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To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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This clinical coverage policy has an effective date of January 1, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect.

Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
10A, *Outpatient Specialized Therapies*
10B, *Independent Practitioners (IP)*
3A, *Home Health Services*
5A-1, *Physical Rehabilitation Equipment and Supplies*
8J, *Children's Developmental Service Agencies (CDSAs)*
1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring*

1.0 Description of the Procedure, Product, or Service

Medically necessary evaluations and treatments provided to an NC Medicaid-eligible beneficiary are covered when,

a. The service(s) are documented on the beneficiary's Individualized Education Program (IEP), Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP) or 504 Plan according to 34 C.F.R. 104.36; and
b. Provided by school staff or contracted personnel.

It is the responsibility of the Local Education Agencies (LEA) to ensure that clinicians, including contractors, are appropriately credentialed.

1.1 Definitions:

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

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

2.1.2 Specific

Medicaid

A beneficiary three years of age through 20 years of age who is enrolled in a public school is eligible. Beneficiary eligibility for health-related services depends upon whether:

a. the beneficiary is Medicaid-eligible when services are provided;

b. the beneficiary's need for treatment services has been confirmed by a licensed Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM), Certified Nurse Midwife (CNM), Physician Assistant (PA), or Nurse Practitioner (NP); and

c. the beneficiary receives the service(s) in the public school setting or a setting identified in an IEP, or IFSP, IHP, BIP or 504 Plan, and is receiving services as part of an IEP, IFSP, IHP, BIP or 504 Plan.

NCHC

NCHC beneficiaries are not eligible for Outpatient Specialized Therapies, Nursing, Counseling and Psychological testing services when provided by Local Education Agencies.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **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 beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the

needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page https://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

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3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid or NCHC shall cover 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 beneficiary'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 beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in **Attachment A** and in **Subsections 3.5 and 3.8**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover audiology, counseling, nursing, occupational therapy, physical therapy, and speech/language therapy services that are medically necessary and documented on any one of the following:
IEP; IFSP; IHP; BIP; or 504 Plan.

3.2.3 NCHC Additional Criteria Covered

NCHC beneficiaries are not eligible for Outpatient Specialized Therapies, Nursing or Counseling and Psychological services when provided by Local Education Agencies.

3.3 Physical Therapy (PT)

Medicaid shall cover medically necessary outpatient physical therapy treatment.

3.4 Occupational Therapy (OT)

Medicaid shall cover medically necessary outpatient occupational therapy treatment.

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3.5 Speech-Language Therapy

Medicaid shall cover medically necessary outpatient speech language therapy treatment.

a. The following criteria applies for a beneficiary birth through 20 years of age:

Language Impairment Classifications Infant and Toddler—Medicaid Beneficiaries Birth to 3 Years	
Mild	• 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 78–84, **or** • A 20 percent–24 percent 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	• 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 percent –29 percent 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	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A 30 percent 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 Medicaid Beneficiaries 3 – 5 Years of Age	
Mild	• 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 78–84, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that

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Language Impairment Classifications Medicaid Beneficiaries 3 – 5 Years of Age	
	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	• 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	• 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 Medicaid Beneficiaries 5 through 20 Years of Age	
Mild	• 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 78–84, **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 beneficiary exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics, or pragmatics.

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Language Impairment Classifications Medicaid Beneficiaries 5 through 20 Years of Age	
Moderate	• 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 beneficiary exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• 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 beneficiary exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation and Phonology Impairment Classifications Medicaid Beneficiaries Birth through 20 Years of Age	
Mild	• 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 percent occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary is expected to have few articulation errors, generally characterized by typical substitutions, omissions, or distortions. Intelligibility not greatly affected but errors are noticeable.
Moderate	• 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 percent occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21 percent –40 percent occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary typically has 3 to 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.
Severe	• 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 percent occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40 percent occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary 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.

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
In using these guidelines for determining eligibility, total number of errors and intelligibility should be considered. A 90 percent criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5%–10 percent of performances on a standardized instrument to be outside the normal range.	

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
When beneficiaries 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. 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.	
After age 4 years, 0 months	Deaffrication, vowelization/vocalization, cluster reduction
After age 5 years, 0 months	Gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3–10 sw/m or 3 percent –10 percent 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 percent 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 percent stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: The service delivery may be raised when the percentage of stuttered words fall in a lower severity rating and the duration and the presence of physical characteristics falls in a higher severity rating.	

Differential Diagnosis for Stuttering
Characteristics of normally dysfluent beneficiaries: • 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-bball.). • 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.

Differential Diagnosis for Stuttering
The following information may be helpful in monitoring beneficiaries 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. More Usual (Typical Dysfluencies) • 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. Crossover Behaviors • 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. More Unusual (Atypical Dysfluencies) • 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.

b. Medically necessary treatment for the use of Augmentative and Alternative Communication (AAC) devices must meet the following criteria listed below, 1 through 4:

1. Selection of the device must meet the criteria specified in clinical coverage policy 5A-1, *Physical Rehabilitation Equipment and Supplies*.
   A. Employ the use of a dedicated speech generating device that produces digitized speech output, using pre-recorded messages (these are typically classified by how much recording time they offer); or
   B. Employ the use of a dedicated speech-generating device that produces synthesized speech output, with messages formulated either by direct selection techniques or by any of multiple methods.
2. AAC therapy treatment programs consist of the following treatment services:
   A. Counseling;
   B. Product Dispensing;
   C. Product Repair and Modification;
   D. AAC Device Treatment and Orientation;
   E. Prosthetic and Adaptive Device Treatment and Orientation; and
   F. Speech and Language Instruction.
3. AAC treatment must be used for the following:
   A. Therapeutic intervention for device programming and development;
   B. Intervention with parent(s), legal guardian(s), family member(s), support workers, and the beneficiary for functional use of the device; and

C. Therapeutic intervention with the beneficiary in discourse with communication partner using his or her device.

4. The above areas of treatment must be performed by a licensed Speech-Language Pathologist with education and experience in augmentative communication to provide therapeutic intervention, to help a beneficiary communicate effectively using his or her device in all areas pertinent to the beneficiary. Treatment may be provided when the results of an authorized AAC evaluation recommend either a low-tech or a high-tech system. Possible reasons for additional treatment are:
   A. update of device;
   B. replacement of current device;
   C. significant revisions to the device and vocabulary; and
   D. medical changes.

c. Telehealth

A select set of speech and language evaluation and treatment interventions may be billed by LEAs when provided to student beneficiaries using a telehealth delivery method as described in **Clinical Coverage Policy 1-H**. Telehealth delivery may be medically necessary when a student is medically homebound, during an extended school closure, or if their school is remote or underserved such that access to appropriately qualified providers is limited.

3.6 Audiology Therapy (Aural Rehabilitation) Practice Guidelines

Medicaid shall cover medically necessary audiology services when the beneficiary demonstrates the following:

a. the presence of any degree or type of hearing loss on the basis of the results of an audiological (aural) rehabilitation evaluation; or
b. the presence of impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.

A beneficiary shall have one or more of the following deficits to initiate therapy:

a. hearing loss (any type) with a pure tone average greater than 25dB **HL** (decibels Hearing Level)**,** in either ear;
b. Standard Score more than one SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing which must be documented based on the results of a central auditory test battery; or
c. less than one-year gain in skills (auditory, language, speech, processing) during a period of 12-calendar months.

