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.

Table of Contents

This clinical coverage policy has an effective date of April 1, 2023; 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*
10C, *Outpatient Specialized Therapies, Local Education Agencies (LEAs)*
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

An Independent Practitioner Provider (IPP) 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.

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 policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
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.

2.1.2 Specific

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

a. Medicaid

IPP providers may only render services to Medicaid beneficiaries under 21 years of age.

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/

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 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.

3.1.1 Telehealth Services

As outlined in **Attachment A** and in **Subsection 3.2.1.3.e**, 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,* on NC Medicaid's website at https://medicaid.ncdhhs.gov/

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover medically necessary outpatient specialized therapies when the service is ordered by a 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 when prior authorization is received.

3.2.1.1 Physical Therapy (PT)

Medicaid shall cover medically necessary outpatient physical therapy treatment when prior authorization is received. Refer to **Section 5.0.**

3.2.1.2 Occupational Therapy (OT)

Medicaid shall cover medically necessary outpatient occupational therapy treatment when prior authorization is received. Refer to **Section 5.0.**

3.2.1.3 Speech/ Language Therapy

Medicaid shall cover medically necessary outpatient speech language therapy treatment when prior authorization is received. Refer to **Section 5.0.**

a. Medically necessary treatment for oral phase, pharyngeal phase, or oropharyngeal phase dysphagia must document ANY of the following deficits.
    1. Evaluation findings must address ONE of the following deficits consistent with a dysphagia diagnosis:
        A. Coughing and choking while eating or drinking;
        B. Coughing, choking or drooling with swallowing;
        C. Wet-sounding voice;
        D. Changes in breathing when eating or drinking;
        E. Frequent respiratory infections;
        F. Known or suspected aspiration pneumonia;
        G. Masses on the tongue, pharynx or larynx;
        H. Muscle weakness, or myopathy, involving the pharynx;
        I. Neuromuscular degenerative disease likely to affect swallowing regardless of the presence of a communication difficulty;
        J. Medical issues that affect feeding, swallowing, and nutrition; or,
        K. Oral function impairment or deficit that interferes with feeding.

    2. The deficit findings listed in **Subsection 3.2.1.3.a** must be indicated through ONE of the following:
        A. Video fluoroscopic swallowing exam (VFSE), also sometimes called a modified barium swallow exam (MBS);
        B. Fiber optic endoscopic evaluation of swallowing (FEES); or
        C. Clinical feeding and swallowing evaluation.

b. For a beneficiary who is a minority language speaker, there is a continuum of proficiency in English.
    1. Determination of the minority language speaker's proficiency on the continuum must be documented as ONE of the following:
        A. Bilingual English proficient: a beneficiary who is bilingual and who are fluent in English or have greater control of English than the minority language;
        B. Limited English proficient: bilingual or monolingual beneficiary who is proficient in their native language but not English; or
        C. Limited in both English and the minority language: a beneficiary who is limited in both English and the minority language exhibit limited communication competence in both languages.
    2. Evaluation must include both objective and subjective measures to determine if the beneficiary is more proficient in either the English language or the minority language.

3. For speech and language therapy services to be medically necessary for a beneficiary who is a minority language speaker ALL the following criteria must be met:
   A. all speech deficits must be present in the language in which the beneficiary has the highest proficiency;
   B. all language deficits must be present in the language in which the beneficiary has the highest proficiency;
   C. the delivery of services must be in the language in which the beneficiary has the highest receptive language proficiency; and
   D. If the use of interpreters or translators is the only alternative, the speech-language pathologist or audiologist shall:
      i. Provide sufficient instruction to the interpreter or translator regarding the purposes, procedures and goals of the tests and therapy methods;
      ii. For each date of service, ensure that the interpreter or translator understands their role as it relates to the clinical procedures to be used and responses expected to address the goal;
      iii. Use the same interpreter or translator with a given beneficiary as consistently as possible; and
      iv. Use observation or other nonlinguistic measures as supplements to the translated measures: such as beneficiary's interaction with parents, peers, and pragmatic analysis.

c. The following criteria apply to Medicaid beneficiaries under 21 years of age:

