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Related Clinical Coverage Policies
Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:
10A, *Outpatient Specialized Therapies*
5A, *Durable Medical Equipment*

1.0 Description of the Procedure, Product, or Service

An Independent Practitioner Provider is an individual or group of individuals who are licensed in the field of occupational therapy, physical therapy, audiology, respiratory therapy, or speech/language pathology and who are not providing services through an institutional provider (Child Development Service Agency (CDSA), Home Health Agency, Hospital, or Local Education Agency (LEA)) or are not employed by a physician's office. The covered services are assessments and treatments performed by qualified Independent Practitioner (IP) service providers from the following disciplines:

1.1 Audiology Services

1.1.1 Assessment

All assessments shall yield a written evaluation report. This service may include testing and clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas:

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

1.1.2 Treatment

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

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

1.2 Speech/Language (ST) Services

1.2.1 Assessment

All assessments shall yield a written evaluation report. This service may include testing and clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas:

a. expressive language;
b. receptive language;
c. auditory processing, discrimination, and memory;

d. augmentative and alternative communication;
e. vocal quality
f. resonance patterns;
g. articulation/phonological development;
h. pragmatic language;
i. rhythm/fluency;
j. oral mechanism/swallowing; or
k. hearing status based on pass/fail criteria.

1.2.2 Treatment

This service may include one or more of the following, as appropriate:
a. articulation/phonological training;
b. language therapy;
c. augmentative and alternative communication training;
d. auditory processing/discrimination training;
e. fluency training;
f. voice therapy;
g. oral motor training; swallowing therapy; or
h. speech reading (cued speech and lip reading).

1.3 Occupational Therapy (OT) Services

1.3.1 Assessment

All assessments shall yield a written evaluation report. This service may include testing and clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas:
a. activities of daily living assessment;
b. sensorimotor assessment;
c. neuromuscular assessment;
d. fine motor assessment;
e. feeding/oral motor assessment;
f. visual perceptual assessment;
g. perceptual motor development assessment;
h. musculo-skeletal assessment;
i. gross motor assessment; or
j. functional mobility assessment.

1.3.2 Treatment

This service may include one or more of the following, as appropriate:
a. activities of daily living training;
b. neuromuscular development;
c. muscle strengthening, endurance training;
d. feeding/oral motor training;
e. adaptive equipment application;
f. visual perceptual training;
g. facilitation of gross motor skills;
h. facilitation of fine motor skills;
i. fabrication and application of splinting and orthotic devices;

j. manual therapy techniques;
k. sensorimotor training;
l. pre-vocational training;
m. functional mobility training; or
n. perceptual motor training.

1.4 Physical Therapy (PT) Services

1.4.1 Assessment

All assessments shall yield a written evaluation report. This service may include testing and clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas:

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

1.4.2 Treatment

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

a. manual therapy techniques;
b. fabrication and application of orthotic device;
c. therapeutic exercise;
d. functional training;
e. facilitation of motor milestones;
f. sensory motor training;
g. cardiac training;
h. pulmonary enhancement;
i. adaptive equipment application;
j. feeding/oral motor training;
k. activities of daily living training;
l. gait training;
m. posture and body mechanics training;
n. muscle strengthening;
o. gross motor development;
p. modalities;
q. therapeutic procedures;

r. hydrotherapy;
s. manual manipulation; or
t. wheelchair management.

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 or NCHC 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.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>

Medicaid beneficiaries with a need for specialized therapy services confirmed by a licensed Medical Doctor, (MD), Doctor of Podiatric Medicine, (DPM), Doctor of Osteopathic Medicine, (DO), Physician Assistant, (PA), Nurse Practitioner, (NP) or Certified Nurse Midwife, (CNM) are eligible to receive specialized therapies.
Note: There is a required referral process for a beneficiary who is enrolled through the Carolina ACCESS (CA) program.

Note: Medicare beneficiaries are exempt from this policy.

b. <u>NCHC</u>

NCHC beneficiaries with a need for specialized therapy services confirmed by a licensed Medical Doctor, (MD), Doctor of Podiatric Medicine, (DPM), Doctor of Osteopathic Medicine, (DO), Physician Assistant, (PA), Nurse Practitioner, (NP) or Certified Nurse Midwife, (CNM) are eligible to receive specialized therapies.
Note: There is a required referral process for a beneficiary who is enrolled through the Carolina ACCESS (CA) program.

