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1.0 Description of Service

The covered services are assessments and treatments performed by qualified Independent Practitioner (IP) service providers from the following disciplines:

1.1 Audiology Services

1.1.1 Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- a. auditory sensitivity (including pure tone air and bone conduction, speech detection, and speech reception thresholds)
- b. auditory discrimination in quiet and noise
- c. impedance audiometry (tympanometry and acoustic reflex testing)
- d. hearing aid evaluation (amplification selection and verification)
- e. central auditory function
- f. evoked otoacoustic emissions
- g. brainstem auditory evoked response (a.k.a.. ABR)

1.1.2 Treatment

Service may include one or more of the following, as appropriate:

- a. auditory training
- b. speech reading
- c. augmentative and alternative communication training (including sign language and cued speech training)

1.2 Speech/Language (ST) Services

1.2.1 Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for the following areas, and shall yield a written evaluation report.

- a. expressive language
- b. receptive language
- c. auditory processing, discrimination, and memory
- d. augmentative and alternative communication
- e. vocal quality
- f. resonance patterns
- g. articulation/phonological development
- h. pragmatic language

- i. rhythm/fluency
- j. oral mechanism/swallowing
- k. hearing status based on pass/fail criteria

Note: Any of the above named areas of functioning may also be addressed as a specialized assessment, following performance of the overall evaluation of the child's speech/language skills.

1.2.2 Treatment

Service may include one or more of the following, as appropriate:

- a. articulation/phonological training
- b. language therapy
- c. augmentative and alternative communication training
- d. auditory processing/discrimination training
- e. fluency training
- f. voice therapy
- g. oral motor training; swallowing therapy
- h. speech reading

1.3 Occupational Therapy (OT) Services

1.3.1 Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- a. activities of daily living assessment
- b. sensorimotor assessment
- c. neuromuscular assessment
- d. fine motor assessment
- e. feeding/oral motor assessment
- f. visual perceptual assessment
- g. perceptual motor development assessment
- h. musculo-skeletal assessment
- i. gross motor assessment
- j. functional mobility assessment

1.3.2 Treatment

Service may include one or more of the following, as appropriate:

- a. activities of daily living training
- b. neuromuscular development
- c. muscle strengthening, endurance training
- d. feeding/oral motor training
- e. adaptive equipment application
- f. visual perceptual training
- g. facilitation of gross motor skills

- h. facilitation of fine motor skills
- i. fabrication and application of splinting and orthotic devices
- j. manual therapy techniques
- k. sensorimotor training
- l. pre-vocational training
- m. functional mobility training
- n. perceptual motor training

1.4 Physical Therapy (PT) Services

1.4.1 Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- a. neuromotor assessment
- b. range of motion, joint integrity, functional mobility, and flexibility assessment
- c. gait, balance, and coordination assessment
- d. posture and body mechanics assessment
- e. soft tissue assessment
- f. pain assessment
- g. cranial nerve assessment
- h. clinical electromyographic assessment
- i. nerve conduction, latency and velocity assessment
- j. manual muscle test
- k. reflex integrity
- l. activities of daily living assessment
- m. cardiac assessment
- n. pulmonary assessment
- o. sensory motor assessment
- p. feeding/oral motor assessment

1.4.2 Treatment

Service may include one or more of the following, as appropriate:

- a. manual therapy techniques
- b. fabrication and application of orthotic device
- c. therapeutic exercise
- d. functional training
- e. facilitation of motor milestones
- f. sensory motor training
- g. cardiac training
- h. pulmonary enhancement
- i. adaptive equipment application

- j. feeding/oral motor training
- k. activities of daily living training
- l. gait training
- m. posture and body mechanics training
- n. muscle strengthening
- o. gross motor development
- p. modalities
- q. therapeutic procedures
- r. hydrotherapy
- s. manual manipulation
- t. wheelchair management

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.

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.

Note: There is a required referral process for a recipient who is enrolled through the Carolina ACCESS (CA) program.