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 7^{th} –15^{th} 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 demonstrates a 6 to 12-month developmental 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 developmental 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 developmental 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 1 year, 7 months to 2-year developmental 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 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	
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 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, 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 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 - 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 for Medicaid beneficiaries' birth through 20 years of age	
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 percent - 10 percent of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of Phonological Rules for Medicaid beneficiaries' birth through 20 years of age	
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
After age 5 years, 0 months	Gliding

Eligibility Guidelines for Stuttering for Medicaid beneficiaries' birth through 20 years of age	
Borderline/Mild	3 – 10 stuttered words per minute (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 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 for Medicaid beneficiaries' birth through 20 years of age
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 (such as, b-b-ball, but not b-b-b ball.). • Schwa is not perceived (such as, 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. Medically necessary treatment for the use of Augmentative and Alternative Communication (AAC) devices must meet the following criteria:
   1. Selection of the device must meet ALL 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 authorized 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.

e. Telehealth

1. A select set of speech and language evaluation and treatment interventions may be provided to a beneficiary using a telehealth delivery method as described in **Clinical Coverage Policy 1-H**. Telehealth delivery may be medically necessary when a beneficiary's medical condition is such that exposure to others should be avoided, or if their location is remote or underserved such that access to appropriately qualified providers is limited.
2. To ensure a beneficiary receives high quality care aligned with best practices, the following criteria must be considered when making decisions about providing care using a telehealth delivery method:
   A. Unless in-person care is contraindicated or unavailable, telehealth must be used as an adjunct to in-person care and not as a replacement.
   B. Telehealth must be used in the best interest of the beneficiary and not as a convenience for the therapist.
   C. Telehealth must never be used solely to increase therapist productivity.

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

3.2.1.4 Audiology Therapy (Aural Rehabilitation)

a. Medicaid shall cover medically necessary audiology services when the beneficiary demonstrates the following:
   1. the presence of any degree or type of hearing loss on the basis of the results of an audiological (aural) rehabilitation evaluation; or
   2. the presence of impaired or compromised auditory processing abilities based on the results of a central auditory test battery.

b. A beneficiary shall have ONE or more of the following deficits to initiate therapy:

1. hearing loss (any type) with a pure tone average greater than 25dB **HL** (decibels Hearing Level)**,** in either ear;
2. 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 on the basis of the results of a central auditory test battery; or
3. less than one -year gain in skills (auditory, language, speech, processing) during a period of 12-calendar months.

c. Aural rehabilitation consists of:
   1. facilitating receptive and expressive communication of a beneficiary with hearing loss;
   2. achieving improved, augmented or compensated communication processes;
   3. improving auditory processing, listening, spoken language processing, auditory memory, overall communication process; and
   4. benefiting learning and daily activities.

d. Evaluation for aural rehabilitation

   Service delivery requires the following elements:

   1. The provider shall check the functioning of hearing aids, assistive listening systems and devices, and sensory aids prior to the evaluation.
   2. 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, or manual language modalities;
      C. speech and voice production;
      D. perception of speech and non-speech stimuli in multiple modalities;
      E. listening skills;
      F. speech-reading; and
      G. communication strategies.
   3. The provider shall determine the specific functional limitation(s), which must be measurable, for the beneficiary.

e. Evaluation for 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:

   1. Communication, medical, and educational history;
   2. Medicaid shall cover the following Central auditory tests for the identification of CAPD:

A. auditory discrimination test;

B. auditory temporal processing and patterning test;

C. dichotic speech test;

D. monaural low-redundancy speech test;

E. binaural interaction test;

F. electroacoustic measures; and

G. electrophysiologic measures.

3. 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.

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

5. Functional deficits consist of 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 (such as siren, car horn, doorbell, baby crying, etc.);
   D. understand conversational speech (in person or via telephone);
   E. hear and understand teacher in classroom setting;
   F. hear and understand classmates during class discussion;
   G. hear and understand co-workers or supervisors during meetings at work;
   H. hear and process the super-segmental aspects of speech or the phonemes of speech; or
   I. localize sound.

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

3.2.1.5 Evaluation Services

Medicaid shall cover evaluation services when rendered by a qualified IPP. 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 to collect assessment data from inventories, surveys, and questionnaires. An evaluation visit also incorporates any immediate treatment warranted based on the evaluation results. No prior authorization is needed for evaluation visits or for treatment rendered as part of an evaluation visit.

