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Related Clinical Coverage Policies
Refer to http://dma.ncdhhs.gov for the related coverage policies listed below:
3A, *Home Health Services*
5A, *Durable Medical Equipment*
10B, *Independent Practitioners*
10C, *Local Education Agencies*
10D, *Independent Practitioners Respiratory Therapy Services*

1.0 Description of the Procedure, Product, or Service

Outpatient specialized therapies consist of evaluations, re-evaluations, and multidisciplinary evaluations as well as therapeutic physical, occupational, speech, respiratory, and audiology services provided by all provider types and in all settings except hospital and rehabilitation inpatient settings.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only ONE of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)
Medicaid
None Apply.
NCHC
None Apply.

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 clinician).

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

EPSDT provider page**:** http://dma.ncdhhs.gov

2.2.2 EPSDT does not apply to NCHC beneficiaries

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

The Division of Medical Assistance (DMA) shall deny the claim for coverage for a NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for a NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid and NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover medically necessary outpatient specialized therapies when the 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. Home Health services may only be ordered by an MD or DO.

3.2.1.1 Physical Therapy (PT)

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

3.2.1.3 Speech Language Therapy (ST)

Medicaid and NCHC 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 contain documented findings.
    1. These 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. Neurologic disorders likely to affect swallowing;
        J. Medical issues that affect feeding, swallowing, and nutrition; or,
        K. Oral function impairment or deficit that interferes with feeding.

    2. These findings 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 is fluent in English or has greater control of English than the minority language;
        B. **Limited English proficient:** a bilingual or monolingual beneficiary who is proficient in his or her 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 exhibits limited communication competence in both languages.

2. Evaluation must contain 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 must:
      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, the provider must ensure the interpreter or translator understands his or her 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 (1) beneficiary's interaction with parents, (2) beneficiary's interaction with peers, (3) pragmatic analysis.

c. The following criteria apply to Medicaid beneficiaries under 21 years of age and to NCHC beneficiaries between the ages of six (6) through 18 years

Language Impairment Classifications Infant/Toddler – Medicaid Beneficiaries Birth to 3 Years	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th –15th percentile, **or** • A language quotient or standard score of 78 – 84, **or** • A 20% - 24% delay on instruments that determine scores in months, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd – 6th percentile, **or** • A language quotient or standard score of 70 – 77, **or** • A 25% - 29% delay on instruments which determine scores in months, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A 30% or more delay on instruments that determine scores in months, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications Medicaid Beneficiaries –3 – 5 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th – 15th percentile, **or** • A language quotient or standard score of 78 – 84, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12 month delay, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd – 6th percentile, **or** • A language quotient or standard score of 70 – 77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13 to 18 month delay, **or** • Additional documentation 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 indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications Medicaid Beneficiaries 5 through 20 Years of Age and NCHC Beneficiaries 6 through 18 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th – 15th percentile, **or** • A language quotient or standard score of 78 – 84 **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrate a 1 year to 1 year, 6 month delay, **or** • Additional documentation 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 month to 2 year delay, **or** • Additional documentation 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 indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation/Phonology Impairment Classifications Medicaid Beneficiaries birth through 20 Years of Age and NCHC Beneficiaries 6 through 18 Years of Age	
Mild	• Standard scores 1 to1.5 standard deviations below the mean, **or** • Scores in the 7th – 15th percentile, **or** • One phonological process that is not developmentally appropriate, with a 20% occurrence, **or** • Additional documentation indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary is expected to have few articulation errors, generally characterized by typical substitutions, omissions, or distortions. Intelligibility not greatly affected but errors are noticeable.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd – 6th percentile, **or** • Two or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21% - 40% occurrence, **or** • Additional documentation indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary typically has 3 - 5 sounds in error, which are one year below expected development. Error patterns may be atypical. Intelligibility is affected and conversational speech is occasionally unintelligible.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, **or** • Additional documentation 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 are evident. Conversational speech is generally unintelligible.

Articulation Treatment Goals Based on Age of Acquisition	
Age of Acquisition	**Treatment Goal(s)**
Before Age 2	Vowel sounds
After Age 2, 0 months	/m/, /n/, /h/, /w/, /p/, /b/
After Age 3, 0 months	/f/, /k/, /g/, /t/, /d/
After Age 4, 0 months	/n/, /j/
After Age 5, 0 months	voiced th, sh, ch, /l/, /v/, j
After Age 6, 0 months	/s/, /r/, /z/, /s/ blends, /r/ blends, vowelized /r/, voiceless th, /l/ blends
In using these guidelines for determining eligibility, total number of errors and intelligibility must be considered. A 90% criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5% - 10% of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of Phonological Rules	
Age of Acquisition	**Treatment Goal(s)**
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
When a beneficiary develops idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and must be addressed in therapy. Minor processes or secondary patterns including 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 and vocalization, cluster reduction
After age 5 years, 0 months	Gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: The service delivery may be raised to the higher level when: the percentage of stuttered words and the duration fall in a lower severity rating, and the presence of physical characteristics falls in a higher severity rating.	

Differential Diagnosis for Stuttering

Characteristics of normally dysfluent beneficiaries:

- Nine dysfluencies or less per every 100 words spoken.
- Majority types of dysfluencies include: whole-word, phrase repetitions, interjections, and revisions.
- No more than two unit repetitions per part-word repetition (e.g., b-b-ball, but not b-b-b ball.).
- Schwa is not perceived (e.g., bee-bee-beet. is common, but not buh-buh-buh-beet).
- Little if any difficulty in starting and sustaining voicing; voicing or airflow between units is generally continuous; dysfluencies are brief and effortless.

The following information may be helpful in monitoring beneficiaries for fluency disorders. This information indicates dysfluencies that are considered typical in beneficiaries, crossover behaviors that may be early indicators of true stuttering and what characteristics are typical of true stutterers.

More Usual (Typical Dysfluencies)

- Silent pauses; interjections of sounds, syllables or words; revisions of phrases or sentences; monosyllabic word repetitions or syllable repetitions with relatively even rhythm and stress; three or less repetitions per instance; phrase repetitions.

Crossover Behaviors

- Monosyllabic word repetitions or syllable repetitions with relatively even stress and rhythm but four or more repetitions per instance, monosyllabic word repetitions or syllable repetitions with relatively uneven rhythm and stress with two or more repetitions per instance.

More Unusual (Atypical Dysfluencies)

- Syllable repetitions ending in prolongations; sound, syllable or word prolongations; or prolongations ending in fixed postures of speech mechanism, increased tension noted in the act.

d. 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 the ALL the criteria specified in clinical coverage policy 5A, *Durable Medical Equipment*, **Subsection 5.3.2.4**
      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 members, 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 include:
      A. update of device;
      B. replacement of current device;
      C. significant revisions to the device and~~/or~~ vocabulary; and
      D. medical changes.

3.2.1.4 Audiology Therapy (Aural Rehabilitation)

a. Medicaid and NCHC 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 audiologic (aural) rehabilitation evaluation; or

   2. the presence of impaired or compromised auditory processing abilities on the basis of 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 in either ear;
2. Standard Score more than one (1) 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 (1)-year gain in skills (auditory, 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
   1. Service delivery requires ALL the following elements:
      A. The provider shall check the functioning of hearing aids, assistive listening systems and devices, and sensory aids prior to the evaluation.
      B. Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary's skills, in both clinical and natural environments, for the following:
         i. medical and audiological history;
         ii. reception, comprehension, and production of language in oral, or manual language modalities;
         iii. speech and voice production;
         iv. perception of speech and non-speech stimuli in multiple modalities;
         v. listening skills;
         vi. speech-reading; and
         vii. communication strategies.
      C. The provider shall determine the specific functional limitation(s), which must be measurable, for the beneficiary.

e. Evaluation for Central Auditory Processing Disorders (CAPD)
   1. 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 ALL the following:
      A. Communication, medical, and educational history;

B. Medicaid and NCHC shall cover the following Central auditory tests for the identification of CAPD:

i. auditory discrimination test;

ii. auditory temporal processing and patterning test;

iii. dichotic speech test;

iv. monaural low-redundancy speech test;

v. binaural interaction test;

vi. electroacoustic measures; and

vii. electrophysiologic measures.

C. Interpretation of evaluations are derived from the beneficiary's performance on multiple tests The diagnosis of CAPD must be based on a score of two (2) standard deviations below the mean on at least two (2) central auditory tests.

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

F. Functional deficits consist of a beneficiary's inability to:

i. hear normal conversational speech;
ii. hear conversation via the telephone;
iii. identify, by hearing, environmental sounds necessary for safety (such as siren, car horn, doorbell, baby crying);
iv. understand conversational speech (in person or via telephone);
v. hear and understand teacher in classroom setting;
vi. hear and understand classmates during class discussion;
vii. hear and understand co-workers or supervisors during meetings at work;
viii. hear and process the super-segmental aspects of speech or the phonemes of speech; or
ix. localize sound.

Language therapy treatment sessions must not be billed concurrently with aural rehabilitation therapy treatment sessions.

3.2.1.5 Evaluation Services

Evaluation services are the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol may include interviews with parent(s), legal guardian(s), other family members, other service

providers, and teachers as a means to collect assessment data from inventories, surveys, and questionnaires.

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 ALL the following:

a. duration of the therapy treatment plan consisting of the start and end date (no more than six (6) 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;
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
i. 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

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 report the date and signature of the person receiving the order, must be recorded in the

beneficiary's health record and shall be countersigned by the physician within 60 calendar days. All verbal orders are valid up to six (6) months from the documented date of **receipt**. All written orders are valid up to six (6) 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 (6) 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) process. An LEA provider shall review, renew and revise the IEP annually along with obtaining a dated physician order with signature. The IEP requirement of parent notification must occur at regular intervals throughout the year as stipulated by NC Department of Public Instruction. Such notification must detail how progress is sufficient to enable the child to achieve the IEP goals by the end of the school year.
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 defined as the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol contains interviews with parent(s), legal guardian(s), other family members, other service providers, and teachers as a means to collect assessment data from inventories, surveys, and questionnaires. 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. The re-evaluation report must report 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.

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 ; or
   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 changes in the beneficiary's:

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

3.2.1.10 Respiratory Therapy (RT)

Refer to clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services* on DMA's website at http://dma.ncdhhs.gov.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

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

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

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover procedures, products, and services related to this policy when:

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover Outpatient Specialized Therapies when:

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

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover:
   1. LEA services
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No non-emergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for all Outpatient Specialized Therapies treatments. The provider shall obtain prior approval before rendering Outpatient Specialized Therapies treatments. In order 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

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

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

For occupational therapy (OT) and physical therapy (PT) prior approval, a written report of an evaluation must occur within **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 report 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.

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 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.

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 Beneficiaries under the Age of 21 Years

Prior approval is required prior to the start of all treatment services. For an LEA, the prior approval process is deemed met by the IEP process.

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

The provider shall submit a request to DHHS utilization review contractor to start the approval process. Please note that approval, if granted, is for medical approval only and does not guarantee payment or ensure beneficiary eligibility on the date of service.