Note: Medicare recipients are exempt from this policy.

2.2 Limitations

Recipients must be under the age of 21 years and must be Medicaid-eligible when the services are provided.

2.3 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/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSTProvider.htm>

3.0 When the 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, see **Section 2.0** 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.

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 for Birth to 21 Years.

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 <u>lower</u>, 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.

Language Impairment Classifications <i>Preschool – Age 3 Years to Kindergarten-Eligible</i>	
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 <i>School Age – Kindergarten-Eligible to Age 21</i>	
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 <i>All Ages</i>	
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 of Adult Phonological Rules	
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 stutters.</p> <p><u>More Usual (Typical Dysfluencies)</u> 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> <p><u>Crossover Behaviors</u> 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> <p><u>More Unusual (Atypical Dysfluencies)</u> 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.</p>

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

Note:

1. These criteria define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment.
2. 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.

Any time the individual's communication needs change for medical reasons, additional treatment sessions should be requested. In addition, if an individual's device no longer meets his/her communication needs, additional treatment sessions should be requested.

Possible reasons to request authorization 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 individuals 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
- d. 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.

Short-term Goals: Improve the overall communication process as defined in functional limitations.

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. Client has achieved functional goals and outcomes.
- b. Client's performance is WNL for chronological age on standardized measures of language, speech, audition, and/or auditory processing (as applicable to the client).
- c. Client/parent are 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 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, see **Section 2.0** of this policy.

4.1 General Criteria

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

- e. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- f. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- g. the procedure, product, or service unnecessarily duplicates that of another provider; or
- h. 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

Note: There is a required referral process for a recipient who is enrolled through the CA program.

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, see **Section 2.0** of this policy.

5.1 Patient's Location

A patient may receive IP therapy services in the office, home, school, through the Head Start program, and/or child care (i.e., regular and developmental day care) settings.

5.2 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.

5.3 Prior Approval

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.

Medicaid's initial authorization for duration of treatment cannot exceed the lowest of the following ranges with a cap of 52 visits during a 6-month time period.

5.3.1 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 visits requested by the therapist, not to exceed a time limit of 6 months

5.3.2 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 requested by the therapist, 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 (up to 52 visits). Length of visit and duration are determined by the client's level of severity and rate of change.

5.4 Amount of Service

The amount of service is determined by the prior approval process.

5.5 Other Limitations

5.5.1 Assessment Services

Each written evaluation report should contain a final summary listing the diagnosis/statement of the problem including the primary medical diagnosis, if known, and a secondary treatment-related diagnosis, as well as the recommendations for treatment. The diagnosis should include a statement concerning the degree of severity of each condition exhibited by the patient. The summary should also indicate whether the child has received any known assessments within the past six months for the type of service being billed.

For occupational therapy (OT) and physical therapy (PT) assessment must occur within **12 months** of the requested beginning date of treatment. When continued treatment is requested, an annual reassessment summary of the child's status and performance must be done.

For audiology services (AUD) and speech/language services (ST), a written report of an assessment must occur within **6 months** of the requested beginning date of treatment. When continued treatment is requested, an annual reassessment report must be done.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service.

5.5.2 Treatment Services

All treatment services shall be provided face to face on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible recipients) of four children per group.

Treatment services **do not include** consultation activities, specific objectives involving English as a second language, or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

6.0 Providers Eligible to Bill for the Service

It is the responsibility of the provider agency to verify in writing that staff meet the qualifications listed in 42 CFR 440.110 and 440.185. A copy of this verification (current licensure or registration) must be maintained by the provider agency. All providers must be enrolled with Medicaid. The provider of the service must be the biller of the service or be listed as the attending provider on the claim form if a group practice is billing.

6.1 Audiology

Eligible providers must have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiology.