Note: Medicare beneficiaries are exempt from this policy.

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: http://www.ncdhhs.gov/dma/epsdt/

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

The Division of Medical Assistance (DMA) 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 DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when 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.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover medically necessary outpatient specialized therapies when the beneficiary meets the criteria as recommended by the authoritative bodies (national standards, best practice guidelines, etc.) for each discipline.

3.2.2 Physical Therapy

Medicaid and NCHC 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.

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

functional impairment that impedes ability to participate in productive activities.

3.2.3 Occupational Therapy

Medicaid and NCHC accept the medical necessity criteria for 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.

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

3.2.4 Speech/Language-Audiology Therapy

Medicaid and NCHC accept the medical necessity criteria most recently recommended for Speech/Language-Audiology therapy treatment as follows:

a. CMS Publication 100-3 Medicare National Coverage Determinations Manual 170.3-Speech Language Pathology Services for the Treatment of Dysphagia (Rev.55, Issued: 05-05-06, Effective :10-01-06, Implementation: 10-2-06 and subsequent updates) and Publication 100-2 The Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, Sections 220 and 230.3 (Rev 36, Issued:06-24-05, Effective: 06-06-05, Implementation:06-06-05 and subsequent updates) These publications can be found at http://www.cms.hhs.gov/manuals/IOM/list.asp;

b. American Speech-Language-Hearing Association (ASHA) guidelines regarding bilingual services (http://www.asha.org) Position Statement *Clinical Management of Communicatively Handicapped Minority Language Populations*;

c. Medicaid beneficiaries, birth to 21 years of age, and NC Health Choice beneficiaries six (6) through 18 years of age who meet the following criteria:

Language Impairment Classifications **Infant/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% - 24% delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd – 6th percentile, **or** • A language quotient or standard score of 70 – 77, **or** • A 25% - 29% delay on instruments which determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A 30% or more delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

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 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 and NCHC Beneficiaries 6 through 18 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7^{th} – 15^{th} 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 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 2^{nd} – 6^{th} percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1 year, 7 month to 2 year delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2^{nd} percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation/Phonology Impairment Classifications Medicaid Beneficiaries, birth through 20 Years of Age, and NCHC Beneficiaries 6 through 18 Years of Age	
Mild	• Standard scores 1 to1.5 standard deviations below the mean, **or** • Scores in the 7th – 15th percentile, **or** • One phonological process that is not developmentally appropriate, with a 20% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary is expected to have few articulation errors, generally characterized by typical substitutions, omissions, and/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% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary typically has 3 - 5 sounds in error, which are one year below expected development. Error patterns may be atypical. Intelligibility is affected and conversational speech is occasionally unintelligible.
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% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, **or** • Additional documentation of examples indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. 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% criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5% - 10% of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of 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 a beneficiary develops 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, gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: The service delivery may be raised to the higher level when: the percentage of stuttered words and the duration fall in a lower severity rating, 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-b ball.). • Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet). • Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.
The following information may be helpful in monitoring beneficiaries for fluency disorders. This information indicates dysfluencies that are considered typical in beneficiaries, 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.

d. **Augmentative and Alternative Communication** (AAC) standards for treatment from ASHA *Augmentative Communication Strategies*, volume II, 1988 and any subsequent editions.
The criteria must:

1. define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment.
2. not override or replace existing limits on coverage for services, either as dollar amounts or as acceptable billing codes.

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

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

AAC treatment codes are used for the following:

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

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

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

Possible reasons to request authorization for additional treatment include:

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

3.2.5 Audiology Therapy (Aural Rehabilitation) Practice Guidelines

The basis for audiology referral is the presence of:

a. any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation assessment; or
b. impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.
a. A beneficiary must have one or more of the following deficits to initiate therapy:Hearing loss (any type) >25 dBHL at 2 or more frequencies in either ear;
b. Standard Score more than 1 SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing;
c. Impaired or compromised auditory processing abilities as documented on the basis of the results of a central auditory test battery; or
d. Less than 1-year gain in skills (auditory, language, speech, processing) during a 12-month period of time.