5.4 Visit Limitations Beneficiaries 21 Years of Age and Older

Prior approval is required at the start of all treatment services. In addition to **Subsection 5.2.1**, for a beneficiary 21 years of age and older, the provider shall use the applicable diagnosis or procedure code, found in **Attachment A** (B)(C) of the policy on the prior authorization request.

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

The provider shall submit a request to DHHS utilization review contractor to start the approval process. Please note that approval, if granted, is for medical approval only and does not guarantee payment or ensure beneficiary eligibility on the date of service.

Beneficiaries 21 years of age and older are restricted to annual and episodic visit limits. Annual therapy evaluation and treatment visits are separate and in addition to episodic evaluation and treatment visits. Episodic evaluation and treatment visits must be expended prior to annual evaluation and treatment visits when the episode occurs prior to the use of the annual visits. Limits on visits refer to combined PT, OT, and ST visits from all therapy providers in any outpatient setting. Specific diagnoses and procedures covered by the provisions of each visit limit group are listed in **Attachment A**, Section (B) of this policy. Specific diagnoses and procedures are required for prior authorization review (refer to **Subsection 5.2.1**). If multiple disciplines treat on the same date of service, each counts separately toward the total visit limit.

Any beneficiary 21 years of age and older may have one (1) therapy evaluation per calendar year.

a. Annual therapy visits
A beneficiary 21 years of age and older may have one (1) evaluation visit and a total of three (3) therapy treatment visits per calendar year, if the beneficiary has a neurological or lymphedema diagnosis listed in **Attachment A** of this policy. Evaluation and treatment visits obtained prior to the beneficiary's 21st birthday will count towards the evaluation and treatment visit for that calendar year.

b. Episodic therapy visits
   1. A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within four (4) calendar months following a neurosurgical procedure listed in **Attachment A** of this policy.
   2. A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within four (4) calendar months following a musculoskeletal surgical procedure listed in **Attachment A** of this policy, **or** within two (2) calendar months of cast removal, hardware removal or both **or** elimination of weight bearing restrictions or immobilization post musculoskeletal surgical procedure listed in **Attachment A** of this policy.

A new neurosurgical procedure or musculoskeletal surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits.

3. A beneficiary 21 years of age and older may have up to two (2) therapy evaluations and a total of eight (8) therapy treatment visits, when:
   a. the beneficiary is within six (6) calendar months of discharge from inpatient services for a joint replacement or hip fracture surgical procedure listed in **Attachment A** of this policy, **or** within two (2) calendar months of cast removal, hardware removal or both **or** elimination of weight bearing restriction or immobilization post musculoskeletal surgical procedure listed in Attachment A of this policy.

   b. the beneficiary is within six (6) calendar months of receipt of upper extremity or lower extremity prosthesis, or

   c. the beneficiary is within six (6) calendar months of discharge from inpatient services for a laryngectomy surgical procedure listed in **Attachment A** of this policy.

A new joint replacement, hip fracture surgical procedure or receipt of new prosthesis allows for a new episode of two (2) therapy evaluations and eight (8) therapy treatment visits.

A beneficiary 21 years of age and older may have up to three (3) therapy evaluations, and a total of 24 therapy treatment visits when the beneficiary is within nine (9) calendar months of discharge from inpatient services for a cerebrovascular accident (CVA), traumatic brain injury (TBI) or spinal cord injury (SCI) diagnosis listed in Attachment A of this policy. A documented occurrence of a new CVA, TBI or SCI with a corresponding inpatient stay allows for a new episode of up to three (3) therapy evaluations and a total of 24 therapy treatment visits.

Refer to **Attachment A**, Sections B and C for qualifying diagnoses and CPT codes.

Note: Home Health: Physician referral, orders, plan of care, and documentation must adhere to Medicare, Medicaid and NCHC guidelines as outlined in DMA's clinical coverage policy 3A, *Home Health Services.* The service must also be in accordance with all other Home Health program guidelines, including the appropriateness of providing service in the home. The policy can be found on DMA's website at http://dma.ncdhhs.gov.

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

5.5.1 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 (6) calendar months.

5.5.2 Speech-Language-Audiology Therapy

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

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 (6) calendar months.

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

5.5.3 Respiratory Therapy

Refer to clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services* on DMA's website at http://dma.ncdhhs.gov.

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

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice as defined by the appropriate licensing entity.

Eligible providers are: Medicaid-enrolled local education agencies, independent practitioners, home health agencies, children's developmental service agencies, health departments, federally qualified health centers, rural health clinics, hospital outpatient services, and physician offices who employ licensed physical therapists, occupational therapists, respiratory therapists, speech-language pathologists, or audiologists.

Medicaid covers medically necessary outpatient specialized therapies for beneficiaries under 21 when provided by any allowable outpatient provider, and over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and area mental health centers.

NCHC covers medically necessary outpatient specialized therapies when provided by any allowable outpatient provider.

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 §484.4.

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

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

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

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

7.1 Compliance

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

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

7.2 Documenting Services

Each provider shall maintain and allow DMA to access ALL the following documentation for each beneficiary:

a. The beneficiary name and identification number;
b. A copy of the treatment plan (IEP accepted for LEAs only);
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. Home Health services may only be ordered by an MD or DO;
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 (that is, 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, contained in the written evaluation report and the annual re-evaluation report when applicable;
h. Any other documentation relating to the financial, health, or other records necessary to fully disclose the nature and extent of services billed to Medicaid or NCHC; and

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

7.3 Post-Payment Reviews

Medicaid and DHHS Utilization Review Contractor(s) shall perform reviews for monitoring utilization, quality, and appropriateness of all services rendered as well as compliance with all applicable clinical coverage policies. 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.

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 Beneficiary'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), 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 Services may not be provided on the same day.

8.0 Policy Implementation and History

Original Effective Date: October 1, 2002

History:

Date	Section Revised	Change
02/26/2003	5.2, Treatment Services, item #4 7.0, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/2003	5.2, Treatment Services, item #3 5.2, Treatment Services, item #4	The phrase "intensity of services" revised to "length of visits."
04/01/2003	5.3, Prior Approval	Prior approval criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/2003	3.0, When the Service Is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform to billing guidelines; effective with date of publication 10/01/02.
06/01/2003	8.0, Billing Guidelines	Addition of V code diagnosis for treatment services.
07/01/2003	3.4, Respiratory Therapy	Medical necessity criteria added for respiratory therapy.
07/01/2003	5.3, Prior Approval Process	Respiratory therapy guidelines were added.
07/01/2003	8.0, Billing Guidelines	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/2003	Section 3.1.1, Home Health Maintenance Physical Therapy	Criteria were added for Home Health Maintenance Physical Therapy.
10/01/2003	Section 3.2, Occupational Therapy	A statement was added to indicate that Home Health Maintenance Occupational Therapy was not covered.
10/01/2003	Section 3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/2003	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/2003	Section 5.3.1, item c, Physical and Occupational Therapy	Item c was added to address prior approval for physical therapy maintenance.

Date	Section Revised	Change
10/01/2003	Subsection 5.3.2, item c, Speech/Language-Audiology Therapy	Item c was added to address prior approval for audiology.
12/01/2003	Subsection 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
07/01/2004	Subsection 5.2, Treatment Services	Added requirement for LEAs for annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Subsection 5.2 and 7.2	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
12/01/2006	Subsection 2.2	The special provision related to EPSDT was revised.
12/01/2006	Section 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
03/01/2007	Section 3.0	A reference was added to indicate that medical necessity is defined by the policy guidelines recommended by the authoritative bodies for each discipline.
03/01/2007	Subsection 3.3	A reference to ASHA guidelines regarding bilingual services was added as a source of medical necessity criteria for Speech/Language-Audiology therapy treatment for Spanish speaking recipients
03/01/2007	Subsection 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.
03/01/2007	Subsection 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.
03/01/2007	Section 6.0	A reference to 42 CFR 440.110 and 440.185 was added to this section.
03/01/2007	Subsection 7.1	Item 3 Physicians order clarified
03/01/2007	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.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
05/01/2007	Section 8	Added UB-04 as an accepted claims form.
12/01/2009	Subsection 2.1	Moved first paragraph ("recipients with a need for specialized therapy services") to follow standard statement.
12/01/2009	Subsection 2.2	Added legal citation for EPSDT.
12/01/2009	Sections 3.0, 4.0, & 6.0	Updated section titles to standard phrasing.
12/01/2009	Subsection 3.1	Added standard section.

Date	Section Revised	Change
12/01/2009	Subsection 3.2	Added title to existing criteria; changed "services" to "outpatient specialized therapies"; deleted Note on home health maintenance.
12/01/2009	Subsection 3.2.2 (was 3.1.1)	Deleted this section on home health maintenance physical therapy.
12/01/2009	Subsections 3.2.3 and 3.2.5	Deleted mentions of home health maintenance occupational and audiology therapy.
12/01/2009	Subsection 3.2.4 (was 3.3), letter c	Changed the word "patients" to "recipients" and rephrased.
12/01/2009	Subsection 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."
12/01/2009	Subsection 3.2.6	Spelled out first appearance of IPP (Independent Practitioner Program); corrected age range.
12/01/2009	Subsection 4.1	Added standard section.
12/01/2009	Subsection 4.2	Added title to existing criteria; added the word "outpatient" before the phrase "specialized therapies"; deleted the word "following" from "policy guidelines."
12/01/2009	Subsection 5.1 (Place of Service)	Moved this statement to Attachment A, letter F.
12/01/2009	New Subsection 5.1	Added statement that prior approval is required at start of treatment services. Deleted the word "initial" from the introductory statement. Deleted letters f and g (information about 6 unmanaged visits vs. 6 months of service; information about evaluation and prior approval by Children's Developmental Services Agency).
12/01/2009	Subsection 5.2	Changed section title to "Recipients under the Age of 21 Years"; deleted The Carolinas Center for Medical Excellence; changed criteria from 6 visits or 6 months to 52 visits in 6 months; deleted paragraph on Medicaid's initial authorization; added instructions on requesting approval for additional visits. Added: "Medicare recipients are exempt from this policy."
12/01/2009	Subsection 5.3	Added new section on visit limitations for adults.
12/01/2009	Subsection 5.4	Added section title.
12/01/2009	Subsection 5.4.1	Deleted information on home health maintenance physical therapy; added "medically necessary" before the word "visits"; deleted "requested by the therapist."
12/01/2009	Subsection 5.4.2	Deleted reference to 52 visits; deleted "requested by the therapist."
12/01/2009	Subsection 5.4.3	Deleted 52-visit cap in this location; deleted paragraph that LEAs meet requirement by IEP process; deleted note that prior approval is not required for recipients with a CDSA evaluation; deleted "Medicare recipients are exempt from the prior approval process"
12/01/2009	Section 6.0	Added standard paragraph about providers; updated and clarified language.
12/01/2009	Subsection 7.1	Added standard statement about compliance and renumbered subsequent headings.