Aural rehabilitation consists of:

a. facilitating receptive and expressive communication of a beneficiary with hearing loss;
b. achieving improved, augmented or compensated communication processes;
c. improving auditory processing, listening, spoken language processing, auditory memory, overall communication process; and
d. benefiting learning and daily activities.

Evaluation for aural rehabilitation
Service delivery requires all the following elements listed below. The provider shall:

a. check the functioning of hearing aids, assistive listening systems and devices, and sensory aids prior to the evaluation;
b. evaluate the beneficiary's skills, in both clinical and natural environments through interview, observation, and clinical testing for the following:
    1. medical and audiological history;
    2. reception, comprehension, and production of language in oral, or manual language modalities;
    3. speech and voice production;
    4. perception of speech and non-speech stimuli in multiple modalities;
    5. listening skills;
    6. speechreading; and
    7. communication strategies.
c. determine the specific functional limitation(s), which must be measurable, for the beneficiary.

3.6.1 Evaluation—Central Auditory Processing Disorders (CAPD)

CAPD evaluation is to be completed by an audiologist and consists of tests to evaluate the beneficiary's overall auditory function. Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary for the following:

a. Communication, medical, and educational history;
b. Identification of CAPD by the following Central auditory tests:
    1. auditory discrimination test;
    2. auditory temporal processing and patterning test;
    3. dichotic speech test;
    4. monaural low-redundancy speech test;
    5. binaural interaction test;
    6. electroacoustic measures; and
    7. electrophysiologic measures.
c. Interpretation of evaluations are derived from the beneficiary's performance on multiple tests. The diagnosis of CAPD must be based on a score of two standard deviations below the mean on at least two central auditory tests;
d. determination of the specific functional limitation(s), which must be measurable for the beneficiary such as any of the following;
    1. hear normal conversational speech;
    2. hear conversation via the telephone;
    3. identify, by hearing, environmental sounds necessary for safety (such as siren, car horn, doorbell, and baby crying);
    4. understand conversational speech (in person or via telephone);
    5. hear and understand teacher in classroom setting;
    6. hear and understand classmates during class discussion;

7. hear and understand co-workers or supervisors during meetings at work;
8. hear and process the super-segmental aspects of speech or the phonemes of speech; or
9. localize sound.

Note: Language therapy treatment sessions must not be provided on the same date of service as aural rehabilitation therapy treatment sessions.

3.7 Nursing Services

Nursing services are services directly related to a written plan of care (POC) based on an order from a licensed MD, DPM, DO, PA, NP or CNM. The Treatment Plan or Plan of Care must be developed by a Registered Nurse (RN).

3.8 Psychological and Counseling Services

This service may consist of psychological testing, clinical observation and counseling services as appropriate for chronological or developmental age for one or more of the following areas of functioning:

a. Cognitive
b. Emotional and personality;
c. Adaptive behavior;
d. Behavior; and/or
e. Perceptual or visual motor.

The service must be provided by one of the following:

a. Licensed Psychologist (LP);
b. Licensed Psychological Associate (LPA);
c. Licensed Clinical Mental Health Counselor (LCMHC);
d. Licensed Clinical Mental Health Counselor Associate (LCMHCA);
e. Licensed Clinical Social Worker (LCSW);
f. Licensed Clinical Social Worker Associate (LCSWA); or
g. School Psychologist (SP).

Telehealth

A select set of psychological and counseling treatment interventions may be billed by LEAs when provided to student beneficiaries using a telehealth delivery method as described in Clinical Coverage Policy 1-H. Telehealth delivery may be medically necessary when a student is medically homebound, experiencing an acute crisis, during an extended school closure, or if their school is remote or underserved such that access to appropriately qualified providers is limited.

Note: CPT codes that may be billed when service is furnished via telehealth are indicated in **Attachment A, Section C: Codes**.

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3.9 Evaluation Services

3.9.1 Vision Screening Services

Vision Screening Services must be administered by licensed registered nurses (RNs) or licensed practical nurses (LPNs) prior to providing a billable psychological evaluation, occupational therapy evaluation, physical therapy evaluation or speech/language evaluation service.

3.9.2 Hearing Screening Services

Hearing Screening Services must be administered by licensed RNs, Audiologists or Speech/Language Pathologists prior to providing a billable psychological evaluation, occupational therapy evaluation, physical therapy evaluation or speech/language evaluation service.

3.9.3 Evaluation services

Evaluation Services are the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol can consist of interviews with parent(s), legal guardian(s), other family member(s), other service providers, and teachers to collect assessment data from inventories, surveys, and questionnaires.

3.10 Treatment Plan (Plan of Care)

The Treatment Plan must be established once an evaluation has been administered and prior to the beginning of treatment services. The Treatment Plan is developed in conjunction with the beneficiary, parent(s) or legal guardian(s), teacher and medical professional. The Treatment Plan must consider performance in both clinical and natural environments. Treatment must be culturally appropriate. Short- and Long-Term functional goals and specific objectives must be determined from the evaluation. Goals and objectives must be reviewed at least annually and must target functional and measurable outcomes. The Treatment Plan must be a specific document.
Each treatment plan in combination with the evaluation or re-evaluation written report must contain ALL the following:

a. duration of the treatment plan consisting of the start and end date (no more than 12 calendar months);
b. discipline specific treatment diagnosis and any related medical diagnoses;
c. Rehabilitative or habilitative potential;
d. defined goals (specific and measurable goals that have reasonable expectation to be achieved within the duration of the treatment plan) for each therapeutic discipline;
e. skilled interventions, methodology, procedures, modalities and specific programs to be utilized;
f. frequency of services;
g. length of each treatment visit in minutes;
h. name, credentials and signature of professional completing Treatment Plan dated on or prior to the start date of the treatment plan; and
i. treatment plan date, beneficiary's name and date of birth or Medicaid identification number.

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3.11 Treatment Services

a. Treatment services are the **medically necessary**:
   1. therapeutic PT, OT, ST, and audiology procedures, modalities, methods and interventions, that occur after the initial evaluation has been completed;
   2. Nursing services directly related to a written plan of care (POC) based on an order from a licensed MD, DPM, DO, PA, NP or CNM; and
   3. Psychological and counseling services.

b. Treatment services must address the observed needs of the beneficiary, must be performed by the qualified service provider, and must adhere to ALL the following requirements:
   1. A verbal order or a signed and dated written order must be obtained for services prior to the start of services. All verbal orders must:
      A. contain the date and signature of the person receiving the order;
      B. be recorded in the beneficiary's record; and
      C. be countersigned by the physician within 60 calendar days.
   2. All verbal orders are valid up to 12 calendar months from the documented date of **receipt**. All written orders are valid up to 12 calendar months from the date of the physician's signature;
   3. Backdating is not allowed;
   4. All services must be provided according to a treatment plan that meets the requirements in **Subsection 3.10**;
   5. Service providers shall review and renew or revise treatment plans and goals no less often than every 12 calendar months;
   6. For a Local Education Agency (LEA), the prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes. An LEA provider shall review, renew and revise the IEP, IFSP, IHP, BIP or 504 Plan annually along with and obtaining a dated physician order with signature. The IEP, IFSP, IHP, BIP or 504 Plan requirement of parent notification must occur at regular intervals throughout the year as stipulated by NC Department of Public Instruction. Such notification must detail how progress is sufficient to enable the child to achieve the IEP, IFSP, IHP, BIP or 504 Plan goals by the end of the school year; and
   7. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or order 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 or unauthorized use, and reconstruction of records in the event of a system breakdown; and Stamped signatures are not permitted.