Underlying Referral Premise

Aural rehabilitation includes:

a. facilitates receptive and expressive communication of individuals with hearing loss, or,
b. achieves improved, augmented or compensated communication processes, or,
c. improves auditory processing, listening, spoken language processing, overall communication process; or,
d. benefits learning and daily activities.

Evaluation – Audiologic (Aural) Rehabilitation

Service delivery requires the following elements:

The provider shall check the functioning of hearing aids, assistive listening systems and devices, and sensory aids prior to the assessment.

Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary's skills (in both clinical and natural environments) for the following:

a. medical and audiological history;
b. reception, comprehension, and production of language in oral, signed or written modalities;
c. speech and voice production;
d. perception of speech and non-speech stimuli in multiple modalities;
e. listening skills;
f. speech reading (cued speech and lip reading); and
g. communication strategies.

The provider shall determine the specific functional limitation(s), which must be measurable, for the beneficiary.

Evaluation – Central Auditory Processing Disorders (CAPD)

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

Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary for the following:

a. communication, medical, educational history.
b. central auditory behavioral tests. Types of central auditory behavioral tests include:
    1. Tests of temporal processes.
    2. Tests of dichotic listening.
    3. Low redundancy monaural speech tests.

4. Tests of binaural interaction.

c. central auditory electrophysiologic tests include:
   1. Auditory brainstem response (ABR);
   2. Middle latency evoked response (MLR);
   3. N1 and P2 (late potentials) responses and P300;
   4. Mismatched negativity (MMN);
   5. Middle ear reflex; and
   6. Crossed suppression of otoacoustic emissions

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

   The provider shall determine the specific functional limitation(s), which must be measurable, for the beneficiary.

Functional Deficits

Functional deficits include a beneficiary's inability to:

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

Treatment Planning

The treatment plan is developed in conjunction with the beneficiary, caregiver and medical provider and considers performance in both clinical and natural environments. Language therapy treatments sessions shall not be billed concurrently with aural rehabilitation therapy treatment sessions. Treatment must be culturally appropriate. Short- and long-term functional communication goals and specific objectives are determined from assessment. The amount of time, place(s), and professional or lay person(s) involved must be designated. Generalization of skills and strategies is enhanced by extending practice to the natural environment through collaboration among key professionals. Goals and objectives shall be reviewed periodically to determine appropriateness and relevance and shall include measurable targets within these areas.

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

Long-term Goals: Decrease or eliminate functional deficit.

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

3.2.6 Discharge/Follow-up

Discharge

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

a. Beneficiary has achieved functional goals and outcomes.

b. Beneficiary's performance is within normal limits (WNL) for chronological age on standardized measures of language, speech, audition, and/or auditory processing; or.

c. Non-compliance with treatment plan (including caregiver).

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

Follow-Up

Readmittance of a beneficiary to an audiologic (aural) rehabilitation may result from changes in:

a. functional status;

b. living situation;

c. school or child care; or

d. caregiver, or personal interests.

3.2.7 Medicaid Additional Criteria Covered

None Apply.

3.2.8 NCHC Additional Criteria Covered

None Apply.

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 Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, and 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 medical necessity criteria listed in **Section 3.0;**

c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

e. therapy services are solely for maintenance.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover outpatient specialized therapies when the policy guidelines are not met. Prior approval is required before the start of any treatment services.

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

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

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 Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for all outpatient specialized therapies treatment visits. The provider shall obtain prior approval before rendering outpatient specialized therapies treatment visits.

5.2 Prior Approval Requirements

5.2.1 General

Prior approval is required prior to the start of all treatment services.

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request;
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy; and
c. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

Detailed information and instructions for registering and submitting requests is available on The Carolinas Center of Medical Excellence (CCME) website: https://www.medicaidprograms.org/NC/ChoicePA

5.2.2 Specific

Providers shall submit a request to DMA's vendor to start the approval process. Please note that approval, if granted, is for medical approval only and does not guarantee payment or ensure beneficiary eligibility on the date of service.

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

5.2.3 Physical and Occupational Therapy:

Physical and Occupational therapy services are limited to:

a. the maximum of the usual range of visits for a condition as published in the most recent edition of Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns or Occupational Therapy Practice Guidelines Series, or

b. the number of visits requested by the therapist, not to exceed a time limit of six (6) calendar months.