Date	Section Revised	Change
12/01/2009	Subsection 7.2 (was 7.1)	Added DO and DPM as providers who may issue orders; changed "patient" to "recipient"; deleted requirement to keep copy of prior approval form.
12/01/2009	Subsection 7.3 (was 7.2)	Changed title from "Utilization Reviews" to "Post-Payment Validation Reviews"; deleted "CCME," changed "may" to "will," and added the word "all"; added statement on post-payment reviews and follow-up; deleted examples of review topics.
12/01/2009	Section 8.0	Moved to Attachment A, reorganized, and renamed "Claims-Related Information."
12/01/2009	Section 9.0	Renumbered to Section 8.0.
12/05/2011	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 10A under Session Law 2011-145, § 10.41.(b)
01/01/2012	Subsections 2.1 and 5.4.3	Changed "Medicare recipients are exempt from this policy." to "Medicare recipients are exempt from prior approval process and visit limits in this policy"
01/01/2012	Subsection 5.1	Added clarification regarding acceptable orders.
01/01/2012	Subsection 5.3	Change the number of visits and evaluations. Remove additional visit allowance
01/01/2012	Subsection 5.4	Change title from all recipients to Under 21
01/01/2012	Section 6.0	Clarify who "can work under the direction/supervision of"
01/01/2012	Subsection 7.2	Add credentials to requirement
01/01/2012	Attachment A	Added diagnosis codes for evaluations
02/13/2012	Subsection 5.3	Technical correction to clarify visits
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
06/01/2012	Attachment A	Added additional diagnosis codes for evaluations
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
12/01/2013	Subsection 6.1	Removed statement, "Only therapy assistants may work under the direction of the licensed therapist."
01/01/2014	Subsection 4.2.3	Deleted statement, "**Note**: Subsection 4.2.3(b) applies to NCHC only."
01/01/2014	Subsection 6.1	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, "h. 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	Subsection 7.2	Replace the word "and" with "included in".

Date	Section Revised	Change
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 1.1	Definition removed, " Respiratory therapy services in this policy refer to services by independently enrolled respiratory therapists, not the treatments and services provided in the physician's office for respiratory care"
06/01/2014	Subsection 3.2.1.5 and 3.2.1.6. All section(s) and attachment(s) related to respiratory therapy services	*Respiratory Therapy* Services removed from this policy as they are covered in 10 D, *Independent Practitioners Respiratory Therapy.*
06/01/2014	Subsection 3.2.1	The following removed, "Prior approval is required for all treatment services. For Local Education Agencies' (LEA)'s, the prior approval process is deemed met by the Individualized Education Program IEP process."
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	Subsection 3.2.2	"Medicaid covers medically necessary outpatient specialized therapies for beneficiaries under 21 when provided by any allowable outpatient provider and over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and area mental health centers. Changed to "None Apply."
06/01/2014	Subsection 3.2.3	"NCHC covers medically necessary outpatient specialized therapies when provided by any allowable outpatient provider." Changed to "None Apply."
06/01/2014	Subsection 5.2.2	Removed "None" and added: "In addition to Subsection 5.2.1, for beneficiaries over 21 years of age, the provider shall use on the prior authorization request, the applicable diagnosis or procedure code, found in Attachment A of the policy." Added: Medicare beneficiaries are exempt from this policy.
06/01/2014	Subsection 5.5	Removed: A beneficiary 21 years of age or older may have 3 combined treatment visits and 1 evaluation visit of all therapies combined (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit.

Date	Section Revised	Change
06/01/2014	Subsection 5.5	Added: Beneficiaries 21 years of age and older are restricted to annual and episodic visit limits. Limits on visits refer to combined PT, OT, and ST visits from all therapy providers in any outpatient setting. Specific diagnoses and procedures covered by the provisions of each visit limit group are listed in Attachment A, Section (B) of this policy. Specific diagnoses and procedures are required for prior authorization review (refer to **Subsection 5.2.1** If multiple disciplines treat on the same date of service, each count separately toward the total visit limit. All beneficiaries 21 years of age and older may have one (1) therapy evaluation per calendar year.
06/01/2014	Subsection 5.5	Added: A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit per calendar year, if the beneficiary has: a. a neurodegenerative or lymphedema diagnosis; b. is within 60 calendar days post musculoskeletal or neurological surgical procedure.
06/01/2014	Subsection 5.5	Changed the limit for beneficiaries who have had an amputation, joint replacement or post-op hip fracture from 10 to 8 treatments.
06/01/2014	Subsection 5.5	Changed the limit for beneficiaries who have had a stroke, traumatic brain injury or spinal cord injury from 30 to 24 treatments.
06/01/2014	Subsection 5.5	Added: “Refer to Attachment A for qualifying ICD9, ICD10, and CPT codes.”
06/01/2014	Subsection 6.1	Deleted: " Respiratory therapists shall follow 42 CFR 440.185"
06/01/2014	Subsection 6.1	Deleted; "Physical therapists, occupational therapists, speech–language pathologists, and audiologists shall meet the qualifications according to 42 CFR 440.110" Added: "484.4. The physical therapist, occupational therapist, speech-language pathologist, … and audiologist shall comply with their entire practice act for the discipline regarding providing quality services, supervision of services and billing of services."

Date	Section Revised	Change
06/01/2014	Subsection 6.1	Replaced "are defined by the following program types" with "include." Replaced "qualified" with "licensed." Changed "42 CFR 440.110" to "42 CFR 484.4"/ Replaced "follow" with "comply with." Added: "The physical therapist, occupational therapist, speech-language pathologist, respiratory therapist, and audiologist shall comply with the entire practice act for the discipline regarding providing quality services, supervision of services and billing of services. The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice. Eligible providers may only bill for procedures, products, and services that are within the scope of their clinical practice (the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience practices in their specifically defined field), as defined by the appropriate licensing entity. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of a licensed therapist, physician, or qualified personnel. Speech language pathologists in their clinical fellowship year may work under the supervision of the licensed therapist. The supervising therapist is the biller of the service. Added: "unrevoked and unsuspended"

Date	Section Revised	Change
06/01/2014	Subsection 6.1	Added: **Occupation 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 42CFR § 484.4. G.S. Chapter 90, Article 18B Physical Therapy Title 21 NCAC, Chapter 48 Physical Therapy Examiners **Speech-Language Pathologist** Speech Pathologist defined under 42 CFR § 440.110(c (2)(i)(ii)(iii). Speech-language pathologist requirements are specified under 42CFR § 484.4. Speech-Language Pathologist defined in G.S. 293(5). Speech-Language Pathologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists **Audiologist** Qualified audiologist defined under 42 CFR§ 440.110(c) (3)(i)(ii)(A)(B) Audiologist qualifications specified under 42 CFR 484.4 Audiologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists

Date	Section Revised	Change
06/01/2014	Subsection 6.1	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 the licensed therapist. The supervising therapist is the biller of the service. 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.
06/01/2014	Subsection 7.4	Added: 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, a copy of the patient's current IEP should also be obtained by the billing provider and maintained in the patient's file. Likewise, if the patient is concurrently receiving the same type of treatment service as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program), a copy of the current Individualized Family Service Plan (IFSP) should be obtained by the billing provider and maintained in the patient's file. All services combined cannot exceed medical necessity criteria. Services should not be provided on the same day. Furthermore, a copy of the patient's current IEP or IFSP should be obtained by the billing provider when the provider is providing services, under a contractual agreement, for the special education or early intervention program. **Note:** The requirement to obtain a copy of the patient's IEP or IFSP does not apply to treatment services that do not extend beyond a maximum of four weeks of treatment.
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: "In order for a Medicaid beneficiary 21 years and older to have treatments or evaluations as outlined in **Subsection 5.5,** the following diagnosis codes must apply to the beneficiary and must be included on the billed therapy claim. There is a time element involved in qualifying for services."
06/01/2014	Attachment A	Added ICD-9 and CPT codes

Date	Section Revised	Change
06/01/2014	Attachment A (E)	Added: Timed units billed must meet CMS regulations: 1 unit: ≥8 minutes through 22 minutes 2 units: ≥23 minutes through 37 minutes 3 units: ≥38 minutes through 52 minutes 4 units: ≥53 minutes through 67 minutes 5 units: ≥68 minutes through 82 minutes 6 units: ≥83 minutes through 97 minutes 7 units: ≥98 minutes through 112 minutes 8 units: ≥113 minutes through 127 minutes
06/01/2014	Attachment A (E)	Added: **Assessment services** are defined as the administration of an evaluation protocol, involving testing and/or clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service providers, and/or teachers as a means to collect assessment data from inventories, surveys, and/or questionnaires. Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid or NCHC program, or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service. **Treatment services** are defined as therapeutic procedures addressing the observed needs of the patient, which are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, and/or teachers **should be included** in order to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible beneficiaries) of four children per group. Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.
06/01/2014	Attachment A	Added applicable ICD-10 codes, effective 10/1/2015

Date	Section Revised	Change
07/01/2014	Subsection 5.5	Removed "A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit per calendar year, if the beneficiary has: a) a neurodegenerative or lymphedema diagnosis; or b) is within 60 calendar days post musculoskeletal or neurological surgical procedure." Added: "A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit per calendar year, if the beneficiary has a neurodegenerative or lymphedema diagnosis. A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit if the beneficiary is within 60 calendar days post musculoskeletal or neurological surgical procedure. A different musculoskeletal or neurological surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits."
07/01/2014	Attachment A	Removed V54.89 from ICD-9-CM List for 2 evaluations and 8 treatments
07/01/2014	Attachment A	Revised ICD-9-CM List for 3 evaluations and 24 treatments to be chronological and added 432.0, 432.1, and 432.9 ICD-9 codes.
07/01/2014	Attachment A	Added Musculoskeletal surgical procedure codes 22532-22865 and 27126-27187.
08/15/2014	Attachment A	Added to the ICD-9-CM Table for 3 treatments the codes 741.0 and 741.9. Added codes for open treatment of fractures to the table of Musculoskeletal CPT Codes for 3 treatments. Added codes for arthroplasty and hemiarthroplasty to the table for Musculoskeletal CPT Codes for 2 evaluations and 8 treatments. Added corresponding ICD-10-CM codes for 432.0, 432.1, 432.9, 741.0, 741.9.
10/01/2014	Subsection 7.2	Added to item (i): 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).
10/01/2014	Attachment A	Removed the Codes 953.0, 953.1, 953.2, 953.3, 953.4, 953.5, 953.8 and 953.9 from the table for 3 evaluations and 24 treatments.
10/01/2014	Attachment A	Removed the Codes S14, S24 and S34 from the table for 1 evaluation and 3 treatments.
12/01/2014	Subsection 5.4 and 5.5	Added correct hyperlink for requesting PA: https://www.medicaidprograms.org/NC/ChoicePA
12/01/2014	Subsection 7.2	Remove from Section 7.2 (i): "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 Section 7.2 (i): "The rescheduled date of service documentation must reference the missed date of service."
12/01/2014	Attachment A	Removed ICD-10 code references