6.2 Speech/Language

Eligible providers must have:

- a. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists,
- b. an ASHA Certificate of Clinical Competence (i.e., CCC) in Speech/Language Pathology, or there must be documentation that the service provider **has completed:**
 1. the requirements and work experience necessary for the Speech/Language Pathology CCC, or
 2. the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech/Language Pathology CCC.
- c. Treatment services may be performed by a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner.

6.3 Occupational Therapy

- a. Assessment services must be provided by a licensed occupational therapist.
- b. Treatment services must be provided by a licensed occupational therapist or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.
- c. In addition to the above, assessment and treatment of children with special health care needs and/or developmental disabilities must be provided or supervised by a licensed occupational therapist with an annual 20 percent pediatric caseload.

6.4 Physical Therapy

- a. Assessment services must be provided by a licensed physical therapist.
- b. Treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

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.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including but not limited to 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 Medicaid identification number.
- b. A copy of the treatment plan (IEP accepted for LEAs).
- 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. This element must be present in a note for each billed date of service.
- e. 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.
- f. 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
- 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 Medicaid.
- i. All services provided "under the direction of" must have supervision provided and documented according to the Practice Act of the licensed therapist.

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.

7.4 Requirements When the Type of Treatment Services Are the Same as Those Provided by the Child’s Public School or Early Intervention Program

If treatment services provided by the IP are the same type of health-related services the patient concurrently receives as part of the public school's special education program, a copy of the patient's current Individualized Education Plan (IEP) should also be obtained by the billing provider and maintained in the patient’s file. Likewise, if the patient is concurrently receiving the same type of treatment service as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program), a copy of the current IFSP should be obtained by the billing provider and maintained in the patient’s file. All services combined can not exceed medical necessity criteria. Services should not be provided on the same day.

Furthermore, a copy of the patient's current IEP or IFSP should be obtained by the billing provider when the IP is providing services, under a contractual agreement, for the special education or early intervention program.

Note: The requirement to obtain a copy of the patient's IEP or IFSP does not apply to treatment services that do not extend beyond a maximum of four weeks of treatment.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
01/01/03	8.2, Units of Service	Conversion to CPT codes
02/26/03	5.2, Treatment Services, item #4 7.1, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/03	3.0, When the Service is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
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	8.2, Units of Service	End-dated codes replaced with CPT codes.
05/01/03	6.5, Respiratory Therapists	Updated licensure requirements for respiratory therapist; effective with date of policy publication 10/01/02.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform with billing guidelines; effective with date of publication 10/01/02.
06/01/03	8.4, Filing a Claim	Addition of V code diagnosis for treatment services and clarification of billing instructions.

Date	Section Revised	Change
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.
07/01/03	8.4, Filing a Claim	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/03	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 5.3.2, 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.
1/1/05	Section 8.2, Physical Therapy Treatment	Code 97601 was end-dated
1/1/05	Section 8.2, Audiology Assessment	CPT code 92589 was end-dated and replaced with 92620 and 92621
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 5.2 and 5.3	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
1/1/06	Section 8.2	CPT procedure code 95210 was end-dated and replaced with 92626, 92627, 92630 and 92633; 97504 was end-dated and replaced with 97760; 97520 was end-dated and replaced with 97761; 97703 was end-dated and replaced with 97762.
6/1/06	Section 8.2	CPT procedure codes 92626 and 92627 were deleted from the list of codes for Speech/Language Treatment and added to the list of codes for Speech/Language Assessment and Audiology Assessment.

Date	Section Revised	Change
7/1/06	Section 8.2	CPT code 97020 was deleted from the list of covered codes for Physical Therapy Treatment.
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
1/1/07	Section 8.2	CPT code 94657 was end-dated and replaced with CPT code 99504.
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.
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.

Date	Section Revised	Change
1/1/08	Section 8.2	Added CPT code 96125 (1 unit = 1 hour) to Occupational Therapy Assessment and Speech/Language Assessment.
9/1/08	Section 1.3.1	Removed “pre-vocational assessment” from list of services provided by occupational therapists.
1/1/09	Section 8.2	Added CPT code 95992 to physical therapy treatment group (annual code update).
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 2.3	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 3.2.4 (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 3.2.5	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 5.2	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).

