the treatment plan (IEP accepted for LEAs).
- b. 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.
- c. Description of services (intervention and outcome/client response) performed and dates of service. This element must be present in a note for each billed date of service.
- d. The duration of service (i.e., length of assessment and/or treatment session **in minutes**). This element must be present in a note for each billed date of service.

- e. The signature and credentials of the person providing each service. Each billed date of service must be individually documented and signed by the person providing the service.
- f. A copy of each test performed or a summary listing all test results, and the written evaluation report.
- g. Any other documentation relating to the financial, medical, or other records necessary to fully disclose the nature and extent of services billed to Medicaid.

### 7.3 Post-Payment Validation Reviews

Medicaid or agents acting on behalf of Medicaid 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, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider.

While services provided by LEAs are excluded from prior authorization, they will be subject to post-payment review.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** October 1, 2002

**Revision Information:**

Date	Section Revised	Change
02/26/03	5.2, Treatment Services, item #4 7.0, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/03	5.2, Treatment Services, item #3 5.2, Treatment Services, item #4	The phrase "intensity of services" revised to "length of visits."
04/01/03	5.3, Prior Approval	Prior approval criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/03	3.0, When the Service Is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform to billing guidelines; effective with date of publication 10/01/02.
06/01/03	8.0, Billing Guidelines	Addition of V code diagnosis for treatment services.
07/01/03	3.4, Respiratory Therapy	Medical necessity criteria added for respiratory therapy.
07/01/03	5.3, Prior Approval Process	Respiratory therapy guidelines were added.

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
07/01/03	8.0, Billing Guidelines	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/03	Section 3.1.1, Home Health Maintenance Physical Therapy	<u>Criteria were</u> added for Home Health Maintenance Physical Therapy.
10/01/03	Section 3.2, Occupational Therapy	A statement was added to indicate that Home Health Maintenance Occupational Therapy was not covered.
10/01/03	Section 3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/03	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/03	Section 5.3.1, item c, Physical and Occupational Therapy	Item c was added to address prior approval for physical therapy maintenance.
10/01/03	Section 5.3.2, item c, Speech/Language-Audiology Therapy	Item c was added to address prior approval for audiology.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
7/01/04	Section 5.2, Treatment Services	Added requirement for LEAs for annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 5.2 and 7.2	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
12/1/06	Section 2.2	The special provision related to EPSDT was revised.
12/1/06	Section 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
3/1/07	Section 3.0	A reference was added to indicate that medical necessity is defined by the policy guidelines recommended by the authoritative bodies for each discipline.

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
3/1/07	Section 3.3	A reference to ASHA guidelines regarding bilingual services was added as a source of medical necessity criteria for Speech/Language-Audiology therapy treatment for Spanish speaking recipients
3/1/07	Section 5.2	Item 6.c. was updated to indicate that a request submitted for continuation of service must include documentation of the recipient's progress. Item 7 was corrected to comply with federal regulations. The note at the end of the section was deleted from the policy.
3/1/07	Section 5.3	This section was updated to indicate that prior approval is required after six unmanaged visits or the end of the six-month period. A reference was also added to indicate the prior approval requests may be submitted electronically.
3/1/07	Section 6.0	A reference to 42 CFR 440.110 and 440.185 was added to this section.
3/1/07	Section 7.1	Item 3 Physicians order clarified
3/1/07	Section 8.0	A reminder was added to this section to clarify that prior approval must be requested using the billing provider number and that services initiated through a CDSA are exempt from the prior approval requirement for six months and must, therefore, enter the date of the physician's order on the claim form.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
5/1/07	Section 8	Added UB-04 as an accepted claims form.
12/01/09	Section 2.1	Moved first paragraph ("recipients with a need for specialized therapy services") to follow standard statement.
12/01/09	Section 2.2	Added legal citation for EPSDT.
12/01/09	Sections 3.0, 4.0, & 6.0	Updated section titles to standard phrasing.
12/01/09	Section 3.1	Added standard section.
12/01/09	Section 3.2	Added title to existing criteria; changed "services" to "outpatient specialized therapies"; deleted Note on home health maintenance.
12/01/09	Section 3.2.2 (was 3.1.1)	Deleted this section on home health maintenance physical therapy.
12/01/09	Sections 3.2.3 and 3.2.5	Deleted mentions of home health maintenance occupational and audiology therapy.