Date	Section Revised	Change
04/01/2015	Subsection 3.2.1.3	Removed the word "adult" from the phonological rules table
04/01/2015	Subsection 7.3	Clarified information regarding Post Payment Reviews
04/01/2015	Subsection 7.4	Added section regarding Pre-Payment Reviews
04/01/2015	Attachment A	Added CPT Codes 27440 - 27447 to chart for 2 evaluations and 8 treatments
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.
10/06/2015	Attachment A	Removed time-frame specifications from ICD-10 tables. Time frames are specified in Subsection 5.5.
04/01/2016	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. Home Health services may only be ordered by an MD or DO.
04/01/2016	Subsection 3.2.1.1	Added: Medicaid and NCHC may cover medically necessary outpatient physical therapy treatment if prior authorization is received. Refer to Section 5.0.
04/01/2016	Subsection 3.2.1.2	Added: Medicaid and NCHC may cover medically necessary occupational therapy treatment if prior authorization is received. Refer to Section 5.0.
04/01/2016	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. Refer to Section 5.0.
04/01/2016	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
04/01/2016	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.
04/01/2016	Subsection 3.2.1.5	Subsection added: "Evaluation Services"
04/01/2016	Subsection 3.2.1.6	Defined the components of the Treatment Plan
04/01/2016	Subsection 3.2.1.7	Subsection added: "Treatment Services"
04/01/2016	Subsection 3.2.1.8	Subsection added: "Re-Evaluation Services"

Date	Section Revised	Change
04/01/2016	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).
04/01/2016	Subsection 5.1	Added: In order to obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.
04/01/2016	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.
04/01/2016	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.
04/01/2016	Subsection 5.3	Subsection 5.3, Treatment Services – Moved to Subsection 3.2.1.7
04/01/2016	Subsection 5.5	Removed "A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit if the beneficiary is within 60 calendar days post musculoskeletal or neurological surgical procedure. A different musculoskeletal or neurological surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits."

Date	Section Revised	Change
04/01/2016	Subsection 5.4	Added: "A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within 60 calendar days following a qualifying neurological surgical procedure. A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within 60 calendar days following a qualifying musculoskeletal surgical procedure, **or** within 30 calendar days of cast removal, hardware removal or both or elimination of weight bearing restrictions post musculoskeletal surgical procedure. A different neurological surgical procedure or musculoskeletal surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits."
04/01/2016	Subsection 7.5	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.
04/01/2016	Attachment A:	Moved codes 20930, 20931, 20936, 20937, 20938, 20975 from Neurosurgical CPT Codes for 3 treatments, to Musculoskeletal Surgical CPT Codes for 3 treatments.
06/01/2016	Subsection 3.2.1.3	Removed: **If** the targeted speech sound(s) is age appropriate (see age of acquisition under articulation). And removed the phonological process of gliding from 4 years and 0 months. Added a new column "After age 5 years, 0 months and inserted the phonological process of gliding.

Date	Section Revised	Change
05/15/2016	Subsection 3.2.1.4	b. Removed: hearing loss (any type) >25 dBHL at two (2) or more frequencies in either ear; Added: hearing loss (any type) with a pure tone average greater than 25dB in either ear; c. Added "auditory memory" to the sentence, "improving auditory processing, listening, spoken language processing, auditory memory, overall communication process;". d. Removed: "signed or written and added manual language in the sentence, "reception, comprehension, and production of language in oral, or manual language modalities; e. Removed the sentence, "CAPD evaluation is to be interdisciplinary (involving audiologist and speech-language pathologist) completed by an audiologist and consists of tests to evaluate the overall communication behavior, such as spoken language processing and production." And added the sentence, "CAPD evaluation is to be completed by an audiologist and consists of tests to evaluate the beneficiary's overall auditory function." e.F. Removed the sentence, "read on grade level (as result of auditory processing difficulty);" and added the sentence, "hear and process the super-segmental aspects of speech or the phonemes of speech;".
05/15/2016	Subsection 5.4	Added "or immobilization" to the sentence, "A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within 60 calendar days following a musculoskeletal surgical procedure listed in Attachment A of this policy, **or** within 30 calendar days of cast removal, hardware removal or both or elimination of weight bearing restrictions or immobilization post musculoskeletal surgical procedure listed in Attachment A of this policy."
05/15/2016	Attachment A: E	Replaced statement, "All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible beneficiaries) of four children per group." – which was inadvertently left out during revision process.
11/01/2016	Attachment A: C	Added the following musculoskeletal surgical codes to the table **Musculoskeletal Surgical CPT Codes for 3 treatments: 27236, 27244, 27248, 27253, 27254, 27258, 27259, 27269, 27280, 27282, 27284 and 27286.**
11/01/2016	Attachment A: B	Added the following ICD-10-CM diagnosis codes to the table, **ICD-10-CM Cerebrovascular Diseases and Diseases of Lymphatic Vessels and Lymph Nodes Diagnoses which allow for a maximum of 3 treatment visits:** G46.0. G46.1, G46.2, G46.5, G46.6, G46.7 and G46.8

Date	Section Revised	Change
11/01/2016	Attachment A: B	Added the following ICD-10-CM diagnosis codes to the table, **ICD-10-CM Intracranial Injuries Diagnoses which allow for a maximum of 3 treatment visits:** S06.1X0D, S06.1X0S, S06.1X1D, S06.1X1S, S06.1X2D, S06.1X2S, S06.1X3D, S06.1X3S, S06.1X4D, S06.1X4S, S06.1X5D, S06.1X5S, S06.1X6D, S06.1X6S, S06.1X7D, S06.1X7S, S06.1X8D, S06.1X8D, S06.1X9D and S06.1X9S
11/01/2016	Attachment A: B	Corrected codes in table "ICD-10-CM Vascular Syndromes in Cerebrovascular Disease, Non-traumatic Subarachnoid Hemorrhage and Unspecified Non-traumatic Intracranial Hemorrhage Diagnoses which allow for a maximum of 3 evaluations and 24 treatments"
06/01/2017	Subsection 5.4 and Attachment A	Added: the beneficiary is within three (3) calendar months of discharge from inpatient services for a laryngectomy surgical procedure listed in **Attachment A** of this policy.
06/01/2017	Attachment A	Codes were added, 31360 31365, R47.1 R49.0 and R49.1.
09/01/2017	Attachment A	CPT codes 27700 and 27702 were moved to the chart: Musculoskeletal Surgical CPT Codes for 2 evaluations and 8 treatments (Multiple CPT codes performed as a single procedure on the same date of service do not qualify for more than 8 treatment visits.)
09/07/2017	Section 8.0 and Attachment A	Corrected minor format issues. No change to policy scope or coverage and no change to Amended Date.
10/01/2017	Section 5.4	Clarify annual and episodic therapy visits and adjust specified time frames to request prior approval for therapy.
10/15/2015	Attachment A	Removed end-dated ICD-10-CM Codes
12/15/2017	Attachment A	Corrected the charts containing codes that had errors and that were out of order.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)

Note: Separate CMS-1500 claim forms/837P transactions must be filed for evaluation and treatment services, and for each type of service provided. Because individual and group speech therapy are considered the same type of service, they can be listed on the same claim form.

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 or LEA) or are not employed by a physician's office.

Independent practitioner providers may only bill for services rendered to a Medicaid beneficiary under 21 years of age and a NCHC beneficiary 6 through 18 years of age.

Refer to specific clinical coverage policies for each area. Policies are posted on DMA's website at http://dma.ncdhhs.gov.

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

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

In order for a Medicaid beneficiary 21 years and older to have treatments or evaluations as outlined in **Subsection 5.4,** the following diagnosis codes must apply to the beneficiary and must be documented on the request for prior authorization and the billed therapy claim. There is a time element involved in qualifying for services.

ICD-10-CM Cerebral Cryptococcosis, Diabetic Neuropathy and Disorders of Sphingolipid Metabolism and other Lipid Storage Disorders Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
B45.1	E09.44	E11.43	E75.11	E75.25
E08.40	E09.49	E11.44	E75.19	E75.29
E08.41	E10.40	E11.49	E75.21	E75.3
E08.42	E10.41	E13.40	E75.22	E75.4
E08.43	E10.42	E13.41	E75.23	E75.5
E08.44	E10.43	E13.42	E75.240	E75.6
E08.49	E10.44	E75.00	E75.241	
E09.40	E10.49	E75.01	E75.242	
E09.41	E11.40	E75.02	E75.243	
E09.42	E11.41	E75.09	E75.248	
E09.43	E11.42	E75.10	E75.249	

ICD-10-CM Diseases of the Nervous System Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
G00.0	G24.8	G40.419	G70.01	G83.82
G00.1	G24.9	G40.501	G70.1	G83.83
G00.2	G25.0	G40.509	G70.2	G83.84
G00.3	G25.1	G40.801	G70.80	G83.89
G00.8	G25.2	G40.802	G70.81	G83.9
G00.9	G25.3	G40.803	G70.89	G90.01
G01	G25.4	G40.804	G70.9	G90.09
G02	G25.5	G40.811	G71.0	G90.1
G03.0	G25.61	G40.812	G71.11	G90.2
G03.1	G25.69	G40.813	G71.12	G90.3
G03.2	G25.70	G40.814	G71.13	G90.4
G03.8	G25.71	G40.821	G71.14	G90.50
G03.9	G25.79	G40.822	G71.19	G90.511
G04.00	G25.81	G40.823	G71.2	G90.512
G04.01	G25.82	G40.824	G71.3	G90.513
G04.02	G25.83	G40.89	G71.8	G90.519
G04.1	G25.89	G40.901	G71.9	G90.521
G04.2	G25.9	G40.909	G72.0	G90.522
G04.30	G26	G40.911	G72.1	G90.523
G04.31	G30.0	G40.919	G72.3	G90.529
G04.32	G30.1	G45.4	G72.41	G90.59
G04.39	G30.8	G50.0	G72.49	G90.8
G04.81	G30.9	G50.1	G72.81	G90.9
G04.89	G31.01	G50.8	G72.89	G91.0
G04.90	G31.09	G50.9	G72.9	G91.1
G04.91	G31.1	G51.0	G73.1	G91.2
G05.3	G31.2	G51.1	G73.3	G91.3
G05.4	G31.81	G51.2	G73.7	G91.4
G06.0	G31.82	G51.3	G80.0	G91.8
G06.1	G31.83	G51.4	G80.1	G91.9
G06.2	G31.84	G51.8	G80.2	G92
G07	G31.85	G51.9	G80.3	G93.0