5.2.4 Speech/Language-Audiology Therapy:

a. Speech/Language and Audiology therapy services are limited to the need for services based upon the severity of the deficit:
   1. Mild Impairment range of visits: 6 – 26
   2. Moderate Impairment range of visits: Up to 46
   3. Severe Impairment range of visits: Up to 52,

or

b. the number of visits requested by the therapist, not to exceed a time limit of six (6) calendar months

c. Audiology: 30 to 60 minute sessions, 1 to 3 times a week, in increments of six (6) calendar months (up to 52 visits). Length of visit and duration are determined by the client's level of severity and rate of change.

5.3 Amount of Service

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

5.4 Other Limitations

5.4.1 Assessment Services

Each written evaluation report should include the diagnosis/statement of the problem including:

a. the primary medical diagnosis, if known;

b. a secondary treatment-related diagnosis; and

c. the recommendations for treatment.

The diagnosis should include a statement concerning the degree of severity of each condition exhibited by the patient. The report should also indicate whether the child has received any known assessments within the past six months for the type of service being billed.

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

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

Assessment services **do not include:**

a. interpretive conferences;
b. educational placement or care planning meetings; or
c. mass or individual screenings aimed at selecting children who may have special needs.

Note: Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service.

5.4.2 Treatment Services

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

a. Prior approval is required at the start of treatment services.
b. All services must be provided according to a written plan.
c. The written plan for services must include defined goals for each therapeutic discipline.
d. Each plan must include a specific content, frequency, and length of visits of services for each therapeutic discipline. Specific content refers to the therapy-specific intervention(s), including planned modalities, therapeutic techniques, and/or treatment approaches, requiring the skill of a licensed therapist and which target achievement of the stated goals (i.e., what the therapist plans to do to elicit patient responses)
e. A verbal or a written order must be obtained for services***** prior to the start of the services. Backdating is not allowed.

(*****Services are all therapeutic PT/OT/ST/RT activities **beyond** the entry evaluations. This includes recommendations for specific programs, providers, methods, settings, frequency, and length of visits.)

f. Service providers must review and renew or revise plans and goals no less often than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than six months after the most recent physician order signature date and before the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.

g. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original. 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. Stamped signatures are not permitted.

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

Treatment services **do not include:**

a. consultation activities;
b. specific objectives involving English as a second language; or
c. a treatment plan primarily dealing with maintenance/monitoring activities.

Note: Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

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

To be eligible to bill for 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.

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.

6.1 Audiology

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

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 NCGS Chapter 90, Article 22,

Licensure Act for Speech and Language Pathologists and Audiologists

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

6.2 Speech/Language

Eligible providers must have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists and an ASHA Certificate of Clinical Competence (CCC) in Speech/Language Pathology or there must be documentation that the service provider **has completed** the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech/Language Pathology CCC.

Treatment services can be performed by a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner.

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.

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 NCGS Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists

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

6.3 Occupational Therapy

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

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 GS Chapter 90, Article 18D Occupational Therapy also known as North Carolina Occupational Therapy Practice Act.

Title 21NCAC Chapter 38 Occupational Therapy

6.4 Physical Therapy

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

A qualified physical therapist defined under42 CFR § 440.110(a)(2), who meets the qualifications as specified under 42CFR § 484.4.

NCGS Chapter 90, Article 18B Physical Therapy

Title 21 NCAC Chapter 48 Physical Therapy Examiners

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries 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 DMA'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 must maintain and allow DMA to access the following documentation for each beneficiary:

a. The beneficiary name and Medicaid or NCHC identification number;
b. A copy of the treatment plan;
c. A copy of the MD, DO, DPM, CNM, PA, or NP's order for treatment services. Home Health services may only be ordered by an MD or DO;
d. Description of services (skilled intervention and outcome/client response) performed and dates of service. This element must be present in a note for each billed date of service;
e. The duration of service (i.e., length of assessment or treatment session in minutes). This element must be present in a note for each billed date of service;
f. The signature and credentials of the person providing each service. Each billed date of service must be individually documented and signed by the person providing the service;
g. A copy of each test performed or a summary listing all test results included in the written evaluation report;

h. Any other documentation relating to the financial, medical, or other records necessary to fully disclose the nature and extent of services billed to Medicaid or NCHC;

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

j. When medically necessary, missed dates of service may be rescheduled if completed within 30 calendar days of the missed visit and within the same prior authorization period. Make up sessions must be a separate date of service. When billing in timed units, additional units of time must not be added to subsequent date(s) of service that will then differ from the treatment time specified on the treatment plan or on the PA request. The rescheduled date of service documentation must reference the missed date of service.