3.2.1.6 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), and medical provider. 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 periodically 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 the following:

a. duration of the therapy treatment plan consisting of the start and end date (no more than six 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 therapy plan) for each therapeutic discipline.;
e. skilled interventions, methodology, procedures 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

3.2.1.7 Treatment services

Medicaid shall cover treatment services when rendered by qualified IPP. Treatment services are the **medically necessary** therapeutic PT, OT, ST, and Audiology procedures that occur after the initial evaluation has been completed. Treatment services must address the observed needs of the beneficiary and must be performed by the qualified service provider.

Treatment services must adhere to the following requirements:

a. A verbal or a written order must be obtained for services prior to the start of services. All verbal orders must contain the date and signature of the person receiving the order, must be recorded in the beneficiary's record and must be countersigned by the physician within 60 calendar days. All verbal orders are valid up to six months from the documented date of **receipt**. All written orders are valid up to six months from the date of the physician's signature. Backdating is not allowed.
b. All services must be provided according to a treatment plan that meets the requirements in **Subsection 3.2.1.6**.

c. Service providers shall review and renew or revise treatment plans and goals no less often than every six calendar months.

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

e. For a Local Education Agency (LEA), the prior approval process is deemed met by the Individualized Education Program (IEP), Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP), or 504 Plan processes. An LEA provider shall review, renew and revise the IEP, IFSP, IHP, BIP or 504 Plan annually along with obtaining a dated physician order with signature. The 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 goals by the end of the school year.

f. 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. Stamped signatures are not permitted.

Instructional training of the beneficiary, parent(s) or legal guardian(s) that incorporates activities and strategies to target the goals and facilitate progress must be considered when appropriate for the therapeutic place of service.

3.2.1.8 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 to collect assessment data from inventories, surveys, and questionnaires. When continued treatment is medically necessary, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report.

3.2.1.9 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 (abilities and deficits);
2. living situation;
3. school or childcare; or
4. personal interests.

3.2.1.10 Respiratory Therapy (RT)

Refer to clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services* on NC Medicaid's website at https://medicaid.ncdhhs.gov/.

3.2.2 Medicaid 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 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.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover Outpatient specialized therapies when:

a. the beneficiary does not meet the policy guidelines in **Section 3.0**, and
c. therapy services are solely for maintenance.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

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 shall require prior approval for all outpatient specialized therapies treatment visits. The provider shall obtain prior approval before rendering outpatient specialized therapies treatments. To obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.

Retroactive prior approval is considered when a beneficiary, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Exceptions **may apply**.

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://choicepa.medicaidprograms.org.

5.2.2 Specific

To obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.

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

For prior approval, a written report of an evaluation must occur within **three months** of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report.

Note: Services to a Medicare beneficiary must follow applicable Medicare policy. Prior authorization is not required for treatment provided to a Medicare beneficiary.

5.3 Medical Necessity Visit Guidelines for Beneficiaries Under 21 Years of Age

5.3.1 Physical and Occupational Therapy

Physical and Occupational therapy services are limited to the number of medically necessary visits within an authorization period. An authorization period cannot exceed a time-frame of six calendar months.

5.3.2 Speech-Language and 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
b. Speech-Language and Audiology therapy services are limited to the number of medically necessary visits within an authorization period. An authorization period cannot exceed a time-frame of six calendar months .
c. Audiology: 30- to 60-minute sessions, one to three times a week, in increments of six calendar months. Length of visit and duration are determined by the beneficiary's level of severity and rate of change.

5.3.3 Respiratory Therapy

Refer to clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services* on NC Medicaid's website at https://medicaid.ncdhhs.gov/.

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 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 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 licensing 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.

Speech-language pathologists in their clinical fellowship year may work under the supervision of a licensed speech-language pathologist. The supervising speech-language pathologist is the biller of the service.

Laws and Regulations for each therapy discipline:

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

Physical Therapist

A qualified physical therapist defined under 42 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 42CFR § 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

6.2 Provider Certifications

None Apply.