ICD-10-CM Diseases of the Nervous System Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
G08	G31.89	G52.0	G80.4	G93.1
G09	G31.9	G52.1	G80.8	G93.40
G10	G32.0	G52.2	G80.9	G93.41
G11.0	G32.81	G52.3	G81.00	G93.49
G11.1	G32.89	G52.4	G81.01	G93.5
G11.2	G35	G52.8	G81.02	G93.6
G11.3	G36.0	G52.9	G81.03	G93.7
G11.4	G36.1	G53	G81.04	G93.81
G11.8	G36.8	G54.0	G81.10	G93.82
G11.9	G36.9	G54.1	G81.11	G93.89
G12.0	G37.0	G54.2	G81.12	G93.9
G12.1	G37.1	G54.3	G81.13	G94
G12.20	G37.2	G54.4	G81.14	G95.0
G12.21	G37.3	G54.5	G81.90	G95.11
G12.22	G37.4	G54.6	G81.91	G95.19
G12.29	G37.5	G54.7	G81.92	G95.20
G12.8	G37.8	G54.8	G81.93	G95.29
G12.9	G37.9	G54.9	G81.94	G95.81
G13.0	G40.001	G55	G82.20	G95.89
G13.1	G40.009	G60.0	G82.21	G95.9
G13.2	G40.011	G60.1	G82.22	G96.0
G13.8	G40.019	G60.2	G82.50	G96.11
G14	G40.101	G60.3	G82.51	G96.12
G20	G40.109	G60.8	G82.52	G96.19
G21.0	G40.111	G60.9	G82.53	G96.8
G21.11	G40.119	G61.0	G82.54	G96.9
G21.19	G40.201	G61.1	G83.0	G97.0
G21.2	G40.209	G61.81	G83.10	G97.1
G21.3	G40.211	G61.82	G83.11	G97.2
G21.4	G40.219	G61.89	G83.12	G97.31
G21.8	G40.301	G61.9	G83.13	G97.32
G21.9	G40.309	G62.0	G83.14	G97.41
G23.0	G40.311	G62.1	G83.20	G97.48
G23.1	G40.319	G62.2	G83.21	G97.49
G23.2	G40.A01	G62.81	G83.22	G97.51
G23.8	G40.A09	G62.82	G83.23	G97.52
G23.9	G40.A11	G62.89	G83.24	G97.81
G24.01	G40.A19	G62.9	G83.30	G97.82
G24.02	G40.B01	G63	G83.31	G98.0
G24.09	G40.B09	G64	G83.32	G98.8
G24.1	G40.B11	G65.0	G83.33	G99.0
G24.2	G40.B19	G65.1	G83.34	G99.2
G24.3	G40.401	G65.2	G83.4	G99.8
G24.4	G40.409	G70.00	G83.5	
G24.5	G40.411		G83.81	

ICD-10-CM Cerebrovascular Diseases and Diseases of Lymphatic Vessels and Lymph Nodes Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
G46.0	I63.321	I69.031	I69.232	I69.832
G46.1	I63.322	I69.032	I69.233	I69.833
G46.2	I63.323	I69.033	I69.234	I69.834
G46.3	I63.329	I69.034	I69.239	I69.839
G46.4	I63.331	I69.039	I69.241	I69.841
G46.5	I63.332	I69.041	I69.242	I69.842
G46.6	I63.333	I69.042	I69.243	I69.843
G46.7	I63.339	I69.043	I69.244	I69.844
G46.8	I63.341	I69.044	I69.249	I69.849
I60.00	I63.342	I69.049	I69.251	I69.851
I60.01	I63.343	I69.051	I69.252	I69.852
I60.02	I63.349	I69.052	I69.253	I69.853
I60.10	I63.39	I69.053	I69.254	I69.854
I60.11	I63.40	I69.054	I69.259	I69.859
I60.12	I63.411	I69.059	I69.261	I69.861
I60.2	I63.412	I69.061	I69.262	I69.862
I60.30	I63.413	I69.062	I69.263	I69.863
I60.31	I63.419	I69.063	I69.264	I69.864
I60.32	I63.421	I69.064	I69.265	I69.865
I60.4	I63.422	I69.065	I69.269	I69.869
I60.50	I63.423	I69.069	I69.290	I69.890
I60.51	I63.429	I69.090	I69.291	I69.891
I60.52	I63.431	I69.091	I69.292	I69.892
I60.6	I63.432	I69.092	I69.293	I69.893
I60.7	I63.433	I69.093	I69.298	I69.898
I60.8	I63.439	I69.098	I69.30	I69.90
I60.9	I63.441	I69.10	I69.310	I69.910
I61.0	I63.442	I69.110	I69.311	I69.911
I61.1	I63.443	I69.111	I69.312	I69.912
I61.2	I63.449	I69.112	I69.313	I69.913
I61.3	I63.49	I69.113	I69.314	I69.914
I61.4	I63.50	I69.114	I69.315	I69.915
I61.5	I63.511	I69.115	I69.318	I69.918
I61.6	I63.512	I69.118	I69.319	I69.919
I61.8	I63.513	I69.119	I69.320	I69.920
I61.9	I63.519	I69.120	I69.321	I69.921
I62.00	I63.521	I69.121	I69.322	I69.922
I62.01	I63.522	I69.122	I69.323	I69.923
I62.02	I63.523	I69.123	I69.328	I69.928
I62.03	I63.529	I69.128	I69.331	I69.931
I62.1	I63.531	I69.131	I69.332	I69.932
I62.9	I63.532	I69.132	I69.333	I69.933
I63.00	I63.533	I69.133	I69.334	I69.934
I63.011	I63.539	I69.134	I69.339	I69.939
I63.012	I63.541	I69.139	I69.341	I69.941
I63.013	I63.542	I69.141	I69.342	I69.942
I63.019	I63.543	I69.142	I69.343	I69.943

ICD-10-CM Cerebrovascular Diseases and Diseases of Lymphatic Vessels and Lymph Nodes Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
I63.02	I63.9	I69.143	I69.344	I69.944
I63.031	I67.0	I69.144	I69.349	I69.949
I63.032	I67.1	I69.149	I69.351	I69.951
I63.033	I67.2	I69.151	I69.352	I69.952
I63.039	I67.3	I69.152	I69.353	I69.953
I63.09	I67.4	I69.153	I69.354	I69.954
I63.10	I67.5	I69.154	I69.359	I69.959
I63.111	I67.6	I69.159	I69.361	I69.961
I63.113	I67.7	I69.161	I69.362	I69.962
I63.112	I67.81	I69.162	I69.363	I69.963
I63.119	I67.82	I69.163	I69.364	I69.964
I63.12	I67.83	I69.164	I69.365	I69.965
I63.131	I67.841	I69.165	I69.369	I69.969
I63.132	I67.848	I69.169	I69.390	I69.990
I63.133	I67.89	I69.190	I69.391	I69.991
I63.139	I67.9	I69.191	I69.392	I69.992
I63.19	I68.0	I69.192	I69.393	I69.993
I63.20	I68.2	I69.193	I69.398	I69.998
I63.211	I68.8	I69.198	I69.80	I89.0
I63.213	I69.00	I69.20	I69.810	I89.1
I63.212	I69.010	I69.210	I69.811	I89.8
I63.219	I69.011	I69.211	I69.812	I89.9
I63.22	I69.012	I69.212	I69.813	I97.2
I63.231	I69.013	I69.213	I69.814	
I63.232	I69.014	I69.214	I69.815	
I63.233	I69.015	I69.215	I69.818	
I63.239	I69.018	I69.218	I69.819	
I63.29	I69.019	I69.219	I69.820	
I63.30	I69.020	I69.220	I69.821	
I63.311	I69.021	I69.221	I69.822	
I63.312	I69.022	I69.222	I69.823	
I63.313	I69.023	I69.223	I69.828	
I63.319	I69.028	I69.228	I69.831	
I63.549		I69.231		
I63.59				
I63.6				
I63.8				

ICD-10-CM Sclerosis, Congenital Malformations of the Nervous System, Aphagia, Dysphagia, Dysarthria and Aphonia Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
M34.0	Q01.1	Q04.3	Q05.6	Q07.01
M34.1	Q01.2	Q04.4	Q05.7	Q07.02
M34.8	Q01.8	Q04.5	Q05.8	Q07.03
M34.81	Q01.9	Q04.6	Q05.9	Q07.8
M34.82	Q02	Q04.8	Q06.0	Q07.9
M34.83	Q03.0	Q04.9	Q06.1	R13.0
M34.89	Q03.1	Q05.0	Q06.2	R13.10
M34.9	Q03.8	Q05.1	Q06.3	R13.11
Q00.0	Q03.9	Q05.2	Q06.4	R13.12
Q00.1	Q04.0	Q05.3	Q06.8	R13.13
Q00.2	Q04.1	Q05.4	Q06.9	R13.14
Q01.0	Q04.2	Q05.5	Q07.00	R13.19
				R47.1
				R49.0
				R49.1

ICD-10-CM Intracranial Injuries Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
S06.1X0D	S06.316S	S06.353D	S06.389D	S06.810D
S06.1X0S	S06.319D	S06.353S	S06.389S	S06.810S
S06.1X1D	S06.319S	S06.354D	S06.4X0D	S06.811D
S06.1X1S	S06.320D	S06.354S	S06.4X0S	S06.811S
S06.1X2D	S06.320S	S06.355D	S06.4X1D	S06.812D
S06.1X2S	S06.321D	S06.355S	S06.4X1S	S06.812S
S06.1X3D	S06.321S	S06.356D	S06.4X2D	S06.813D
S06.1X3S	S06.322D	S06.356S	S06.4X2S	S06.813S
S06.1X4D	S06.322S	S06.359D	S06.4X3D	S06.814D
S06.1X4S	S06.323D	S06.359S	S06.4X3S	S06.814S
S06.1X5D	S06.323S	S06.360D	S06.4X4D	S06.815D
S06.1X5S	S06.324D	S06.360S	S06.4X4S	S06.815S
S06.1X6D	S06.324S	S06.361D	S06.4X5D	S06.816D
S06.1X6S	S06.325D	S06.361S	S06.4X5S	S06.816S
S06.1X9D	S06.325S	S06.362D	S06.4X6D	S06.819D
S06.1X9S	S06.326D	S06.362S	S06.4X6S	S06.819S
S06.2X0D	S06.326S	S06.363D	S06.4X9D	S06.820D
S06.2X0S	S06.329D	S06.363S	S06.4X9S	S06.820S
S06.2X1D	S06.329S	S06.364D	S06.5X0D	S06.821D
S06.2X1S	S06.330D	S06.364S	S06.5X0S	S06.821S
S06.2X2D	S06.330S	S06.365D	S06.5X1D	S06.822D
S06.2X2S	S06.331D	S06.365S	S06.5X1S	S06.822S
S06.2X3D	S06.331S	S06.366D	S06.5X2D	S06.823D
S06.2X3S	S06.332D	S06.366S	S06.5X2S	S06.823S
S06.2X4D	S06.332S	S06.369D	S06.5X3D	S06.824D
S06.2X4S	S06.333D	S06.369S	S06.5X3S	S06.824S
S06.2X5D	S06.333S	S06.370D	S06.5X4D	S06.825D
S06.2X5S	S06.334D	S06.370S	S06.5X4S	S06.825S