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. Post-payment validation reviews are conducted using a statistically valid random sample from paid claims. Program Integrity reviews may be conducted in order to address specific complaint(s). Program Integrity or its Utilization Review Contractor may select records of the complainant and those of several other Medicaid beneficiaries when the claim appears similar in nature to the services billed on behalf of the complainant for post payment review. 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 DMA. 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/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.

7.3 Prepayment Claims Review

Therapy Providers may be subject to Prepayment Claims Review under NC General Statutes **§ 108C-7.**

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

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

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

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

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 2002

Revision Information:

Date	Section Revised	Change
01/01/03	8.2, Units of Service	Conversion to CPT codes
02/26/03	5.2, Treatment Services, item #4 7.1, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/03	3.0, When the Service is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/03	5.2, Treatment Services, item #3 5.2, Treatment Services, item #4	The phrase “intensity of services” revised to “length of visits.”
04/01/03	5.3, Prior Approval	Prior approval criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/03	8.2, Units of Service	End-dated codes replaced with CPT codes.
05/01/03	6.5, Respiratory Therapists	Updated licensure requirements for respiratory therapist; effective with date of policy publication 10/01/02.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform with billing guidelines; effective with date of publication 10/01/02.
06/01/03	8.4, Filing a Claim	Addition of V code diagnosis for treatment services and clarification of billing instructions.
07/01/03	3.4, Respiratory Therapy	Medical necessity criteria added for respiratory therapy.
07/01/03	5.3, Prior Approval Process	Respiratory therapy guidelines were added.
07/01/03	8.4, Filing a Claim	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/03	3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/03	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.

Date	Section Revised	Change
10/01/03	Section 5.3.2, item c, Speech/Language-Audiology Therapy	Item c was added to address prior approval for audiology.
12/01/03	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
1/1/05	Section 8.2, Physical Therapy Treatment	Code 97601 was end-dated
1/1/05	Section 8.2, Audiology Assessment	CPT code 92589 was end-dated and replaced with 92620 and 92621
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
1/1/06	Section 5.2 and 5.3	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
1/1/06	Section 8.2	CPT procedure code 95210 was end-dated and replaced with 92626, 92627, 92630 and 92633; 97504 was end-dated and replaced with 97760; 97520 was end-dated and replaced with 97761; 97703 was end-dated and replaced with 97762.
6/1/06	Section 8.2	CPT procedure codes 92626 and 92627 were deleted from the list of codes for Speech/Language Treatment and added to the list of codes for Speech/Language Assessment and Audiology Assessment.
7/1/06	Section 8.2	CPT code 97020 was deleted from the list of covered codes for Physical Therapy Treatment.
12/1/06	Section 2.3	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
1/1/07	Section 8.2	CPT code 94657 was end-dated and replaced with CPT code 99504.
3/1/07	Section 3.0	A reference was added to indicate that medical necessity is defined by the policy guidelines recommended by the authoritative bodies for each discipline.
3/1/07	Section 3.3	A reference to ASHA guidelines regarding bilingual services was added as a source of medical necessity criteria for Speech/Language-Audiology therapy treatment for Spanish speaking recipients
3/1/07	Section 5.2	Item 6.c. was updated to indicate that a request submitted for continuation of service must include documentation of the recipient's progress. Item 7 was corrected to comply with federal regulations. The note at the end of the section was deleted from the policy.