Date	Section Revised	Change
12/01/09	Section 5.3	Changed section title to Prior Approval 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 visits.
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 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	Attachment A (was section 8.0)	Information moved to Attachment A – Claims Related Information
01/01/10	Attachment A	CPT codes 92550 and 92570 added to Audiology Assessment billable codes
06/01/10	Throughout	Independent Practitioners Respiratory Therapy Services removed from this policy with the initial promulgation as separate policy of Policy 10D
01/01/12	Subsection 5.1	Added clarification regarding acceptable orders.
01/01/12	Section 6.0	Clarify who "can work under the direction/supervision of"
01/01/12	Subsection 7.2	Add credentials to requirement

Attachment A: Claims-Related Information

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

A. Claim Type

Separate CMS-1500/837P transaction claim forms must be filed for assessment and treatment services, and separate claim forms must be filed for each type of service provided. It should be noted that individual and group speech therapy, being the same type of service, can be listed on the same claim form.

Remember you must ask for prior approval under the same provider number that you bill under. Prior approval numbers can not be changed by CCME unless a new request is submitted.

Providers 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

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.**

Procedures should be billed using the most comprehensive CPT code to describe the service performed. The Correct Coding Initiative (CCI) was developed by the Centers for Medicare and Medicaid Services (CMS). It bundles the component procedures of the service into the comprehensive code. Only the comprehensive code is paid. If providers submit a claim using component codes in addition to comprehensive codes, the claim will deny. Providers receive an Explanation of Benefits (EOB) code indicating that the component code cannot be billed in addition to the comprehensive code. Additional information about CCI can be found online at <http://www.hcfa.gov/medlearn/ncci.htm>.

All claims should be sent directly to EDS. Refer to the *Basic Medicaid Billing Guide* for instructions

Note: Issuance of prior authorization does **not** preclude compliance with the Medicaid program's stipulation that all claims must be received by EDS within 365 days of the first date of service, in order to be accepted for processing and payment.

Refer to the *Basic Medicaid Billing Guide* for details regarding billing issues.

Refer to **Section 3.0, When the Service is Covered**, and **Section 5.2, Treatment Services**, for additional information.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

Providers 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

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 Code(s)

Audiology Assessment

Code	Unit of Service
92550	(1 unit = 1 event)
92551	(1 unit = 1 event)
92552	(1 unit = 1 event)
92553	(1 unit = 1 event)
92555	(1 unit = 1 event)
92556	(1 unit = 1 event)
92557	(1 unit = 1 event)
92567	(1 unit = 1 event)
92568	(1 unit = 1 event)
92569	(1 unit = 1 event)
92570	(1 unit = 1 test)
92571	(1 unit = 1 event)
92572	(1 unit = 1 event)
92576	(1 unit = 1 event)
92579	(1 unit = 1 event)
92582	(1 unit = 1 event)
92583	(1 unit = 1 event)
92585	(1 unit = 1 event)
92587	(1 unit = 1 event)
92588	(1 unit = 1 event)

(more)

92590	(1 unit = 1 event)
92591	(1 unit = 1 event)
92592	(1 unit = 1 event)
92593	(1 unit = 1 event)
92594	(1 unit = 1 event)
92595	(1 unit = 1 event)
92620	(1 unit = 60 min)
92621	(1 unit = each additional 15 min) must be billed with 92620
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626

Audiology Treatment

Code	Unit of Service
92507	(1 unit = 1 event)

Speech/Language Assessment

Code	Unit of Service
92506	(1 unit = 1 event)
92551	(1 unit = 1 event)
92607	(1 unit = 1 event)
92608	(1 unit = 1 event)
92610	(1 unit = 1 event)
92612	(1 unit = 1 event)
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626
96125	(1 unit = 1 hour)