ICD-10-CM Intracranial Injuries Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
S06.2X6D	S06.334S	S06.371D	S06.5X5D	S06.826D
S06.2X6S	S06.335D	S06.371S	S06.5X5S	S06.826S
S06.2X9D	S06.335S	S06.372D	S06.5X6D	S06.829D
S06.2X9S	S06.336D	S06.372S	S06.5X6S	S06.829S
S06.300D	S06.336S	S06.373D	S06.5X9D	S06.890D
S06.300S	S06.339D	S06.373S	S06.5X9S	S06.890S
S06.301D	S06.339S	S06.374D	S06.6X0D	S06.891D
S06.301S	S06.340D	S06.374S	S06.6X0S	S06.891S
S06.302D	S06.340S	S06.375D	S06.6X1D	S06.892D
S06.302S	S06.341D	S06.375S	S06.6X1S	S06.892S
S06.303D	S06.341S	S06.376D	S06.6X2D	S06.893D
S06.303S	S06.342D	S06.376S	S06.6X2S	S06.893S
S06.304D	S06.342S	S06.379D	S06.6X3D	S06.894D
S06.304S	S06.343D	S06.379S	S06.6X3S	S06.894S
S06.305D	S06.343S	S06.380D	S06.6X4D	S06.895D
S06.305S	S06.344D	S06.380S	S06.6X4S	S06.895S
S06.306D	S06.344S	S06.381D	S06.6X5D	S06.896D
S06.306S	S06.345D	S06.381S	S06.6X5S	S06.896S
S06.309D	S06.345S	S06.382D	S06.6X6D	S06.899D
S06.309S	S06.346D	S06.382S	S06.6X6S	S06.899S
S06.310D	S06.346S	S06.383D	S06.6X9D	S06.9X0D
S06.310S	S06.349D	S06.383S	S06.6X9S	S06.9X0S
S06.311D	S06.349S	S06.384D		S06.9X1D
S06.311S	S06.350D	S06.384S		S06.9X1S
S06.312D	S06.350S	S06.385D		S06.9X2D
S06.312S	S06.351D	S06.385S		S06.9X2S
S06.313D	S06.351S	S06.386D		S06.9X3D
S06.313S	S06.352D	S06.386S		S06.9X3S
S06.314D	S06.352S			S06.9X4D
S06.314S				S06.9X4S
S06.315D				S06.9X5D
S06.315S				S06.9X5S
S06.316D				S06.9X6D
				S06.9X6S
				S06.9X7D
				S06.9X7S
				S06.9X8D
				S06.9X8S
				S06.9X9D
				S06.9X9S

ICD-10-CM Injury of Nerves and Spinal Cord Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
S14.0XXD	S14.131D	S14.3XXS	S24.139D	S34.02XS
S14.0XXS	S14.131S	S14.4XXD	S24.139S	S34.101D
S14.101D	S14.132D	S14.4XXS	S24.141D	S34.101S

ICD-10-CM Injury of Nerves and Spinal Cord Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
S14.101S	S14.132S	S14.5XXD	S24.141S	S34.102D
S14.102D	S14.133D	S14.5XXS	S24.142D	S34.102S
S14.102S	S14.133S	S14.8XXD	S24.142S	S34.103D
S14.103D	S14.134D	S14.8XXS	S24.143D	S34.103S
S14.103S	S14.134S	S14.9XXD	S24.143S	S34.104D
S14.104D	S14.135D	S14.9XXS	S24.144D	S34.104S
S14.104S	S14.135S	S24.0XXD	S24.144S	S34.105D
S14.105D	S14.136D	S24.0XXS	S24.149D	S34.105S
S14.105S	S14.136S	S24.101D	S24.149S	S34.109D
S14.106D	S14.137D	S24.101S	S24.151D	S34.109S
S14.106S	S14.137S	S24.102D	S24.151S	S34.111D
S14.107D	S14.138D	S24.102S	S24.152D	S34.111S
S14.107S	S14.138S	S24.103D	S24.152S	S34.112D
S14.108D	S14.139D	S24.103S	S24.153D	S34.112S
S14.108S	S14.139S	S24.104D	S24.153S	S34.113D
S14.109D	S14.141D	S24.104S	S24.154D	S34.113S
S14.109S	S14.141S	S24.109D	S24.154S	S34.114D
S14.111D	S14.142D	S24.109S	S24.159D	S34.114S
S14.111S	S14.142S	S24.111D	S24.159S	S34.115D
S14.112D	S14.143D	S24.111S	S24.2XXD	S34.115S
S14.112S	S14.143S	S24.112D	S24.2XXS	S34.119D
S14.113D	S14.144D	S24.112S	S24.3XXD	S34.119S
S14.113S	S14.144S	S24.113D	S24.3XXS	S34.121D
S14.114D	S14.145D	S24.113S	S24.4XXD	S34.121S
S14.114S	S14.145S	S24.114D	S24.4XXS	S34.122D
S14.115D	S14.146D	S24.114S	S24.8XXD	S34.122S
S14.115S	S14.146S	S24.119D	S24.8XXS	S34.123D
S14.116D	S14.147D	S24.119S	S24.9XXD	S34.123S
S14.116S	S14.147S	S24.131D	S24.9XXS	S34.124D
S14.117D	S14.148D	S24.131S	S34.01XD	S34.124S
S14.117S	S14.148S	S24.132D	S34.01XS	S34.125D
S14.118D	S14.149D	S24.132S	S34.02XD	S34.125S
S14.118S	S14.149S	S24.133D		S34.129D
S14.119D	S14.151D	S24.133S		S34.129S
S14.119S	S14.151S	S24.134D		S34.131D
S14.121D	S14.152D	S24.134S		S34.131S
S14.121S	S14.152S			S34.132D
S14.122D	S14.153D			S34.132S
S14.122S	S14.153S			S34.139D
S14.123D	S14.154D			S34.139S
S14.123S	S14.154S			S34.21XD
S14.124D	S14.155D			S34.21XS
S14.124S	S14.155S			S34.22XD
S14.125D	S14.156D			S34.22XS
S14.125S	S14.156S			S34.3XXD
S14.126D	S14.157D			S34.3XXS
S14.126S	S14.157S			S34.4XXD
S14.127D	S14.158D			S34.4XXS

ICD-10-CM Injury of Nerves and Spinal Cord Diagnoses which allow for a maximum of 3 treatment visits. Multiple diagnoses do not qualify for more than a total of 3 treatment visits per calendar year.				
S14.127S	S14.158S			S34.5XXD
S14.128D	S14.159D			S34.5XXS
S14.128S	S14.159S			S34.6XXD
S14.129D	S14.2XXD			S34.6XXS
S14.129S	S14.2XXS			S34.8XXD
	S14.3XXD			S34.8XXS
				S34.9XXD
				S34.9XXS

ICD-10-CM Fracture of Ilium Diagnoses which allow for a maximum of 2 evaluations and 8 treatments following an open surgical procedure listed in Section C of Attachment A.				
S32.301D	S32.309K	S32.313G	S32.316D	S32.392K
S32.301G	S32.311D	S32.313K	S32.316G	S32.399D
S32.301K	S32.311G	S32.314D	S32.316K	S32.399G
S32.302D	S32.311K	S32.314G	S32.391D	S32.399K
S32.302G	S32.312D	S32.314K	S32.391G	
S32.302K	S32.312G	S32.315D	S32.391K	
S32.309D	S32.312K	S32.315G	S32.392D	
S32.309G	S32.313D	S32.315K	S32.392G	

ICD-10-CM Fracture of Acetabulum Diagnoses which allow for a maximum of 2 evaluations and 8 treatments following an open surgical procedure listed in Section C of Attachment A..				
S32.401D	S32.423D	S32.442D	S32.461D	S32.476D
S32.401G	S32.423G	S32.442G	S32.461G	S32.476G
S32.401K	S32.423K	S32.442K	S32.461K	S32.476K
S32.402D	S32.424D	S32.443D	S32.462D	S32.481D
S32.402G	S32.424G	S32.443G	S32.462G	S32.481G
S32.402K	S32.424K	S32.443K	S32.462K	S32.481K
S32.409D	S32.425D	S32.444D	S32.463D	S32.482D
S32.409G	S32.425G	S32.444G	S32.463G	S32.482G
S32.409K	S32.425K	S32.444K	S32.463K	S32.482K
S32.411D	S32.426D	S32.445D	S32.464D	S32.483D
S32.411G	S32.426G	S32.445G	S32.464G	S32.483G
S32.411K	S32.426K	S32.445K	S32.464K	S32.483K
S32.412D	S32.431D	S32.446D	S32.465D	S32.484D
S32.412G	S32.431G	S32.446G	S32.465G	S32.484G
S32.412K	S32.431K	S32.446K	S32.465K	S32.484K
S32.413D	S32.432D	S32.451D	S32.466D	S32.485D
S32.413G	S32.432G	S32.451G	S32.466G	S32.485G
S32.413K	S32.432K	S32.451K	S32.466K	S32.485K
S32.414D	S32.433D	S32.452D	S32.471D	S32.486D
S32.414G	S32.433G	S32.452G	S32.471G	S32.486G
S32.414K	S32.433K	S32.452K	S32.471K	S32.486K
S32.415D	S32.434D	S32.453D	S32.472D	S32.491D
S32.415G	S32.434G	S32.453G	S32.472G	S32.491G
S32.415K	S32.434K	S32.453K	S32.472K	S32.491K
S32.416D	S32.435D	S32.454D	S32.473D	S32.492D

ICD-10-CM Fracture of Acetabulum Diagnoses which allow for a maximum of 2 evaluations and 8 treatments following an open surgical procedure listed in Section C of Attachment A..				
S32.416G	S32.435G	S32.454G	S32.473G	S32.492G
S32.416K	S32.435K	S32.454K	S32.473K	S32.492K
S32.421D	S32.436D	S32.455D	S32.474D	S32.499D
S32.421G	S32.436G	S32.455G	S32.474G	S32.499G
S32.421K	S32.436K	S32.455K	S32.474K	S32.499K
S32.422D	S32.441D	S32.456D	S32.475D	
S32.422G	S32.441G	S32.456G	S32.475G	
S32.422K	S32.441K	S32.456K	S32.475K	

ICD-10-CM Fracture of Pubis, Ischium, other parts of Pelvis and unspecified parts of Lumbosacral Spine and Pelvis Diagnoses which allow for a maximum of 2 evaluations and 8 treatments following an open surgical procedure listed in Section C of Attachment A..				
S32.501D	S32.519G	S32.602K	S32.615D	S32.810G
S32.501G	S32.519K	S32.609D	S32.615G	S32.810K
S32.501K	S32.591D	S32.609G	S32.615K	S32.811D
S32.502D	S32.591G	S32.609K	S32.616D	S32.811G
S32.502G	S32.591K	S32.611D	S32.616G	S32.811K
S32.502K	S32.592D	S32.611G	S32.616K	S32.82XD
S32.509D	S32.592G	S32.611K	S32.691D	S32.82XG
S32.509G	S32.592K	S32.612D	S32.691G	S32.82XK
S32.509K	S32.599D	S32.612G	S32.691K	S32.89XD
S32.511D	S32.599G	S32.612K	S32.692D	S32.89XG
S32.511G	S32.599K	S32.613D	S32.692G	S32.89XK
S32.511K	S32.601D	S32.613G	S32.692K	S32.9XXD
S32.512D	S32.601G	S32.613K	S32.699D	S32.9XXG
S32.512G	S32.601K	S32.614D	S32.699G	S32.9XXK
S32.512K	S32.602D	S32.614G	S32.699K	
S32.519D	S32.602G	S32.614K	S32.810D	