Date	Section Revised	Change
3/1/07	Section 5.3	This section was updated to indicate that prior approval is required after six unmanaged visits or the end of the six-month period. A reference was also added to indicate the prior approval requests may be submitted electronically.
3/1/07	Section 6.0	A reference to 42 CFR 440.110 and 440.185 was added to this section.
3/1/07	Section 7.1	Item 3 Physicians order clarified
3/1/07	Section 8.0	A reminder was added to this section to clarify that prior approval must be requested using the billing provider number and that services initiated through a CDSA are exempt from the prior approval requirement for six months and must, therefore, enter the date of the physician's order on the claim form.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age.
1/1/08	Section 8.2	Added CPT code 96125 (1 unit = 1 hour) to Occupational Therapy Assessment and Speech/Language Assessment.
9/1/08	Section 1.3.1	Removed "pre-vocational assessment" from list of services provided by occupational therapists.
1/1/09	Section 8.2	Added CPT code 95992 to physical therapy treatment group (annual code update).
12/01/09	Section 2.1	Moved first paragraph ("beneficiaries with a need for specialized therapy services") to follow standard statement.
12/01/09	Section 2.3	Added legal citation for EPSDT.
12/01/09	Sections 3.0, 4.0, & 6.0	Updated section titles to standard phrasing.
12/01/09	Section 3.1	Added standard section.
12/01/09	Section 3.2	Added title to existing criteria; changed "services" to "outpatient specialized therapies"; deleted Note on home health maintenance.
12/01/09	Section 3.2.4 (was 3.3), letter c	Changed the word "patients" to "recipients" and rephrased.
12/01/09	Section 3.2.5	In "Underlying Referral Premise," letter a, changed "individuals" to "recipients." In "Discharge/Follow-up," changed "client" to "recipient"; spelled out "within normal limits."
12/01/09	Section 3.2.5	Spelled out first appearance of IPP (Independent Practitioner Program); corrected age range.
12/01/09	Section 4.1	Added standard section.
12/01/09	Section 4.2	Added title to existing criteria; added the word "outpatient" before the phrase "specialized therapies"; deleted the word "following" from "policy guidelines."

Date	Section Revised	Change
12/01/09	Section 5.2	Added statement that prior approval is required at start of treatment services. Deleted the word "initial" from the introductory statement. Deleted letters f and g (information about 6 unmanaged visits vs. 6 months of service; information about evaluation and prior approval by Children's Developmental Services Agency).
12/01/09	Section 5.3	Changed section title to Prior Approval deleted The Carolinas Center for Medical Excellence; changed criteria from 6 visits or 6 months to 52 visits in 6 months; deleted paragraph on Medicaid's initial authorization; added instructions on requesting approval for visits.
12/01/09	Section 5.4	Added section title.
12/01/09	Section 5.4.1	Deleted information on home health maintenance physical therapy; added "medically necessary" before the word "visits"; deleted "requested by the therapist."
12/01/09	Section 6.0	Added standard paragraph about providers; updated and clarified language.
12/1/09	Section 7.1	Added standard statement about compliance and renumbered subsequent headings.
12/1/09	Section 7.2 (was 7.1)	Added DO and DPM as providers who may issue orders; changed "patient" to "recipient"; deleted requirement to keep copy of prior approval form.
12/1/09	Section 7.3 (was 7.2)	Changed title from "Utilization Reviews" to "Post-Payment Validation Reviews"; deleted "CCME," changed "may" to "will," and added the word "all"; added statement on post-payment reviews and follow-up; deleted examples of review topics.
12/1/09	Attachment A (was section 8.0)	Information moved to Attachment A –Claims Related Information
1/1/10	Attachment A	CPT codes 92550 and 92570 added to Audiology Assessment billable codes
7/1/2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, **Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."**
6/1/10	Throughout	Independent Practitioners Respiratory Therapy Services removed from this policy with the initial promulgation as separate policy of Policy 10D
1/1/12	Subsection 5.1	Added clarification regarding acceptable orders.
1/1/12	Section 6.0	Clarify who "can work under the direction/supervision of"
1/1/12	Subsection 7.2	Add credentials to requirement