3.12 Re-evaluation Services

Re-evaluation services are the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol can consist of interviews with parent(s), legal guardian(s), other family members, other service providers, and teachers to collect assessment data from inventories, surveys, and questionnaires.

3.13 Discharge and Follow-up

a. Discharge

1. The treatment service must be discontinued when the beneficiary meets **one** of the following criteria:
   A. achieved functional goals and outcomes;
   B. performance is within normal limits for chronological age on standardized measures;
   C. overt and consistent non-compliance with treatment plan on the part of the beneficiary; or
   D. overt and consistent non-compliance with treatment plan on the part of parent(s) or legal guardian(s).
2. At discharge, the licensed practitioner shall identify indicators for potential follow-up care.

b. Follow-Up

Re-admittance of a beneficiary to services may result from any of the following changes in the beneficiary's:

1. functional status;
2. living situation;
3. school or childcare; or
4. personal interests.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover OT, PT, speech-language, audiology, psychological and counseling services, and nursing services when the criteria are not met in **Section 3.0.**

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

The prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes.

5.2 Limitations or Requirements

Each evaluation code can be billed only once in a six-month period unless there is a change in the beneficiary's medical condition.

Medical necessity criteria outlined in **Section 3.0** of this policy must be met.

Except where permitted by covered Psychological and Counseling Services Assessment procedure codes, evaluation services **do not include** interpretive conferences, educational placement or care planning meetings, mass or individual screenings aimed at selecting beneficiaries who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and travel is not billable to Medicaid or to any other payment source, since it is a part of the evaluation process which was considered in the determination of the rate per unit of service.

All treatment services shall be provided as outlined in an IEP, IFSP, IHP, BIP or 504 Plan. Occupational therapy and physical therapy services can be provided in a group setting with a maximum total number (that is both non-eligible and Medicaid-eligible beneficiaries) of three children per group. Speech-language services can be provided in a group setting with a maximum total number (that is both non-eligible and Medicaid-eligible beneficiaries) 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 or monitoring activities. Time spent for preparation, processing of claims, documentation or service provision, and travel is not billable to Medicaid 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.

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5.3 Location of Service

The service must be performed at the location identified on the IEP, IFSP, IHP, BIP or 504 Plan.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

The physical therapist, occupational therapist, speech-language pathologist, and audiologist shall comply with their entire practice act for the discipline regarding providing quality services, supervision of services and billing of services. The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice.

Eligible provider(s) may only bill for procedures, products, and services that are within the scope of their clinical practice (the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience practices in their specifically defined field), as defined by the appropriate licensing entity.

To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of licensed therapist, physician, or qualified personnel.

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.

Below are laws and regulations for each discipline, including:

Occupational Therapist

Qualified occupational therapist defined under 42 CFR § 440.110(b)(2) who meets the qualifications as specified under 42 CFR 484.115(f).

The occupational therapist shall comply with G.S. Chapter 90, Article 18D Occupational Therapy also known as North Carolina Occupational Therapy Practice Act.

Title 21NCAC, Chapter 38 Occupational Therapy

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Physical Therapist

A qualified physical therapist defined under42 CFR § 440.110(a)(2), who meets the qualifications as specified under 42 CFR 484.115(h).

G.S. Chapter 90, Article 18B Physical Therapy

Title 21 NCAC, Chapter 48 Physical Therapy Examiners

Speech-Language Pathologist

Speech Pathologist defined under 42 CFR § 440.110(c (2)(i)(ii)(iii).

Speech-language pathologist requirements are specified under 42 CFR 484.115(n).

Speech-Language Pathologist defined in G.S. 293(5). Speech-Language Pathologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists

Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists

Audiologist

Qualified audiologist defined under 42 CFR§ 440.110(c) (3)(i)(ii)(A)(B)

Audiologist qualifications specified under 42 CFR 484.115(b).

Audiologist shall comply with G.S. Chapter 90, Article 22,

Licensure Act for Speech and Language Pathologists and Audiologists

Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists

Psychological and Counseling Services

Qualifications of Providers: Minimum qualifications for providing services are licensure as a psychological associate or practicing psychologist by the North Carolina State Board of Examiners of Practicing Psychologists, licensure as a licensed Clinical Mental Health Counselor by the North Carolina Board of Licensed Clinical Mental Health Counselors or licensure as a school psychologist by the NC Department of Public Instruction, Licensed Clinical Social Workers, and School Psychologists. Licensed Clinical Social Workers, Licensed Clinical Mental Health Counselors and Licensed Psychologists shall provide documentation of appropriate training and experience, which qualifies them to work with students in an educational setting. All evaluation services must be provided by a licensed psychologist or school psychologist.
G.S. 115C-316.1. (a)(2) Duties of school counselors
G.S. 90-332.1. (a)(2) Exemptions from licensure

Note: To comply with NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC); and certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

Nursing Services

Licensed RNs or licensed practical nurses (LPNs) under the supervision of a registered nurse shall be licensed to practice in the State of North Carolina. Certain tasks may be delegated by the RN to unlicensed school personnel. Delegated staff includes school or contracted staff, such as teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff, or personal care aides.

The RN determines the degree of supervision and training required by the LPN and staff to whom duties have been delegated in accordance with the Nursing Practice Act. The RN shall be available by phone or beeper to individuals being supervised.

The POC must be developed by the RN based on a licensed MD, DPM, DO, PA, NP or CNM written order as required by the North Carolina Board of Nursing.

Title 21 NCAC, Chapter 36 *Nursing*
G.S., Chapter 90, Article 9A *Nursing Practice Act*

Provider Certifications

The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice. The LEA shall verify and maintain licensure or registration or online verification.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documenting Services

Each provider shall maintain and allow NC Medicaid to access the following documentation for each beneficiary:

a. The beneficiary's name and Medicaid identification number;
b. A copy of the treatment plan;
c. A copy of the IEP, IFSP, IHP, BIP or 504 Plan;
d. A copy of the Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM), Certified Nurse Midwife (CNM), Physician Assistant (PA), or Nurse Practitioner (NP)'s order for treatment services. Date signed must precede treatment dates;

e. Description of services (skilled intervention and outcome or beneficiary response) performed and dates of service must be present in a note for each billed date of service;

f. The duration of service (length of evaluation and treatment session **in minutes**) must be present in a note for each billed date of service;

g. 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;

h. A copy of each test performed or a summary listing all test results included in the written evaluation report;

i. For medication administration under nursing services, a flow sheet or equivalent documentation must be used by the nurse or delegated individual. The documentation must show the nurse's or delegated individual's full name and title. The date and time administered as well as nurse's or individual's initials and title must be written after each medication given. A narrative note summarizing the medication administered must be completed at least weekly by the RN with (if appropriate) input from the delegated person administering medication. This note should document results from the medication, side effects of the medication, and any other pertinent data;

j. Other nursing services documented on the POC require the same documentation as all IEP, IFSP, IHP, BIP or 504 Plan services;

k. For delegated services, there must be documentation of training and validation of competency by the RN for the person who will be performing the procedure. In addition, documentation, at a minimum monthly, that the RN monitors the care of the student to ensure that the procedure is being performed safely and effectively. The documentation usually is a form in which the school nurse and the assistant sign and date that the procedure is being done correctly; and

l. All services provided "under the direction of" must have supervision provided and documented according to the Practice Act of the licensed therapist.