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
12/01/09	Section 3.2.4 (was 3.3), letter c	Changed the word “patients” to “recipients” and rephrased.
12/01/09	Section 3.2.5	In “Underlying Referral Premise,” letter a, changed “individuals” to “recipients.” In “Discharge/Follow-up,” changed “client” to “recipient”; spelled out “within normal limits.”
12/01/09	Section 3.2.6	Spelled out first appearance of IPP (Independent Practitioner Program); corrected age range.
12/01/09	Section 4.1	Added standard section.
12/01/09	Section 4.2	Added title to existing criteria; added the word “outpatient” before the phrase “specialized therapies”; deleted the word “following” from “policy guidelines.”
12/01/09	Section 5.1 (Place of Service)	Moved this statement to Attachment A, letter F.
12/01/09	New Section 5.1	Added statement that prior approval is required at start of treatment services. Deleted the word “initial” from the introductory statement. Deleted letters f and g (information about 6 unmanaged visits vs. 6 months of service; information about evaluation and prior approval by Children’s Developmental Services Agency).
12/01/09	Section 5.2	Changed section title to “Recipients under the Age of 21 Years”; deleted The Carolinas Center for Medical Excellence; changed criteria from 6 visits or 6 months to 52 visits in 6 months; deleted paragraph on Medicaid’s initial authorization; added instructions on requesting approval for additional visits.
12/01/09	Section 5.3	Added new section on visit limitations for adults.
12/01/09	Section 5.4	Added section title.
12/01/09	Section 5.4.1	Deleted information on home health maintenance physical therapy; added “medically necessary” before the word “visits”; deleted “requested by the therapist.”
12/01/09	Section 5.4.2	Deleted reference to 52 visits; deleted “requested by the therapist.”

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
12/01/09	Section 5.4.3	Deleted 52-visit cap in this location; deleted paragraph that LEAs meet requirement by IEP process; deleted note that prior approval is not required for recipients with a CDSA evaluation; changed "Medicare recipients are exempt from the prior approval process" to "Medicare recipients are exempt from this policy."
12/01/09	Section 6.0	Added standard paragraph about providers; updated and clarified language.
12/01/09	Section 7.1	Added standard statement about compliance and renumbered subsequent headings.
12/01/09	Section 7.2 (was 7.1)	Added DO and DPM as providers who may issue orders; changed "patient" to "recipient"; deleted requirement to keep copy of prior approval form.
12/01/09	Section 7.3 (was 7.2)	Changed title from "Utilization Reviews" to "Post-Payment Validation Reviews"; deleted "CCME," changed "may" to "will," and added the word "all"; added statement on post-payment reviews and follow-up; deleted examples of review topics.
12/01/09	Section 8.0	Moved to Attachment A, reorganized, and renamed "Claims-Related Information."
12/01/09	Section 9.0	Renumbered to Section 8.0.
1/1/12	Subsections 2.1 and 5.4.3	Changed "Medicare recipients are exempt from this policy." to "Medicare recipients are exempt from prior approval process and visit limits in this policy"
1/1/12	Subsection 5.1	Added clarification regarding acceptable orders.
1/1/12	Subsection 5.3	Change the number of visits and evaluations. Remove add'l visit allowance
1/1/12	Subsection 5.4	Change title from all recipients to Under 21
1/1/12	Section 6.0	Clarify who "can work under the direction/supervision of"
1/1/12	Subsection 7.2	Add credentials to requirement
1/1/12	Attachment A	Added diagnosis codes for evaluations

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including appropriate referrals for recipients enrolled in Medicaid managed care programs.

### 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.

Please refer to specific clinical coverage policies for each area. Policies are linked from DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

### 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.

V57.0	Respiratory Therapy
V57.1	Physical Therapy
V57.21	Occupational Therapy
V57.3	Speech Therapy

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.

In order for a recipient to have either 2 evaluations or 3 evaluations as outlined in Section 5.3 the following diagnosis codes must be billed. Remember there is a time element involved in qualifying for additional visits.

#### ICD 9 diagnosis

DIAGNOSIS LIST FOR 2 evaluations							
V43.60	V43.61	V43.62	V43.63	V43.64	V43.65	V43.66	V54.81
V49.6	V49.60	V49.61	V49.62	V49.63	V49.64	V49.65	V49.66
V49.67	V49.7	V49.70	V49.71	V49.72	V49.73	V49.74	V49.75
V49.76	V49.77	V54.13					

<b>DIAGNOSIS LIST FOR 3 evaluations</b>							
Category 800		Category 801		Category 803		Category 804	
Category 850		Category 851		Category 852			
Category 853		Category 854					
952.00	952.01	952.02	952.03	952.04	952.05	952.06	952.07
952.08	952.09	952.10	952.11	952.12	952.13	952.14	952.15
952.16	952.17	952.18	952.19	952.2	952.3	952.4	952.8
952.9	953.0	953.1	953.2	953.3	953.4	953.5	953.8
953.9							
430	431	433.01	433.11	433.21	433.31	433.81	433.91
434.01	434.11	434.91	435.0	435.1	435.2	435.3	435.8
435.9							

**C. Procedure Codes**

Providers must 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**

Follow program-specific guidelines, if applicable.

**H. Unit Limitations**

Follow program-specific guidelines, if applicable.

**I. Reimbursement**

Providers shall bill their usual and customary charges.