Date	Section Revised	Change
3/12/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 10B under Session Law 2011-145, § 10.41.(b)
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
06/21/13	Section 8.0	Added Original Effective Date: "October 1, 2002" – which was inadvertently removed during policy revision.
12/01/2013	All Sections and Attachments	Replaced "recipient" with "beneficiary."
12/01/2013	Subsection 6.4	Removed statement, "Only therapy assistants may work under the direction of the licensed therapist."
01/01/2014	Section 1.0	Added statement, "An Independent Practitioner Provider is an individual or group of individuals who are licensed in the field of occupational therapy, physical therapy, audiology, respiratory therapy, or speech/language pathology and who are not providing services through an institutional provider (CDSA, Home Health Agency, Hospital, LEA) or are not employed by a physician's office."
01/01/2014	Subsection 7.2	Added statement, "j. All missed dates of service must be made up within 30 calendar days and within the same prior authorization period. Make up sessions must be a separate date of service. When billing in timed units, additional units of time must not be added to subsequent date(s) of service that will then differ from the treatment time specified on the treatment plan or on the PA request."
01/01/2014	Attachment A, C:	Deleted: 92506 (1 unit = 1 event)
01/01/2014	Attachment A, C:	Added: 92521 (1 unit = 1 event) 92522 (1 unit = 1 event) 92523 (1 unit = 1 event: 2 areas assessed) 92524 (1 unit = 1 event)
01/01/2014	Subsection 1.2.1	Added "one or more of"
01/01/2014	Subsection 1.2	Deleted: "Any of the above named areas of functioning may also be addressed as a specialized assessment, following performance of the overall evaluation for the child's speech/language skills."
01/01/2014	Subsection 5.4.1	Replaced: "contain a final summary listing" with "include." Replaced: "summary" with "report".
01/01/2014	Subsection 7.2	Replaced: "and" with "included in".
06/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.

Date	Section Revised	Change
06/01/2014	Subsection 3.2.1.1	Removed: ”beginning, continuing, and terminating treatment as published by the American Physical Therapy Association in their most recent edition of *Physical Therapy: Guide to Physical Therapist Practice, Part Two: Preferred Practice Patterns*.” Added: 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 3.2.1.2	Removed: “beginning, continuing, and terminating treatment as published by the American Occupational Therapy Association in their most recent edition of *Occupational Therapy Practice Guidelines Series*. Added: “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 3.2.1.3	Age ranges of groups more clearly defined in tables.
06/01/2014	Subsection 3.2.1.3	The following was removed: “The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each person’s preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual’s initiative, independence, and sense of personal responsibility and self-worth.”
06/01/2014	Section 3.2.1.4	Added: Language therapy treatments sessions shall not be billed concurrently with aural rehabilitation therapy treatment sessions.
06/01/2014	Section 4.1	Added: c. therapy services are solely for maintenance.
06/01/2014	Section 5.2	Removed: After 52 visits per beneficiary, per discipline, in a 6-month period, approval is required for continued treatment.

Date	Section Revised	Change
06/01/2014	Section 6.0	Removed: Physical therapists, occupational therapists, speech–language pathologists, and audiologists shall meet the qualifications according to 42 CFR 484.4 Added: 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.
06/01/2014	Subsection 6.1	**Added: Audiology** 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

Date	Section Revised	Change
06/01/2014	Section 6.2	Replaced: 1. valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists, and 2. an ASHA Certificate of Clinical Competence (i.e., CCC) in Speech/Language Pathology, or there must be documentation that the service provider **has completed:** the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech/Language Pathology CCC. With: a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists and an ASHA Certificate of Clinical Competence (CCC) in Speech/Language Pathology or there must be documentation that the service provider **has completed** the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech/Language Pathology CCC.
06/01/2014	Subsection 6.2	**Speech-Language** 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

Date	Section Revised	Change
06/01/2014	Subsection 6.1	Added: **Occupation Therapy** 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 Therapy** A qualified physical therapist defined under 42 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
06/01/2014	Subsection 7.1	Removed: Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements. Added: 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 DMA'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).
06/01/2014	Attachment A	Added: "Independent practitioner providers may only bill for services rendered to Medicaid beneficiaries under 21 years of age and NCHC beneficiaries under 19 years of age."
06/01/2014	Attachment A	Added applicable ICD-10 codes, effective 10/1/2015
10/01/2014	Subsection 7.2	Added to item (j.): Date of service documentation must include objective measures of any change in status associated with the missed visit(s) and medical necessity rationale for the make-up session(s).
12/01/2014	Subsection 5.2	Added correct hyperlink for requesting PA: https://www.medicaidprograms.org/NC/ChoicePA