If group therapy is provided, this must be noted in the provider's documentation for each beneficiary receiving services in the group. For providers who provide services to several children simultaneously in a classroom setting, the documentation must reflect this and the duration of services noted in the chart must accurately reflect how much time the provider spent with the beneficiary during the day. Such documentation ensures that an adequate audit trail exists and that Medicaid claims are accurate.

The student's IEP, IFSP, IHP, BIP or 504 Plan which is generally only revised once a calendar year, does not serve as documentation sufficient to demonstrate that a service was actually provided, to justify its medical need, or to develop a Medicaid claim. The IEP, IFSP, IHP, BIP or 504 Plan represents what services are to be provided and at what frequency. It does not document the provision of these services.

Practitioners and clinicians shall keep their own records of each encounter, documenting the date of treatment, time spent, treatment or therapy methods used, progress achieved, and any additional notes required by the needs of the beneficiary. These notes must be signed by the clinician and retained for future review by state or federal Medicaid reviewers. Records must be available to NC Medicaid and its agents and to the U.S. Department of Health and Human Services and CMS upon request.

Lack of appropriate medical justification may be grounds for denial, reduction or recoupment of reimbursement.

LEAs are responsible for ensuring that salaried and contracted personnel adhere to these requirements.

7.3 Post-Payment Reviews

Medicaid and DHHS Utilization Review Contractor(s) shall perform reviews for monitoring utilization, quality, and appropriateness of all services rendered as well as compliance with all applicable clinical coverage policies. NC Medicaid Program Integrity conducts post-payment reviews according to 10A NCAC 22F and N.C.G.S 108-C. Program Integrity post-payment reviews may be limited in scope to address specific complaints of provider aberrant practices or may be conducted using a statistically valid random sample of paid claims. Program Integrity and its authorized contractors analyze and evaluate provider claim data to establish conclusions concerning provider practices. Data analysis results can instigate post- or pre-payment reviews.

Overpayments are determined from review of the paid claims data selected for review or based on the statistically valid random sampling methodology approved for use by NC Medicaid. The findings of the post-payment review or utilization review are sent to the provider who is the subject of the review, in writing. Notices of error findings, Educational or Warning Letters and Tentative Notices of Overpayment findings contain a description of the findings, the basis for the findings, the tentative overpayment determination and information regarding the provider's appeal rights.

8.0 Policy Implementation and History

Original Effective Date: August 1, 2003

History:

Date	Section Revised	Change
10/01/2003	Subsection 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.
10/01/2003	Subsection 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/2003	Appendix A	The mailing address for the form was changed.
12/01/2003	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
07/01/2004	All sections and attachment(s)	Psychological changed to Psychological/Counseling
07/01/2004	Subsection 1.5, Psychological/Counseling Services Treatment services	Sociodrama and social skills training changed to individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of nonverbal communication and sensory integrative therapy
07/01/2004	Subsection 5.2, Treatment Services # 5	Requirement for six-month plan review and physician's order changed to annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
07/01/2004	Subsection 5.2, Treatment Services # 4 Subsection 7.1, Documenting Services	Extended through school year 2005 that the order must be obtained prior to services being billed, not before treatment rendered.
07/01/2004	Subsection 5.5, Other Limitations Subsection 8.1, Billing Guidelines	Added reimbursement for initial assessments if the service is an identified need in the IEP
07/01/2004	Subsection 6.1, Audiology Subsection 6.2, Speech/Language	Changed provider qualifications to allow CCC equivalency
01/01/2005	Subsection 8.2, Audiology Assessment	CPT code92589 was end-dated and replaced with 92620 and 92621

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Date	Section Revised	Change
07/01/2005	Subsection 5.2, Treatment Services # 4 Subsection 7.1, Documenting Services	Extended through school year 2006 that the order must be obtained prior to services being billed, not before treatment rendered.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/01/2005	Subsection 8.3	The Place of Service code was converted to 03.
01/01/2006	Subsection 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; 96100 was end-dated and replaced with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
06/01/2006	Subsection 5.2, Treatment Services # 4 Subsection 7.1, Documenting Services	Extended through school year 2007 that the order must be obtained prior to services being billed, not before treatment rendered.
06/01/2006	Subsection 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.
07/01/2006	Attachment A	The Certification of Non-Federal Match Form was replaced with a new version of the form.
10/01/2006	Attachment A	The Certification of Non-Federal Match Form was replaced with a new version of the form.
12/01/2006	Subsection 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
03/01/2007	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.
03/01/2007	Subsection 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
03/01/2007	Section 6.0	A reference to 42 CFR 440.110 and 440.60 was added to this section.
04/01/2007	Section 6.0	Clarified that online verification of staff credentials is acceptable.
04/01/2007	Subsection 2.3, and Sections 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.

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Date	Section Revised	Change
07/01/2007	Subsection 5.2, Note on letter d; and Subsection 7.1, Note on letter c	Expanded coverage through school year 2008.
01/01/2008	Subsection 8.2	Added CPT code 96125 (1 unit = 1 hour) to Occupational Therapy Assessment and Speech/Language Therapy Assessment.
07/01/2008 (eff. 07/17/2007)	Subsection 1.3	Removed pre-vocational assessment and training from the services provided.
07/01/2008 (eff. 07/17/2007)	Subsection 1.6	This section was added to define nursing services.
07/01/2008 (eff. 07/17/2007)	Subsection 3.4	This section was added to define the medical necessity criteria for coverage of nursing services.
07/01/2008 (eff. 07/17/2007)	Section 4.0	Added nursing services to the list of services that are not covered when the medical necessity criteria are not met; added heading 4.1, Medical Necessity, to differentiate this paragraph from the standard EPSDT notice.
07/01/2008 (eff. 07/17/2007)	Subsection 5.2, item d	Text was added to indicate that a physician's order must be obtained prior to rendering nursing services.
07/01/2008 (eff. 07/17/2007)	Subsection 6.1	Removed requirement for audiologists to hold master's or doctoral degrees.
07/01/2008 (eff. 07/17/2007)	Subsection 6.6	This section was added to document eligibility requirements for nursing service providers.
07/01/2008 (eff. 07/17/2007)	Subsection 7.1	Items h through k were added to indicate documents that must be maintained for nursing services.
07/01/2008 (eff. 07/17/2007)	Subsection 8.1	Information regarding collaboration with the student's primary physician was added and billable services were indicated.
07/01/2008 (eff. 07/17/2007)	Subsection 8.2	Billing codes and units for nursing services were added.
07/01/2008	Subsections 5.2, item d, and 7.1	Removed note pertaining to school years 2003 through 2008.
07/01/2008	Attachment A	Updated Certification of Non-Federal Match Form.
01/01/2009	Subsection 8.2	Added CPT code 95992 to physical therapy treatment table (annual update).
12/01/2009	Sections 3.0, 4.0	Standard coverage and non-coverage statements added
12/01/2009	Attachment A (was section 8.0)	Information moved to Attachment A –Claims Related Information
01/01/2010	Attachment A	CPT codes 92550 and 92570 added to Audiology Assessment billable codes