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 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 name and Medicaid identification number;

b. A copy of the treatment plan;

c. 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;

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

e. The duration of service (length of evaluation or treatment session **in minutes**) 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; and

i. When medically necessary, missed dates of service may be rescheduled if completed within 30 calendar days after 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. 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.

7.4 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 any provider are the same type of health-related services the beneficiary concurrently receives as part of the public school's special education program, or as part of an early intervention program (that is, Head Start, early childhood intervention service or developmental day care program), services cannot be provided on the same day.

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.
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.
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."
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 C
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
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.
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.
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, 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
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
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
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.
06/01/2017	Subsection 1.0	Added: The IPP provider may only render services to beneficiaries **under** 21 years of age.
06/01/2017	Subsection 1.1, 1.2, 1.3 and 1.4	Removed subsection 1.1, 1.2, 1.3 and 1.4.
06/01/2017	Subsection 3.2.1	Added: Medicaid and NCHC shall cover medically necessary outpatient specialized therapies when the service is ordered by a 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 and when prior authorization is received.
06/01/2017	Subsection 3.2.1.1	Added: Medicaid and NCHC may cover medically necessary outpatient physical therapy treatment if prior authorization is received.
06/01/2017	Subsection 3.2.1.2	Added: Medicaid and NCHC may cover medically necessary occupational therapy treatment if prior authorization is received.
06/01/2017	Subsection 3.2.1.3	Added: Medicaid and NCHC may cover medically necessary outpatient speech-language and audiology therapy treatment if prior authorization is received.
06/01/2017	Subsection 3.2.1.3	Removed: 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
06/01/2017	Subsection 3.2.1.3	Added specific guidelines for dysphagia therapy and speech therapy services for minority language speakers. Added guidelines for augmentative communication therapy and aural rehabilitation therapy.
06/01/2017	Subsection 3.2.1.5	Subsection added: "Evaluation Services"
06/01/2017	Subsection 3.2.1.6	Defined the components of the Treatment Plan
06/01/2017	Subsection 3.2.1.7	Subsection added: "Treatment Services"
06/01/2017	Subsection 3.2.1.8	Subsection added: "Re-Evaluation Services"
06/01/2017	Subsection 3.2.1.9	Removed: c. non-compliance with treatment plan (including

		caregiver). Added: 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).
06/01/2017	Subsection 5.1	Added: In order to obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.
06/01/2017	Subsection 5.2.2	Removed: For occupational therapy (OT) and physical therapy (PT), an 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.
06/01/2017	Subsection 5.2.2	Added: For occupational therapy (OT) and physical therapy (PT), an evaluation must occur within 6 months of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation summary of the child's status and performance must be documented. The re-evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable. Added: For audiology services (AUD) and speech/language services (ST) prior approval: The re-evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.
06/01/2017	Subsection 5.3	Revised section 5.3.1, 5.3.2 and added Subsection 5.3.3
06/01/2017	Subsection 6.0	Added: To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall: d. meet Medicaid or NCHC qualifications for participation; d. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and e. bill only for procedures, products, and services that are within the scope of their clinical practice as defined by the appropriate licensing entity. NCHC covers medically necessary outpatient specialized therapies when provided by any allowable outpatient provider.
06/01/2017	Subsection 6.1	Added: The physical therapist, occupational therapist, speech-language pathologist, and audiologist shall comply with their 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 licensing 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. Speech- language pathologists in their clinical fellowship year may work under the supervision of a licensed speech-language pathologist. The supervising speech-language pathologist is the biller of the service. **Laws and Regulations for each therapy discipline:** **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 under 42 CFR § 440.110(a)(2), who meets the qualifications as specified under 42 CFR § 484.4. G.S. Chapter 90, Article 18B Physical Therapy Title 21 NCAC, Chapter 48 Physical Therapy Examiners
06/01/2017	Subsection 6.1	**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
06/01/2017	Subsection 6.2	Added: c. 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;
06/01/2017	Subsection 7.3	Added: 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. DMA 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 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 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.
06/01/2017	Subsection 7.5	Added: If treatment services provided by any provider are the same type of health-related services the beneficiary concurrently receives as part of the public school's special education program, or as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program), the combined frequency of services must be medically necessary to address the beneficiary's deficits. The provider must document on the PA request as well as on the Treatment Plan the frequency at which the beneficiary receives the same type of health-related treatment services provided as part of the public school's special education program or as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program). Services may not be provided on the same day.
06/01/2017	All Sections and Attachments	Replaced "assessment" with "evaluation".
06/01/2017	Attachment A Section A	Removed: 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. Added: Prior approval must be obtained under the same NPI for which the service(s) will be billed. Removed: Providers are required to bill the primary diagnosis that justifies the need for the specialized therapy. **Remember: The primary treatment ICD-10-CM code must be entered first on the claim form.** Removed: All claims should be sent directly to DMA's fiscal agent. 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 **Section 3.0, When the Procedure, Product, or Service is Covered,** and **Subsection 5.4.2, Treatment Services,** for additional information.
06/01/2017	Attachment A Section E.	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
07/21/2017	Attachment A	Replaced Codes inadvertantly deleted during amendment process. No change to Amended Date.
02/15/2019	Attachment A, Section E	Removed a strikethrough ~~/or~~ that was overlooked in the amendment process. No change to Amended Date.
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.
06/01/2019	Subsection 3.2.1.7	Added to first paragraph: Medicaid and NCHC shall cover treatment services when rendered by qualified IPP. Added to criterion e. Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP), or 504 Plan. Revision is effective 10/01/2018.
06/01/2019	Subsection 5.2.2	Added: IFSP, IHP, BIP or 504 Plan processes. Revision is