ICD-10-CM Fracture of Femur Diagnoses which allow for a maximum of 2 evaluations and 8 treatments following an open surgical procedure listed in Section C of Attachment A.				
S72.001D	S72.002Q	S72.011N	S72.019K	S72.022H
S72.001E	S72.002R	S72.011P	S72.019M	S72.022J
S72.001F	S72.009D	S72.011Q	S72.019N	S72.022K
S72.001G	S72.009E	S72.011R	S72.019P	S72.022M
S72.001H	S72.009F	S72.012D	S72.019Q	S72.022N
S72.001J	S72.009G	S72.012E	S72.019R	S72.022P
S72.001K	S72.009H	S72.012F	S72.021D	S72.022Q
S72.001M	S72.009J	S72.012G	S72.021E	S72.022R
S72.001N	S72.009K	S72.012H	S72.021F	S72.023D
S72.001P	S72.009M	S72.012J	S72.021G	S72.023E
S72.001Q	S72.009N	S72.012K	S72.021H	S72.023F
S72.001R	S72.009P	S72.012M	S72.021J	S72.023G
S72.002D	S72.009Q	S72.012N	S72.021K	S72.023H
S72.002E	S72.009R	S72.012P	S72.021M	S72.023J
S72.002F	S72.011D	S72.012Q	S72.021N	S72.023K
S72.002G	S72.011E	S72.012R	S72.021P	S72.023M

ICD-10-CM Fracture of Femur Diagnoses which allow for a maximum of 2 evaluations and 8 treatments following an open surgical procedure listed in Section C of Attachment A.				
S72.002H	S72.011F	S72.019D	S72.021Q	S72.023N
S72.002J	S72.011G	S72.019E	S72.021R	S72.023P
S72.002K	S72.011H	S72.019F	S72.022D	S72.023Q
S72.002M	S72.011J	S72.019G	S72.022E	S72.023R
S72.002N	S72.011K	S72.019H	S72.022F	
S72.002P	S72.011M	S72.019J	S72.022G	

ICD-10-CM Vascular Syndromes in Cerebrovascular Disease, Non-traumatic Subarachnoid Hemorrhage and Unspecified Non-Traumatic Intracranial Hemorrhage Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
G46.0	I60.00	I60.32	I61.0	I61.9
G46.1	I60.01	I60.4	I61.1	I62.00
G46.2	I60.02	I60.50	I61.2	I62.01
G46.3	I60.10	I60.51	I61.3	I62.02
G46.4	I60.11	I60.52	I61.4	I62.03
G46.5	I60.12	I60.6	I61.5	I62.1
G46.6	I60.2	I60.7	I61.6	I62.9
G46.7	I60.30	I60.8	I61.8	
G46.8	I60.31	I60.9		

ICD-10-CM Cerebral Infarction and Other Cerebrovascular Disease Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
I63.00	I63.20	I63.333	I63.443	I63.8
I63.011	I63.211	I63.339	I63.449	I63.9
I63.012	I63.212	I63.341	I63.49	I67.0
I63.013	I63.213	I63.342	I63.50	I67.1
I63.019	I63.219	I63.343	I63.511	I67.2
I63.02	I63.22	I63.349	I63.512	I67.3
I63.031	I63.231	I63.39	I63.513	I67.4
I63.032	I63.232	I63.40	I63.519	I67.5
I63.033	I63.233	I63.411	I63.521	I67.6
I63.039	I63.239	I63.412	I63.522	I67.7
I63.09	I63.29	I63.413	I63.523	I67.81
I63.10	I63.30	I63.419	I63.529	I67.82
I63.111	I63.311	I63.421	I63.531	I67.83
I63.112	I63.312	I63.422	I63.532	I67.841
I63.113	I63.313	I63.423	I63.533	I67.848
I63.119	I63.319	I63.429	I63.539	I67.89
I63.12	I63.321	I63.431	I63.541	I67.9
I63.131	I63.322	I63.432	I63.542	
I63.132	I63.323	I63.433	I63.543	
I63.133	I63.329	I63.439	I63.549	
I63.139	I63.331	I63.441	I63.59	

I63.19	I63.332	I63.442	I63.6	

ICD-10-CM Sequelae of Cerebrovascular Disease Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
I69.00	I69.120	I69.241	I69.359	I69.890
I69.010	I69.121	I69.242	I69.361	I69.891
I69.011	I69.122	I69.243	I69.362	I69.892
I69.012	I69.123	I69.244	I69.363	I69.893
I69.013	I69.128	I69.249	I69.364	I69.898
I69.014	I69.131	I69.251	I69.365	I69.90
I69.015	I69.132	I69.252	I69.369	I69.910
I69.018	I69.133	I69.253	I69.390	I69.911
I69.019	I69.134	I69.254	I69.391	I69.912
I69.020	I69.139	I69.259	I69.392	I69.913
I69.021	I69.141	I69.261	I69.393	I69.914
I69.022	I69.142	I69.262	I69.398	I69.915
I69.023	I69.143	I69.263	I69.80	I69.918
I69.028	I69.144	I69.264	I69.810	I69.919
I69.031	I69.149	I69.265	I69.811	I69.920
I69.032	I69.151	I69.269	I69.812	I69.921
I69.033	I69.152	I69.290	I69.813	I69.922
I69.034	I69.153	I69.291	I69.814	I69.923
I69.039	I69.154	I69.292	I69.815	I69.928
I69.041	I69.159	I69.293	I69.818	I69.931
I69.042	I69.161	I69.298	I69.819	I69.932
I69.043	I69.162	I69.30	I69.820	I69.933
I69.044	I69.163	I69.310	I69.821	I69.934
I69.049	I69.164	I69.311	I69.822	I69.939
I69.051	I69.165	I69.312	I69.823	I69.941
I69.052	I69.169	I69.313	I69.828	I69.942
I69.053	I69.190	I69.314	I69.831	I69.943
I69.054	I69.191	I69.315	I69.832	I69.944
I69.059	I69.192	I69.318	I69.833	I69.949
I69.061	I69.193	I69.319	I69.834	I69.951
I69.062	I69.198	I69.320	I69.839	I69.952
I69.063	I69.20	I69.321	I69.841	I69.953
I69.064	I69.210	I69.322	I69.842	I69.954
I69.065	I69.211	I69.323	I69.843	I69.959
I69.069	I69.212	I69.328	I69.844	I69.961
I69.090	I69.213	I69.331	I69.849	I69.962
I69.091	I69.214	I69.332	I69.851	I69.963
I69.092	I69.215	I69.333	I69.852	I69.964
I69.093	I69.218	I69.334	I69.853	I69.965
I69.098	I69.219	I69.339	I69.854	I69.969
I69.10	I69.220	I69.341	I69.859	I69.990
I69.110	I69.221	I69.342	I69.861	I69.991
I69.111	I69.222	I69.343	I69.862	I69.992
I69.112	I69.223	I69.344	I69.863	I69.993
I69.113	I69.228	I69.349	I69.864	I69.998

ICD-10-CM Sequelae of Cerebrovascular Disease Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
I69.114	I69.231	I69.351	I69.865	
I69.115	I69.232	I69.352	I69.869	
I69.118	I69.233	I69.353		
I69.119	I69.234	I69.354		
	I69.239			

ICD-10-CM Intracranial Injury, Diffuse Traumatic Brain Injury and Focal Traumatic Brain Injury Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
S06.1X0D	S06.302D	S06.324D	S06.346D	S06.369D
S06.1X0S	S06.302S	S06.324S	S06.346S	S06.369S
S06.1X1D	S06.303D	S06.325D	S06.349D	S06.370D
S06.1X1S	S06.303S	S06.325S	S06.349S	S06.370S
S06.1X2D	S06.304D	S06.326D	S06.350D	S06.371D
S06.1X2S	S06.304S	S06.326S	S06.350S	S06.371S
S06.1X3D	S06.305D	S06.329D	S06.351D	S06.372D
S06.1X3S	S06.305S	S06.329S	S06.351S	S06.372S
S06.1X4D	S06.306D	S06.330D	S06.352D	S06.373D
S06.1X4S	S06.306S	S06.330S	S06.352S	S06.373S
S06.1X5D	S06.309D	S06.331D	S06.353D	S06.374D
S06.1X5S	S06.309S	S06.331S	S06.353S	S06.374S
S06.1X6D	S06.310D	S06.332D	S06.354D	S06.375D
S06.1X6S	S06.310S	S06.332S	S06.354S	S06.375S
S06.1X9D	S06.311D	S06.333D	S06.355D	S06.376D
S06.1X9S	S06.311S	S06.333S	S06.355S	S06.376S
S06.2X0D	S06.312D	S06.334D	S06.356D	S06.379D
S06.2X0S	S06.312S	S06.334S	S06.356S	S06.379S
S06.2X1D	S06.313D	S06.335D	S06.359D	S06.380D
S06.2X1S	S06.313S	S06.335S	S06.359S	S06.380S
S06.2X2D	S06.314D	S06.336D	S06.360D	S06.381D
S06.2X2S	S06.314S	S06.336S	S06.360S	S06.381S
S06.2X3D	S06.315D	S06.339D	S06.361D	S06.382D
S06.2X3S	S06.315S	S06.339S	S06.361S	S06.382S
S06.2X4D	S06.316D	S06.340D	S06.362D	S06.383D
S06.2X4S	S06.316S	S06.340S	S06.362S	S06.383S
S06.2X5D	S06.319D	S06.341D	S06.363D	S06.384D
S06.2X5S	S06.319S	S06.341S	S06.363S	S06.384S
S06.2X6D	S06.320D	S06.342D	S06.364D	S06.385D
S06.2X6S	S06.320S	S06.342S	S06.364S	S06.385S
S06.2X9D	S06.321D	S06.343D	S06.365D	S06.386D
S06.2X9S	S06.321S	S06.343S	S06.365S	S06.386S
S06.300D	S06.322D	S06.344D	S06.366D	S06.389D

ICD-10-CM Intracranial Injury, Diffuse Traumatic Brain Injury and Focal Traumatic Brain Injury Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
S06.300S	S06.322S	S06.344S	S06.366S	S06.389S
S06.301D	S06.323D	S06.345D		
S06.301S	S06.323S	S06.345S		