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Date	Section Revised	Change
01/01/2010	Subsection 5.1	Added clarification regarding acceptable orders and documentation.
01/01/2010	Section 6.0	Clarify who "can work under the direction/supervision of"
01/01/2010	Subsection 7.2	Add credentials to requirement
03/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2013	Attachment A	Removed "I. Certification of Non-Federal Match"
07/01/2013	Attachment B	Removed Attachment B "Certification of Non-Federal Match Form" as no longer applicable
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
12/01/2013	Subsections 6.3, 6.4, 6.5	Removed statement, "Only therapy assistants may work under the direction of the licensed therapist."
01/01/2014	Subsection 1.3.1	Added "one or more of"
01/01/2014	Subsection 7.2.g	Replaced ", and" with "included in"
01/01/2014	Attachment A, C:	Deleted: 92506 (1 unit = 1 test)
01/01/2014	Attachment A, C:	Added: 92521 (1 unit = 1 test) 92522 (1 unit = 1 test) 92523 (1 unit = 2 tests) 92524 (1 unit = 1 test)
06/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
06/01/2014	Subsection 3.3	Removed: "Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in the most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns*." Added: "Medicaid accepts the medical necessity criteria for physical therapy treatment as follows the American Physical Therapy Association (APTA), APTA official statements, APTA position papers, and current physical therapy research from peer reviewed journals."
06/01/2014	Subsection 3.4	Removed: "Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in the most recent edition of *Occupational Therapy Practice Guidelines Series*." Added: "Medicaid accepts the medical necessity criteria occupational therapy treatment as follows the American Occupational Therapy Association (AOTA) most recent edition of The Practice Framework, AOTA official statements, AOTA position papers, and current occupational therapy research from peer reviewed journals."
06/01/2014	Subsection 3.5cc	Changed the Standard Score range for mild language impairment from 78-85 to 78-84 for all aged beneficiaries.

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Date	Section Revised	Change
06/01/2014	Subsection 3.6.5	Added: "Language therapy treatments sessions shall not be billed concurrently with aural rehabilitation therapy treatment sessions."
06/01/2014	Subsection 5.4	Removed: "The IEP may be used as treatment plan." Added: "The IEP can include many of the requirements of the treatment plan but does not sufficiently meet all the requirements, and The treatment plan must include anticipated skilled interventions, frequency of services, duration of the therapy plan and length of each treatment visit for each therapeutic discipline."
06/01/2014	Subsection 6.1	Removed: "LEAs currently enrolled with Medicaid to provide health-related services are eligible to provide this service. Refer to the *Basic Medicaid and NC Health Choice Billing Guide* for information on how to enroll as a Medicaid provider. It is the responsibility of the LEA to verify that clinicians meet the qualifications listed in 42 CFR 440.110 and 440.60. A copy of this verification (current licensure or registration or online verification) must be maintained by the LEA." Added: "The physical therapist, occupational therapist, speech-language pathologist, and audiologist shall comply with their entire practice act for the discipline regarding providing quality services, supervision of services and billing of services. The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice. Eligible providers may only bill for procedures, products, and services that are within the scope of their clinical practice (the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience practices in their specifically defined field), as defined by the appropriate licensing entity. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, a licensed therapist, physician, or qualified personnel. 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. Below are laws and regulations for each discipline, including:"

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Date	Section Revised	Change
06/01/2014	Subsections 6.2, 6.3, 6.4, 6.5, 6.6, 6.7	These Subsections were moved to Subsection 6.1 and worded as follows: **Occupational Therapist** Qualified occupational therapist defined under 42 CFR § 440.110(b)(2) who meets the qualifications as specified under 42 CFR §484.4. The occupational therapist shall comply with G.S. Chapter 90, Article 18D Occupational Therapy also known as North Carolina Occupational Therapy Practice Act. Title 21NCAC, Chapter 38 Occupational Therapy **Physical Therapist** A qualified physical therapist defined under42 CFR § 440.110(a)(2), who meets the qualifications as specified under 42CFR § 484.4. G.S. Chapter 90, Article 18B Physical Therapy Title 21 NCAC, Chapter 48 Physical Therapy Examiners **Speech-Language Pathologist** Speech Pathologist defined under 42 CFR § 440.110(c (2)(i)(ii)(iii). Speech-language pathologist requirements are specified under 42CFR § 484.4. Speech-Language Pathologist defined in G.S. 293(5). Speech-Language Pathologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists **Audiologist** Qualified audiologist defined under 42 CFR§ 440.110(c) (3)(i)(ii)(A)(B) Audiologist qualifications specified under 42 CFR 484.4. Audiologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists

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Date	Section Revised	Change
06/01/2014	Subsections 6.2, 6.3, 6.4, 6.5, 6.6, 6.7 (Continued)	**Psychological/Counseling Services** Qualifications of Providers: Minimum qualifications for providing services are licensure as a psychological associate or practicing psychologist by the North Carolina State Board of Examiners of Practicing Psychologists, or licensure as a school psychologist by the NC Department of Public Instruction, and Licensed Clinical Social Workers. Licensed Clinical Social Workers and Licensed Psychologists shall provide documentation of appropriate training and experience, which qualifies them to work with students in an educational setting. G.S. 115C-316.1.(a)(2) Duties of school counselors G.S. 90-332.1.(a)(2) Exemptions from licensure **Nursing Services** Licensed RNs or licensed practical nurses (LPNs) under the supervision of a registered nurse shall be licensed to practice in the State of North Carolina. Certain tasks may be delegated by the RN to unlicensed school personnel. Delegated staff includes school or contracted staff, such as teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff, or personal care aides. The RN determines the degree of supervision and training required by the LPN and staff to whom duties have been delegated in accordance with the Nursing Practice Act. The RN shall be available by phone or beeper to individuals being supervised. The POC must be developed by the RN based on a licensed MD, DPM, DO, PA, NP or CNM written order as required by the North Carolina Board of Nursing. Title 21 NCAC, Chapter 36 *Nursing* G.S., Chapter 90, Article 9A *Nursing Practice Act* **Provider Certifications** The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice. The LEA shall verify and maintain licensure or registration or online verification.
06/01/2014	Subsection 6.8	**Provider Certifications** moved to Subsection 6.1. Changed from, "None" to "The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice."

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Date	Section Revised	Change
06/01/2014	Attachment A (E)	Added: Timed units billed must meet CMS regulations: 1 unit: ≥8 minutes through 22 minutes 2 units: ≥23 minutes through 37 minutes 3 units: ≥38 minutes through 52 minutes 4 units: ≥53 minutes through 67 minutes 5 units: ≥68 minutes through 82 minutes 6 units: ≥83 minutes through 97 minutes 7 units: ≥98 minutes through 112 minutes 8 units: ≥113 minutes through 127 minutes
07/01/2015	Attachment A	Removed CPT Code 92507 under Audiology Treatment procedures
07/01/2015	Attachment A	Added CPT Codes 92630 and 92633 under Audiology Treatment procedures
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/01/2015	All Sections and Attachments	Removed all references to the discipline specific ICD-9-CM aftercare codes V57.
7/01/2018	Section 1.0	Removed services descriptions section 1.2 through 1.7
7/01/2018	Subsection 3.3	Removed the reference to the American Physical Therapy Association (APTA) and **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.
7/01/2018	Subsection 3.4	Removed the reference to the American Occupational Therapy Association (AOTA) and **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.
7/01/2018	Subsection 3.5	Removed references to publications and the American Speech Hearing Association (ASHA). Added Medicaid shall cover medically necessary outpatient speech language therapy treatment. The following criteria apply for beneficiaries birth through 20 years of age:
7/01/2018	Subsection 3.5	Removed gliding under 4 years, 0 months and added gliding under 5 years and 0 months
7/01/2018	Subsection 3.5	Updated requirements for Augmentative Communication
7/01/2018	Subsection 3.6	Updated requirements for Aural Rehabilitation and Central Auditory Processing Disorder