Date	Section Revised	Change
12/01/2014	Subsection 7.2	Remove from Subsection 7.2 item (j.): Date of service documentation must include objective measures of any change in status associated with the missed visit(s) and medical necessity rationale for the make-up session(s). Add to Subsection 7.2 item (j): "The rescheduled date of service documentation must reference the missed date of service."
12/01/2014	Attachment A	Removed ICD-10 references
04/01/2015	All Sections and Attachments	Updated policy template language
04/01/2015	Subsection 3.2.1.3	Removed “adult” from the statement “Phonology Treatment Goals Based on Age of Acquisition of Adult Phonological Rules”
04/01/2015	Subsection 7.3	Clarified information regarding Post Payment Reviews
04/01/2015	Subsection 7.4	Added section regarding Pre-Payment Reviews
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.

Attachment A: Claims-Related Information

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

A. Claim Type

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

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

Providers are required to bill the primary diagnosis that justifies the need for the specialized therapy. **Remember: The primary treatment ICD-10-CMcode must be entered first on the claim form.**

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

All claims should be sent directly to EDS. Refer to NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

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

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

Refer to **Section 3.0, When the Procedure, Product, or Service is Covered,** and **Subsection 5.4.2, Treatment Services,** for additional information.

"Independent practitioner providers may only bill for services rendered to Medicaid beneficiaries under 21 years of age and NCHC beneficiaries under 19 years of age."

B. International Classification of Diseases, 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.

Audiology Assessment

Code	Unit of Service
92550	(1 unit = 1 event)
92551	(1 unit = 1 event)
92552	(1 unit = 1 event)
92553	(1 unit = 1 event)
92555	(1 unit = 1 event)
92556	(1 unit = 1 event)
92557	(1 unit = 1 event)
92567	(1 unit = 1 event)
92568	(1 unit = 1 event)
92569	(1 unit = 1 event)
92570	(1 unit = 1 test)
92571	(1 unit = 1 event)
92572	(1 unit = 1 event)
92576	(1 unit = 1 event)
92579	(1 unit = 1 event)
92582	(1 unit = 1 event)
92583	(1 unit = 1 event)
92585	(1 unit = 1 event)
92587	(1 unit = 1 event)
92588	(1 unit = 1 event)
92590	(1 unit = 1 event)
92591	(1 unit = 1 event)
92592	(1 unit = 1 event)
92593	(1 unit = 1 event)
92594	(1 unit = 1 event)
92595	(1 unit = 1 event)
92620	(1 unit = 60 min)

92621	(1 unit = each additional 15 min) must be billed with 92620
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626

Audiology Treatment

Code	Unit of Service
92630	(1 unit = 1 event)
92633	(1 unit = 1 event)

Speech/Language Assessment

Code	Unit of Service
92521	(1 unit = 1 event)
92522	(1 unit = 1 event)
92523	(1 unit = 1 event: 2 areas assessed)
92524	(1 unit = 1 event)
92551	(1 unit = 1 event)
92607	(1 unit = 1 event)
92608	(1 unit = 1 event)
92610	(1 unit = 1 event)
92612	(1 unit = 1 event)
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626
96125	(1 unit = 1 hour)

Speech/Language Treatment

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

Occupational Therapy Assessment

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

Occupational Therapy Treatment

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

Physical Therapy Assessment

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

Physical Therapy Treatment

Physical Therapy

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

Physical Therapy

Code	Unit of Service
97016	(1 unit = 1 event)
97018	(1 unit = 1 event)
97022	(1 unit = 1 event)
97024	(1 unit = 1 event)
97026	(1 unit = 1 event)
97028	(1 unit = 1 event)
97032	(1 unit = 15 minutes)
97033	(1 unit = 15 minutes)
97034	(1 unit = 15 minutes)
97035	(1 unit = 15 minutes)
97036	(1 unit = 15 minutes)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97124	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97602	(1 unit = 1 event)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

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.

D. Modifiers

Not Applicable

E. Billing Units

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

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

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

Treatment services are defined as therapeutic procedures addressing the observed needs of the patient, which are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, and/or teachers **should be included** in order to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible 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/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

F. Place of Service

Office, Home, School, through the Head Start program, and/or child care (i.e., regular and developmental day care) settings.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

Co-payments are not required for Independent Practitioner services.

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, see: http://www.ncdhhs.gov/dma/fee/