ICD-10-CM Epidural Hemorrhage, Traumatic Subdural Hemorrhage, Traumatic Subarachnoid Hemorrhage, Other Specified Intracranial Injuries and Unspecified Intracranial Injury Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
S06.4X0D	S06.5X4D	S06.6X9D	S06.822D	S06.896D
S06.4X0S	S06.5X4S	S06.6X9S	S06.822S	S06.896S
S06.4X1D	S06.5X5D	S06.810D	S06.823D	S06.899D
S06.4X1S	S06.5X5S	S06.810S	S06.823S	S06.899S
S06.4X2D	S06.5X6D	S06.811D	S06.824D	S06.9X0D
S06.4X2S	S06.5X6S	S06.811S	S06.824S	S06.9X0S
S06.4X3D	S06.5X9D	S06.812D	S06.825D	S06.9X1D
S06.4X3S	S06.5X9S	S06.812S	S06.825S	S06.9X1S
S06.4X4D	S06.6X0D	S06.813D	S06.826D	S06.9X2D
S06.4X4S	S06.6X0S	S06.813S	S06.826S	S06.9X2S
S06.4X5D	S06.6X1D	S06.814D	S06.829D	S06.9X3D
S06.4X5S	S06.6X1S	S06.814S	S06.829S	S06.9X3S
S06.4X6D	S06.6X2D	S06.815D	S06.890D	S06.9X4D
S06.4X6S	S06.6X2S	S06.815S	S06.890S	S06.9X4S
S06.4X9D	S06.6X3D	S06.816D	S06.891D	S06.9X5D
S06.4X9S	S06.6X3S	S06.816S	S06.891S	S06.9X5S
S06.5X0D	S06.6X4D	S06.819D	S06.892D	S06.9X6D
S06.5X0S	S06.6X4S	S06.819S	S06.892S	S06.9X6S
S06.5X1D	S06.6X5D	S06.820D	S06.893D	S06.9X7D
S06.5X1S	S06.6X5S	S06.820S	S06.893S	S06.9X7S
S06.5X2D	S06.6X6D	S06.821D	S06.894D	S06.9X8D
S06.5X2S	S06.6X6S	S06.821S	S06.894S	S06.9X8S
S06.5X3D			S06.895D	S06.9X9D
S06.5X3S			S06.895S	S06.9X9S

ICD-10-CM Injury of Nerves and Spinal Cord at Neck Level Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.

ICD-10-CM Injury of Nerves and Spinal Cord at Neck Level Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
S14.0XXD	S14.112D	S14.124D	S14.136D	S14.148D
S14.0XXS	S14.112S	S14.124S	S14.136S	S14.148S
S14.101D	S14.113D	S14.125D	S14.137D	S14.149D
S14.101S	S14.113S	S14.125S	S14.137S	S14.149S
S14.102D	S14.114D	S14.126D	S14.138D	S14.151D
S14.102S	S14.114S	S14.126S	S14.138S	S14.151S
S14.103D	S14.115D	S14.127D	S14.139D	S14.152D
S14.103S	S14.115S	S14.127S	S14.139S	S14.152S
S14.104D	S14.116D	S14.128D	S14.141D	S14.153D
S14.104S	S14.116S	S14.128S	S14.141S	S14.153S
S14.105D	S14.117D	S14.129D	S14.142D	S14.154D
S14.105S	S14.117S	S14.129S	S14.142S	S14.154S
S14.106D	S14.118D	S14.131D	S14.143D	S14.155D
S14.106S	S14.118S	S14.131S	S14.143S	S14.155S
S14.107D	S14.119D	S14.132D	S14.144D	S14.156D
S14.107S	S14.119S	S14.132S	S14.144S	S14.156S
S14.108D	S14.121D	S14.133D	S14.145D	S14.157D
S14.108S	S14.121S	S14.133S	S14.145S	S14.157S
S14.109D	S14.122D	S14.134D	S14.146D	S14.158D
S14.109S	S14.122S	S14.134S	S14.146S	S14.158S
S14.111D	S14.123D	S14.135D	S14.147D	S14.159D
S14.111S	S14.123S	S14.135S	S14.147S	S14.159S

ICD-10-CM Injury of Nerves and Spinal Cord at Thorax Level Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
S24.0XXD	S24.111D	S24.132D	S24.143D	S24.152D
S24.0XXS	S24.111S	S24.132S	S24.143S	S24.152S
S24.101D	S24.112D	S24.133D	S24.144D	S24.153D
S24.101S	S24.112S	S24.133S	S24.144S	S24.153S
S24.102D	S24.113D	S24.134D	S24.149D	S24.154D
S24.102S	S24.113S	S24.134S	S24.149S	S24.154S
S24.103D	S24.114D	S24.139D	S24.151D	S24.159D
S24.103S	S24.114S	S24.139S	S24.151S	S24.159S
S24.104D	S24.119D	S24.141D	S24.144S	
S24.104S	S24.119S	S24.141S	S24.149D	
S24.109D	S24.131D	S24.142D	S24.149S	
S24.109S	S24.131S	S24.142S	S24.151D	

ICD-10-CM Injury of Lumbar and Sacral Spinal Cord and Nerves at Abdomen, Lower Back and Pelvis Level Diagnoses which allow for a maximum of 3 evaluations and 24 treatments.				
S34.01XD	S34.104D	S34.113D	S34.122D	S34.131D
S34.01XS	S34.104S	S34.113S	S34.122S	S34.131S
S34.02XD	S34.105D	S34.114D	S34.123D	S34.132D
S34.02XS	S34.105S	S34.114S	S34.123S	S34.132S
S34.101D	S34.109D	S34.115D	S34.124D	S34.139D
S34.101S	S34.109S	S34.115S	S34.124S	S34.139S
S34.102D	S34.111D	S34.119D	S34.125D	

S34.102S S34.103D S34.103S	S34.111S S34.112D S34.112S	S34.119S S34.121D S34.121S	S34.125S S34.129D S34.129S	

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.

In order for a Medicaid beneficiary 21 years and older to have treatments or evaluations as outlined in **Subsection 5.4,** the following surgical procedure codes must apply to the beneficiary and must be documented on the request for prior authorization. There is a time element involved in qualifying for services.

Neurosurgical CPT Codes for 3 treatments (Multiple CPT codes performed as a single procedure on the same date of service do not qualify for more than 3 treatment visits.)				
21343	61313	61697	64581	64792
21344	61314	61698	64585	64802
21615	61315	61700	64590	64804
21616	61316	61702	64595	64809
21700	61322	61705	64612	64818
21705	61510	61708	64613	64820
22532	61512	61720	64614	64821
22533	61518	61735	64620	64822
22534	61519	61781	64630	64823
22556	61520	61782	64633	64831
22558	61521	61783	64634	64832
22585	61526	61850	64635	64834
22610	61530	61860	64636	64835

Neurosurgical CPT Codes for 3 treatments (Multiple CPT codes performed as a single procedure on the same date of service do not qualify for more than 3 treatment visits.)				
22612	61531	61863	64640	64836
22614	61533	61864	64650	64837
22630	61534	61867	64653	64840
22632	61535	61868	64680	64856
22840	61536	61870	64681	64857
22841	61537	61875	64702	64858
22842	61538	61885	64704	64859
22843	61539	61886	64708	64861
22844	61540	61888	64712	64862
22845	61541	62000	64713	64864
22846	61542	62005	64714	64865
22847	61543	62010	64716	64866
22848	61545	62140	64718	64868
22849	61546	62141	64719	64870
22850	61548	62142	64721	64872
22851	61566	62143	64722	64874
22852	61567	62148	64726	64876
22853	61570	62162	64727	64885
22854	61571	62164	64732	64886
22855	61583	62165	64734	64890
22859	61584	62272	64736	64891
32664	61590	63191	64738	64892
35301	61591	63200	64740	64893
35390	61592	63265	64742	64895
35475	61595	63266	64744	64896
35476	61596	63267	64746	64897
37184	61597	63268	64752	64898
37185	61598	63270	64755	64901
37186	61601	63271	64760	64902
37202	61606	63272	64761	64905
37211	61609	63273	64763	64907
37212	61610	63600	64766	64999
37213	61611	63700	64771	69930
37214	61612	63702	64772	69990
37215	61613	63704	64774	75894
37216	61615	63706	64776	75896
37236	61623	63710	64778	75898
37237	61624	64550	64782	75962
37238	61626	64553	64783	75978
37239	61630	64555	64784	76376
61107	61635	64561	64786	76377
61108	61640	64565	64787	95970
61140	61641	64575	64788	95971
61154	61642	64580	64790	95972
61156				95974
61215				0075T
61312				0076T

Musculoskeletal Surgical CPT Codes for 3 treatments (Multiple CPT codes performed as a single procedure on the same date of service do not qualify for more than 3 treatment visits.)				
20930	24665	25931	27290-27295	27846
20931	24685	26055	27380-27499	27880-27882
20936	24900	26060	27506-27507	27884
20937	24920	26070	27511	27886
20938	24925	26075	27513-27514	27888-27889
20975	24930–24931	26080	27519	28200-28360
21445	24935	26340-26596	27524	28415
21454	24940	26615	27535-27536	28445-28446
21465	25260-25492	26665	27540	28465
21490	25515	26685	27556	28485
21495	25525	26715	27566	28505
22318	25526	26735	27590-27592	28525
22325	25545	26746	27594	28531
22532-22870	25574	26765	27596	28555
23395-23491	25607-25609	26785	27598	28585
23515	25628	26910	27650-27699	28615
23530	25645	26951-26952	27703-27745	28645
23550	25652	27097-27187	27758	28675
23585	25670	27202	27759	28800
23615	25676	27215	27766	28805
23630	25685	27217-27218	27769	28810
23660	25695	27226-27228	27784	28820
23670	25900	27236	27792	28825
23680	25905	27244	27814	29800-29999
23900	25907	27248	27822	63001-63051
23920-23921	25909	27253-27254	27826	64721
24300-24498	25915	27258-27259	27827	
24515	25920	27269	27828	
24545	25922	27280	27829	
24575	25924	27282	27832	
24579	25927	27284		
24586	25929	27286		
24615				

Musculoskeletal Surgical CPT Codes for 2 evaluations and 8 treatments (Multiple CPT codes performed as a single procedure on the same date of service do not qualify for more than 8 treatment visits.)				
23470	24362	24366	27132	27700-27702
23472	24363	27125	27440-27443	31360
24360	24365	27130	27445-27447	31365
24361				

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

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
Timed units billed must meet CMS regulations:
1 unit: ≥8 minutes through 22 minutes
2 units: ≥23 minutes through 37 minutes
3 units: ≥38 minutes through 52 minutes
4 units: ≥53 minutes through 67 minutes
5 units: ≥68 minutes through 82 minutes
6 units: ≥83 minutes through 97 minutes
7 units: ≥98 minutes through 112 minutes
8 units: ≥113 minutes through 127 minutes

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

Treatment services **do not contain** 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, or travel is not billable to the Medicaid program or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

All treatment services must be provided on an individualized basis with the exception of speech-language services, which consist of group speech therapy with a maximum total number (that is , both non-eligible and Medicaid-eligible beneficiaries) of four (4) children per group.

F. Place of Service

The provider's type and specialty determines the outpatient setting allowed.

G. Co-payments

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

H. Reimbursement

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