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Date	Section Revised	Change
7/01/2018	Subsection 3.7	Added Nursing services are services directly related to a written plan of care (POC) based on 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) written order. The POC must be developed by a registered nurse (RN).
7/01/2018	Subsection 3.8	Added **Psychological/Counseling Services** This service may include testing and clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning: f. emotional/personality; g. adaptive behavior; or h. behavior. The service must be provided by one of the following: a. Licensed Psychologist (LP) b. Licensed Psychological Associate (LPA) c. Licensed Professional Counselor (LPC) d. Licensed Professional Counselor Associate (LPCA) e. Licensed Clinical Social Worker (LCSW) f. Licensed Clinical Social Worker Associate (LCSWA) g. School Psychologist (SP)
7/01/2018	Subsection 3.9	Added: **Evaluation Services** are the administration of an evaluation protocol, involving testing and 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 parent(s), legal guardian(s), other family member(s), other service providers, and teachers as a means to collect assessment data from inventories, surveys, and questionnaires.

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Date	Section Revised	Change
7/01/2018	Subsection 3.10	Added: **Treatment Plan (Plan of Care)** The Treatment Plan must be established once an evaluation has been administered and prior to the beginning of treatment services. The Treatment Plan is developed in conjunction with the beneficiary, parent(s) or legal guardian(s), teacher and medical professional. The Treatment Plan must consider performance in both clinical and natural environments. Treatment must be culturally appropriate. Short and Long Term functional goals and specific objectives must be determined from the evaluation. Goals and objectives must be reviewed at least annually and must target functional and measurable outcomes. The Treatment Plan must be a specific document. Each treatment plan in combination with the evaluation or re-evaluation written report must contain ALL the following: a. duration of the treatment plan consisting of the start and end date (no more than 12 calendar months); b. discipline specific treatment diagnosis and any related medical diagnoses; c. Rehabilitative or habilitative potential; d. defined goals (specific and measurable goals that have reasonable expectation to be achieved within the duration of the treatment plan) for each therapeutic discipline; e. skilled interventions, methodology, procedures, modalities and specific programs to be utilized; f. frequency of services; g. length of each treatment visit in minutes; and h. name, credentials and signature of professional completing Treatment Plan dated on or prior to the start date of the treatment plan.

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Date	Section Revised	Change
7/01/2018	Subsection 3.11	Added: **Treatment Services** a. Treatment services are the medically necessary: 1.therapeutic PT, OT, ST, and Audiology procedures, modalities, methods and interventions, that occur after the initial evaluation has been completed 2. Nursing services directly related to a written plan of care (POC) based on an order from a licensed MD, DPM, DO, PA, NP or CNM; and 3. Psychological and counseling services. b. Treatment services must address the observed needs of the beneficiary, must be performed by the qualified service provider, and must adhere to all the following requirements: 1. A verbal order or a signed and dated written order must be obtained for services prior to the start of services. All verbal orders must: (1) contain the date and signature of the person receiving the order; (2) be recorded in the beneficiary's record; and (3) be countersigned by the physician within sixty (60) calendar days. 2. All verbal orders are valid up to twelve (12) calendar months from the documented date of receipt. All written orders are valid up to twelve (12) calendar months from the date of the physician's signature; 3.Backdating is not allowed; 4. All services must be provided according to a treatment plan that meets the requirements in Subsection 3.10; 5. Service providers shall review and renew or revise treatment plans and goals no less often than every twelve (12) calendar months; 6. For a Local Education Agency (LEA), the prior approval process is deemed met by the Individualized Education Program (IEP) process. An LEA provider shall review, renew and revise the IEP annually along with and obtaining a dated physician order with signature. The IEP requirement of parent notification must occur at regular intervals throughout the year as stipulated by NC Department of Public Instruction. Such notification must detail how progress is sufficient to enable the child to achieve the IEP goals by the end of the school year; 7. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or order 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 or unauthorized use, and reconstruction of records in the event of a system breakdown; and Stamped signatures are not permitted.

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Date	Section Revised	Change
7/01/2018	Subsection 3.12	Added: **Re-evaluation Services** Re-evaluation services are the administration of an evaluation protocol, involving testing and 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 parent(s), legal guardian(s), other family members, other service providers, and teachers as a means to collect assessment data from inventories, surveys, and questionnaires.
7/01/2018	Subsection 3.13	Added: **Discharge and Follow-up** **a. Discharge** 1. The therapy must be discontinued when the beneficiary meets **one** of the following criteria: A. achieved functional goals and outcomes; B. performance is within normal limits for chronological age on standardized measures; C. overt and consistent non-compliance with treatment plan on the part of the beneficiary; or D. overt and consistent non-compliance with treatment plan on the part of parent(s) or legal guardian(s). 2. At discharge, the therapist shall identify indicators for potential follow-up care. **b. Follow-Up** Re-admittance of a beneficiary to therapy services may result from any of the following changes in the beneficiary's: 1. functional status; 2. living situation; 3. school or child care; or 4. personal interests.
7/01/2018	Subsection 6.1	Under psychological/counseling services added: licensure as a licensed Professional Counselor by the North Carolina Board of Licensed Professional Counselors and School Psychologists.

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Date	Section Revised	Change
7/01/2018	Subsection 7.3	Added: **Post Payment Review** Medicaid and DHHS Utilization Review Contractor(s) shall perform reviews for monitoring utilization, quality, and appropriateness of all services rendered as well as compliance with all applicable clinical coverage policies. NC Medicaid Program Integrity conducts post-payment reviews in accordance with 10A NCAC 22F and N.C.G.S 108-C. Program Integrity post-payment reviews may be limited in scope to address specific complaints of provider aberrant practices or may be conducted using a statistically valid random sample of paid claims. Program Integrity and its authorized contractors also analyze and evaluate provider claim data to establish conclusions concerning provider practices. Data analysis results may instigate post- or pre-payment reviews. Overpayments are determined from review of the paid claims data selected for review or based on the statistically valid random sampling methodology approved for use by NC Medicaid. The findings of the post payment review or utilization review are sent to the therapy provider who is the subject of the review in writing. Notices of error findings, Educational or Warning Letters and Tentative Notices of Overpayment findings contain a description of the findings, the basis for the findings, the tentative overpayment determination and information regarding the provider's appeal rights.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
05/15/2019	Section 1.0	Added after (IEP): ...Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP) or 504 Plan according to 34 C.F.R. 104.36. Revision is effective 10/01/2018.
05/15/2019	Subsection 2.1.2 (c-d)	Added: or IFSP, IHP, BIP or 504 Plan. Deleted: special education. Deleted: criterion d. the beneficiary receives the service(s) in the public school setting, or a setting identified in an IEP or IFSP, and is receiving special education services as part of an IEP/IFSP. Revision is effective 10/01/2018.