Speech/Language Treatment

Code	Unit of Service
92507	(1 unit = 1 event)
92508	(1 unit = 1 event)
92526	(1 unit = 1 event)
92609	(1 unit = 1 event)
92630	(1 unit = 1 visit)
92633	(1 unit = 1 visit)

Occupational Therapy Assessment

Code	Unit of Service
92610	(1 unit = 1 event)
95831	(1 unit = 1 event)
95832	(1 unit = 1 event)
95833	(1 unit = 1 event)
95834	(1 unit = 1 event)
96125	(1 unit = 1 hour)
97003	(1 unit = 1 event)
97004	(1 unit = 1 event)
97750	(1 unit = 15 minutes)
97762	(1 unit = 15 minutes)

Occupational Therapy Treatment

Code	Unit of Service
29075	(1 unit = 1 event)
29085	(1 unit = 1 event)
29105	(1 unit = 1 event)
29125	(1 unit = 1 event)
29126	(1 unit = 1 event)
29130	(1 unit = 1 event)
29131	(1 unit = 1 event)
29240	(1 unit = 1 event)
29260	(1 unit = 1 event)
29280	(1 unit = 1 event)
29530	(1 unit = 1 event)
29540	(1 unit = 1 event)
92065	(1 unit = 1 event)
92526	(1 unit = 1 event)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

Physical Therapy Assessment

Code	Unit of Service
92610	(1 unit = 1 event)
95831	(1 unit = 1 event)
95832	(1 unit = 1 event)
95833	(1 unit = 1 event)
95834	(1 unit = 1 event)
97001	(1 unit = 1 event)
97002	(1 unit = 1 event)
97750	(1 unit = 15 minutes)
97762	(1 unit = 15 minutes)

Physical Therapy Treatment

Physical Therapy

Code	Unit of Service
29075	(1 unit = 1 event)
29085	(1 unit = 1 event)
29105	(1 unit = 1 event)
29125	(1 unit = 1 event)
29126	(1 unit = 1 event)
29130	(1 unit = 1 event)
29131	(1 unit = 1 event)
29240	(1 unit = 1 event)
29260	(1 unit = 1 event)
29280	(1 unit = 1 event)
29405	(1 unit = 1 event)
29425	(1 unit = 1 event)
29505	(1 unit = 1 event)
29515	(1 unit = 1 event)
29530	(1 unit = 1 event)
29540	(1 unit = 1 event)
92526	(1 unit = 1 event)
95992	(1 unit = 1 event)
97010	(1 unit = 1 event)
97012	(1 unit = 1 event)
97016	(1 unit = 1 event)
97018	(1 unit = 1 event)

Physical Therapy

Code	Unit of Service
97022	(1 unit = 1 event)
97024	(1 unit = 1 event)
97026	(1 unit = 1 event)
97028	(1 unit = 1 event)
97032	(1 unit = 15 minutes)
97033	(1 unit = 15 minutes)
97034	(1 unit = 15 minutes)
97035	(1 unit = 15 minutes)
97036	(1 unit = 15 minutes)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97124	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97602	(1 unit = 1 event)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

D. Modifiers

Not applicable

E. Billing Units

The unit of service is determined by the CPT code used. Refer to lists in Section C.

Assessment services are defined as the administration of an evaluation protocol, involving testing and/or clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service providers, and/or teachers as a means to collect assessment data from inventories, surveys, and/or questionnaires.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the

Medicaid program or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service.

Treatment services are defined as therapeutic procedures addressing the observed needs of the patient, which are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, and/or teachers **should be included** in order to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible recipients) of four children per group.

Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

F. Place of Service

A patient may receive IP therapy services in the office, home, school, through the Head Start program, and/or child care (i.e., regular and developmental day care) settings.

G. Co-payments

Co-payments are not required for Independent Practitioner services.

H. Reimbursement

Payment is calculated based on the lower of the billed usual and customary charges and Medicaid's maximum allowable rate. Providers must bill their usual and customary charges.