		effective 10/01/2018.
06/01/2019	Related Clinical Coverage Policies	Added: 5A-1, *Physical Rehabilitation Equipment and Supplies*
06/01/2019	Subsection 1.0	Moved: The IPP provider may only render services to Medicaid beneficiaries **under** 21 years of age and NCHC beneficiaries 6 through 18 years of age. The covered services are evaluation and treatments performed by qualified Independent Practitioner (IP) service providers to Section 2.1.2
06/01/2019	Subsection 3.2.1.3. (a)(1)(I)	Updated citerion I. to read: Neuromuscular degenerative disease likely to affect swallowing regardless of the presence of a communication difficulty;
06/01/2019	Subsection 3.2.1.5	Added: An evaluation visit also incorporates any immediate treatment warranted based on the evaluation results. No prior authorization is needed for evaluation visits or for treatment rendered as part of an evaluation visit.
06/01/2019	Subsection 3.2.1.6 (h)	Removed criterion h.: the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable; and
06/01/2019	Subsection 3.2.1.8	Removed: The re-evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.
06/01/2019	Subsection 5.1	Added: To obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.
06/01/2019	Subsection 5.2	Corrected hyperlink for requesting PA: https://choicepa.medicaidprograms.org
06/01/2019	Subsection 5.2.2	Removed: **For occupational therapy (OT) and physical therapy (PT) prior approval**, a written report of an evaluation must occur within **six (6) months** of the requested beginning date of treatment. Added: **For prior approval**, a written report of an evaluation must occur within **three months** of the requested beginning date of treatment.
06/01/2019	Subsection 5.2.2	Removed the statement: The re-evaluation report must document the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program, when applicable.
06/01/2019	Subsection 5.2.2	Removed the paragraph: **For audiology services (AUD) and speech/language services (ST) prior approval**, a written report of an evaluation must occur within six **(6) months** of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation