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Date	Section Revised	Change
05/15/2019	Subsection 3.2.2	Deleted: Medicaid shall cover services when medically necessary and outlined in an IEP. Added: Medicaid shall cover audiology, counseling, nursing, occupational therapy, physical therapy, and speech/language therapy services that are medically necessary and documented on any one of the following: IEP; IFSP; IHP; BIP; or 504 Plan. Revision is effective 10/01/2018.
05/15/2019	Subsection 3.8	Added: 'psychological' testing, 'counseling services' to body of text, and added Cognitive and Perceptual or visual motor to service list. Revision is effective 10/01/2018.
05/15/2019	Subsection 3.9	Added: 3.9.1 **Vision Screening Services**; 3.9.2 **Hearing Screening Services** and re-numbered existing **Evaluation Services** as 3.9.3. Revision is effective 10/01/2018.
05/15/2019	Subsection 3.11 (b.6)	Added: IFSP, IHP, BIP or 504 Plan processes. Revision is effective 10/01/2018.
05/15/2019	Subsection 5.1	Added: IFSP, IHP, BIP or 504 Plan processes. Revision is effective 10/01/2018.
05/15/2019	Subsection 5.2	Deleted from first sentence of paragraph four: on an individualized face to face basis. Added to first sentence of paragraph four: IFSP, IHP, BIP or 504 Plan. Revision is effective 10/01/2018. Added to second sentence of paragraph four: Occupational therapy and physical therapy services can be provided in a group setting with a maximum total number (that is both non-eligible and Medicaid-eligible beneficiaries) of three children per group. Revision is effective 10/01/2018. Clarified third sentence of paragraph four to read: Speech-language services can be provided in a group setting with a maximum total number (that is both non-eligible and Medicaid-eligible beneficiaries) of four children per group. Revision is effective 10/01/2018.
05/15/2019	Subsection 5.3	Added: IFSP, IHP, BIP or 504 Plan. Revision is effective 10/01/2018.
05/15/2019	Subsection 7.2 (c), (j) & paragraph two	Added: IFSP, IHP, BIP or 504 Plan. Revision is effective 10/01/2018.

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Date	Section Revised	Change
05/15/2019	Attachment A, Section C, Code(s)	Removed outdated CPT codes 92569 and 97762. Replaced CPT code 97762 with 97763. Added: V5008 (hearing screen) to Audiology, SLP and Nursing code lists. Revision is effective 10/01/2018. Added: 97150 (group therapy) to OT and PT lists. Revision is effective 10/01/2018. Added: OT evaluation and re-evaluation codes 97165, 97166, 97167, 97168 which were inadvertently left out during a prior policy update. Replaced end-dated psychological and counseling evaluation code 96101 with 96130, 96131, 96136 & 96137. Revision is effective 01/01/2019. Replaced end-dated psychological and counseling evaluation code 96111 with 96112 & 96113. Revision is effective 01/01/2019. Added: 96121 which is new code paired with newly divided code 96116. Revision is effective 01/01/2019. Replaced end-dated psychological and counseling evaluation code 96118 with 96132 & 96133. Revision is effective 01/01/2019. Added: 99173 (vision screen) to Nursing code list. Revision is effective 10/01/2018.
05/05/2019	Attachment A, Section C, Third Party Liability	Added: IFSP, IHP, BIP or 504 Plan. Revision is effective 10/01/2018.
05/15/2019	Attachment A, Section E, Treatment Services	Removed last sentence from first paragraph: All treatment services must be provided on an individualized basis except for speech-language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible beneficiaries) of four children per group. Revision is effective 10/01/2018.
05/15/2019	Attachment A, Section F, Place of Service	Added: IFSP, IHP, BIP or 504 Plan. Revision is effective 10/01/2018.
05/15/2019	Subsection 5.2	Added to first sentence of paragraph three: Except where permitted by covered Psychological and Counseling Services Assessment procedure codes. Revision is effective 01/01/2019.
05/15/2019	Subsection 6.1	Updated references to Federal Register qualifications for OT, PT, SLP and audiology.
05/15/2019	Subsection 2.1 (b)	Removed reference to NCHC.
05/15/2019	Subsection 3.2.2	**NCHC Additional Criteria Covered** renumbered as Subsection 3.2.3.

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Date	Section Revised	Change
05/15/2019	Subsection 3.10	Added: criterion "i." treatment plan date, beneficiary's name and date of birth or Medicaid identification number.
06/15/2019	Attachment A	Replaced end date code 97762 with code 97763 was omitted, it is now added. Effective amendment date is 05/15/2019
01/15/2020	Attachment A (C)	Removed end dated occupational and physical therapy assessment CPT codes 95831, 95832, 95833 and 95834, effective 12/31/19.
01/15/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
01/15/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
2/10/2020	Section 8.0	Correction made to section 8.0 to show amendment date as 01/15/2020. No change to amendment date
01/01/2021	Related Clinical Coverage Policies	Added 1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring.*
01/01/2021	Throughout	Changed Licensed Professional Counselor to "Licensed Clinical Mental Health Counselor" and Licensed Professional Counselor Associate to "Licensed Clinical Mental Health Counselor Associate". Added the following note to Section 6.1: Note: To comply with NC General Assembly Session Law 2019- 240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC); and certification name for Certified Substance Abuse Counselor (CSAC) is amended to Certified Alcohol and Drug Counselor (CADC). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.
01/01/2021	Subsection 3.1.1	Added the following language: "As outlined in **Attachment A** and in **Subsection 3.8**, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring."
01/01/2021	Subsection 3.8	Added guidance for the delivery of select psychological and counseling treatment interventions using telehealth.
01/01/2021	Attachment A, Section C, Code(s)	Added a column to the Psychological and Counseling Services Treatment codes to indicate if the services were eligible for telehealth along with the following language: **Note:** Telehealth eligible services may be provided to beneficiaries by the eligible providers listed within this policy.

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Date	Section Revised	Change
01/01/2021	Attachment A, Section C, Code(s)	As part of the AMA's annual CPT code update, the audiology evaluation code 92585 was end-dated effective 12/31/2020 and replaced with 92652 and 92653, effective 1/1/2021.
01/01/2021	Attachment A, Section D, Modifiers	Added the following language for telehealth services: **Telehealth Claims**: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring
01/01/2021	Attachment A, Section F, Place of Service	Added language indicating telehealth claims should be filed with the provider's usual place of service code(s)
	Related Clinical Coverage Policies	Added references to clinical coverage policies 3A, *Home Health Services* and 8J, *Children's Developmental Service Agencies (CDSAs)*.
	Subsection 3.1.1	Updated text to include a reference to **Subsection 3.5**.
	Subsection 3.5	Added guidance for the delivery of select speech and language evaluation and treatment interventions using telehealth.
	Attachment A, Section C	Added a column to the speech and language evaluation and treatment code tables to indicate if the services were eligible for telehealth along with the following language: Note: Telehealth eligible services may be provided to beneficiaries by the eligible providers listed within this policy.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

Separate CMS-1500 claim forms must be filed for assessment and treatment services, and separate forms must be filed for each type of service provided. It should be noted that individual and group therapy, being the same type of service, can be listed on the same claim form. All claims must be sent electronically or mailed directly to DHHS fiscal contractor. Refer *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

Providers shall bill their usual and customary charges. Schools that bill Medicaid for health-related services are only paid the federal share of the Medicaid reimbursement rates.

Procedures must be billed using the most comprehensive CPT code to describe the service performed.

Refer to **Section 3.0, When the Product, Procedure, or Service is Covered,** and **Subsection 3.11, Treatment Services,** for additional information.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The unit of service is determined by the CPT code used. Event codes may only be billed one unit a day by the same specialty.