		report. The re-evaluation report must document include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.
06/01/2019	Subsection 6.1	Updated references to Federal Register qualifications for OT, PT, SLP and audiology.
06/01/2019	Subsection 7.5	Removed the statement: the combined frequency of services must be medically necessary to address the beneficiary's deficits. Removed the statement: The provider must document on the PA request as well as on the Treatment Plan the frequency at which the beneficiary receives the same type of health-related treatment services provided as part of the public school's special education program or as part of an early intervention program (that is, Head Start, early childhood intervention service or developmental day care program).
06/01/2019	Attachment A, Section C	Removed end-dated CPT code 97762 and replaced it with CPT code 97763.
06/01/2019	Attachment A, Section E	Removed: **Evaluation services** are 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 teachers as a means to collect assessment data from inventories, surveys, and questionnaires. Added: **Evaluation services:** refer to Subsection 3.2.1.5.
06/01/2019	Attachment A, Section E	Added: Billing for co-treatment services, therapy treatment services provided by OT and PT for a single Medicaid or NCHC beneficiary as a single visit, must not exceed the total amount of time spent with the beneficiary. OT and PT must split the time and bill only timed CPT codes. Co-treatment visits including speech therapy must be at least 38 minutes in session length to bill both one event of speech therapy and one unit of a timed CPT code for occupational or physical therapy. Additional timed CPT codes for occupational or physical therapy may be billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment.
01/01/2020	Attachment A, Section C	Removed end dated occupational and physical therapy evaluation CPT codes 95831, 95832, 95833 and 95834, effective 12/31/19.
01/01/2020	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."
01/01/2020	Attachment A, Section C	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
01/01/2021	Attachment A, Section C	Removed end-dated CPT code 92585 and replaced it with CPT

		codes 92652 and 92653.
07/01/2021	Related Clinical Coverage Policies	Added references to clinical coverage policies 10C, *Outpatient Specialized Therapies, Local Education Agencies (LEAs)* and 1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring.*
07/01/2021	Subsection 3.1.1	Added the following language: "As outlined in Attachment A and in Subsection 3.2.1.3.e, 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."
07/01/2021	Subsection 3.2.1.3	Added guidance for the delivery of select speech and language evaluation and treatment interventions using telehealth.
07/01/2021	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.
07/01/2021	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 was provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.
07/01/2021	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)
10/1/2022	Subsection 3.2.1.3 e. 1	Removed: "access to transportation is inconsistent"
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.

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:

A. Claim Type

Separate CMS-1500/837P transaction claim forms must be filed for evaluation 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.

Prior approval must be obtained under the same NPI for which the service(s) will be billed.

Procedures must 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.

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

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

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

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.

Audiology Evaluation

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)
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)
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
92652	(1 unit = 1 event)
92653	(1 unit = 1 event)

Audiology Treatment

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

Speech/Language Evaluation

Code	Unit of Service	Telehealth Eligible Service
92521	(1 unit = 1 event)	Yes
92522	(1 unit = 1 event)	Yes
92523	(1 unit = 1 event: 2 areas assessed)	Yes
92524	(1 unit = 1 event)	Yes
92551	(1 unit = 1 event)	No
92607	(1 unit = 1 event)	Yes
92608	(1 unit = 1 event)	Yes
92610	(1 unit = 1 event)	No
92612	(1 unit = 1 event)	No
92626	(1 unit = 60 min)	No
92627	(1 unit = each additional 15 min) must be billed with 92626	No
96125	(1 unit = 1 hour)	No

Speech/Language Treatment

Code	Unit of Service	Telehealth Eligible Service
92507	(1 unit = 1 event)	Yes
92508	(1 unit = 1 event)	No
92526	(1 unit = 1 event)	Yes (oral motor only)
92609	(1 unit = 1 event)	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 Evaluation

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

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)
97763	(1 unit = 15 minutes)

Physical Therapy Evaluation

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

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

Code	Unit of Service
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)
97763	(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

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 communications or remote patient monitoring.

E. Billing Units

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

Refer to lists in **Attachment A: Section C**.

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

Evaluation services: refer to **Subsection 3.2.1.5**.

Evaluation services are not 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 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 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 teachers **should be included** to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis except for speech/language services, which include group speech therapy with a maximum total number (that is both non-eligible and Medicaid-eligible beneficiaries) of four children per group.

Treatment services are not 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 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.

Billing for co-treatment services, therapy treatment services provided by OT and PT for a single Medicaid beneficiary as a single visit, must not exceed the total amount of time spent with the beneficiary. OT and PT must split the time and bill only timed CPT codes. Co-treatment visits including speech therapy must be at least 38 minutes in session length to bill both one event of speech therapy and one unit of a timed CPT code for occupational or physical therapy. Additional timed CPT codes for occupational or physical therapy may be billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment.

F. Place of Service

Office, Home, School, through the Head Start program, and childcare (regular and developmental day care) settings.

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/meetings-notices/medicaid-state-plan-public-notices

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: https://medicaid.ncdhhs.gov/