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Audiology Therapy ~~Assessment~~ Evaluation

CPT Code	Unit of Service
92550	(1 unit = 1 test)
92551	(1 unit = 1 test)
92552	(1 unit = 1 test)
92553	(1 unit = 1 test)
92555	(1 unit = 1 test)
92556	(1 unit = 1 test)
92557	(1 unit = 1 test)
92567	(1 unit = 1 test)
92568	(1 unit = 1 test)
92570	(1 unit = 1 test)
92571	(1 unit = 1 test)
92572	(1 unit = 1 test)
92576	(1 unit = 1 test)
92579	(1 unit = 1 test)
92582	(1 unit = 1 test)
92583	(1 unit = 1 test)
92587	(1 unit = 1 test)
92588	(1 unit = 1 test)
92590	(1 unit = 1 test)
92591	(1 unit = 1 test)
92592	(1 unit = 1 test)
92593	(1 unit = 1 test)
92594	(1 unit = 1 test)
92595	(1 unit = 1 test)
92620	(1 unit = 60 min)
92621	Each additional 15 minutes (1 unit = 1 test) must be used with 92620
92626	(1 unit = 60 min)
92627	Each additional 15 minutes (1 unit = 15 minutes) must be used with 92626
92652	(1 unit = 1 test)
92653	(1 unit = 1 test)
V5008	(1 unit = 1 test)

Audiology Therapy Treatment

CPT Code	Unit of Service
92630	(1 unit = 1 visit)
92633	(1 unit = 1 visit)

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Speech-Language Therapy ~~Assessment~~ Evaluation

CPT Code	Unit of Service	Telehealth Eligible Service
92521	(1 unit = 1 test)	Yes
92522	(1 unit = 1 test)	Yes
92523	(1 unit = 2 tests)	Yes
92524	(1 unit = 1 test)	Yes
92551	(1 unit = 1 test)	No
92607	(1 unit = 1 test)	Yes
92608	Each additional 30 minutes (1 unit = 1 test) must be used with 92607	Yes
92610	(1 unit = 1 test)	No
92612	(1 unit = 1 test)	No
92626	(1 unit = 60 min)	No
92627	Each additional 15 minutes (1 unit = 15 minutes) must be used with 92626	No
96125	(1 unit = 1 hour)	No
V5008	(1 unit = 1 test)	No

Speech-Language Therapy Treatment

CPT Code	Unit of Service	Telehealth Eligible Service
92507	(1 unit = 1 visit)	Yes
92508	(1 unit = 1 visit)	No
92526	(1 unit = 1 visit)	Yes (feeding only)
92609	(1 unit = 1 visit)	Yes
92630	(1 unit = 1 visit)	No
92633	(1 unit = 1 visit)	No

Note: Telehealth eligible services may be provided to beneficiaries by the eligible providers listed within this policy.

Occupational Therapy ~~Assessment~~ Evaluation

CPT Code	Unit of Service
92610	(1 unit = 1 event)
96125	(1 unit = 1 hour)
97165	(1 unit = 1 event)
97166	(1 unit = 1 event)
97167	(1 unit = 1 event)
97168	(1 unit = 1 event)
97750	(1 unit = 15 minutes)

Occupational Therapy Treatment

CPT 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)

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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)
97150	(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)
97763	(1 unit = 15 minutes)

Physical Therapy ~~Assessment~~ Evaluation

CPT Code	Unit of Service
92610	(1 unit = 1 event)
97161	(1 unit = 1 event)
97162	(1 unit = 1 event)
97163	(1 unit = 1 event)
97164	(1 unit = 1 event)
97750	(1 unit = 15 minutes)

Physical Therapy Treatment

CPT 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)
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)

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95992	(1 unit = 1 event)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97150	(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)
97763	(1 unit = 15 minutes)

Psychological and Counseling Services ~~Assessment~~ Evaluation

CPT Code	Unit of Service	Telehealth Eligible Service
90791	(1 unit = 1 hour)	No
96110	(1 unit = event)	No
96112 96113	(1 unit = first hour) (1 unit = each additional 30 minutes); must be used with 96112	No No
96116 96121	(1 unit = first hour) (1 unit = each additional hour); must be used with 96116	No No
96130 96131	(1 unit = first hour) (1 unit = each additional hour); must be used with 96130	No No
96132 96133	(1 unit = first hour) (1 unit = each additional hour); must be used with 96132	No No
96136 96137	(1 unit = first 30 minutes) (1 unit = each additional 30 minutes); must be used with 96136	No No

Psychological and Counseling Services Treatment

CPT Code	Unit of Service	Telehealth Eligible Services
90832	1 unit = 23 – 37 minutes	Yes
90834	1 unit = 38 – 52 minutes	Yes
90837	1 unit = 53 – 67 minutes	Yes
90847	1 unit = 1 visit	Yes
90853	1 unit = 1 visit	Yes

Note: Telehealth eligible services may be provided to beneficiaries by the eligible providers listed within this policy.

Nursing Services

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HCPCS or CPT Code	Unit of Service
99173	(1 unit = 1 event)
S5125	(1 unit = 15 minutes)
T1002	(1 unit = 15 minutes)
T1003	(1 unit = 15 minutes)
V5008	(1 unit = 1 event)

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Third-Party Liability

Medicaid shall not pay medical care when a third party covers a beneficiary, that is private insurance or CHAMPUS, who is responsible to make payment for service(s) otherwise covered by Medicaid.

Any Medicaid provider, including LEAs, shall agree to first bill the third party before billing Medicaid. It is recognized that federal policy for implementing Part B services of the Individual's with Disabilities Education Act (IDEA) places restrictions on a school to seek third party reimbursement for health-related services since Local Education Agencies shall provide a free and appropriate education. The North Carolina Department of Public Instruction, Division of Exceptional Children's Services is advising that LEAs **not** bill Medicaid when the beneficiary's Medicaid identification card indicates the existence of third-party insurance coverage. This ensures that schools remain in compliance with IDEA requirements.

If the LEA obtains evidence that the existing health insurance does not cover IEP, IFSP, IHP, BIP or 504 Plan required health services, Medicaid may be billed for those services. The "free and appropriate education" requirements of the North Carolina Department of Public Instruction are satisfied if pertinent information regarding the contact with the third-party carrier is recorded.

D. Modifiers

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Timed units billed must meet CMS regulations:

1 unit: ≥8 minutes through 22 minutes
2 units: ≥23 minutes through 37 minutes
3 units: ≥38 minutes through 52 minutes
4 units: ≥53 minutes through 67 minutes
5 units: ≥68 minutes through 82 minutes
6 units: ≥83 minutes through 97 minutes
7 units: ≥98 minutes through 112 minutes
8 units: ≥113 minutes through 127 minutes

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 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 teachers to collect assessment data from inventories, surveys, and questionnaires.

Evaluation 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, 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 beneficiary, 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 teachers must be provided to facilitate carry-over of treatment objectives into the child's daily routine.

Treatment services are not consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance or monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, 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

The service must be performed at the location identified on the IEP, IFSP, IHP, BIP or 504 Plan.

Telehealth claims should be filed with the provider's usual place of service code(s)

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:

https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

Co-payments are not required for Local Education Agencies.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

Payment is calculated based on the lower of the billed usual and customary charges and Medicaid's maximum allowable rate. Providers shall bill their usual and customary charges. A cost-based methodology is used for all LEAs. Cost-based methodology will consist of a cost report, time study and reconciliation. If payments exceed Medicaid-allowable costs, the provider will remit the federal share of the overpayment at the time the cost report is submitted; and if the actual, certified costs of an LEA provider exceed the interim payments, NC Medicaid will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.