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Related Clinical Coverage Policies
Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:
10A, *Outpatient Specialized Therapies*
10B, *Independent Practitioners (IP)*

1.0 Description of the Procedure, Product, or Service

The covered services described below are assessments and treatments provided to NC Medicaid *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*) -eligible beneficiaries through a beneficiary's Individualized Education Program (IEP) and performed by school staff or contracted personnel. It is the responsibility of the Local Education Agencies (LEA) to ensure that clinicians, including contractors, are appropriately credentialed.

1.1 Definitions:

None Apply.

1.2 Audiology Services

1.2.1 Assessment

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

a. auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds;
b. auditory discrimination in quiet and noise;
c. impedance audiometry, including tympanometry and acoustic reflex;
d. hearing aid evaluation;
e. central auditory function; or
f. auditory brainstem evoked response.

1.2.2 Treatment

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

a. auditory training;
b. speech reading; or
c. augmentative communication.

1.3 Speech/Language Services

1.3.1 Assessment

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

a. receptive and expressive language;
b. auditory memory, discrimination, and processing;
c. vocal quality and resonance patterns;
d. phonological development;
e. pragmatic language;

f. rhythm/fluency;
g. oral mechanism;
h. swallowing assessment;
i. augmentative communication; or
j. hearing status based on pass/fail criteria.

1.3.2 Treatment

This service may include one or more of the following as appropriate:
a. articulation therapy;
b. language therapy; receptive and expressive language;
c. augmentative communication training;
d. auditory processing, discrimination, and training;
e. fluency training;
f. disorders of speech flow;
g. voice therapy;
h. oral motor training; swallowing therapy; or
i. speech reading.

1.4 Occupational Therapy Services

1.4.1 Assessment

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

1.4.2 Treatment

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

m. functional mobility training; or
n. perceptual motor training.

1.5 Physical Therapy Services

1.5.1 Assessment

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

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

1.5.2 Treatment

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

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

1.6 Psychological/Counseling Services

1.6.1 Assessment

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

a. cognitive;
b. emotional/personality;
c. adaptive behavior;
d. behavior; or
e. perceptual or visual motor.

1.6.2 Treatment

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

a. cognitive-behavioral therapy;
b. rational-emotive therapy;
c. family therapy;
d. individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication and sensory integrative therapy; or
e. sensory integrative therapy.

1.7 Nursing Services

Nursing services are services directly related to a written plan of care (POC) based on a licensed Medical Doctor (MD), Doctor of Podiatric Medicine (DPM), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP) or Certified Nurse Midwife (CNM) written order. The POC must be developed by a registered nurse (RN). These services include but are not limited to:

a. bladder catheterizations;
b. suctioning;
c. medication administration and management, including observing for adverse reactions, response, or lack of response to medication and informing the student about the medications;
d. oxygen administration, tracheotomy, and ventilator care;
e. enteral feedings;
f. other treatments ordered by the physician and outlined in the POC;
g. collaboration with the student's primary physician regarding all medical/mental health–related medically necessary services that are outlined in the Individualized Education Plan (IEP); and
h. training and oversight of delegated services by an RN, including the following:
    1. assessing capabilities of personnel in relation to client status and plan of nursing care and providing adequate training;
    2. delegating responsibility or assigning nursing care functions to personnel qualified to assume such responsibility and to perform such functions;
    3. accountability for nursing care given by all personnel to whom that care is assigned and delegated; and
    4. direct observation of clients and evaluation of nursing care given

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.

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

2.1.2 Specific

Medicaid

Beneficiaries 3 years of age through 20 years of age who are enrolled in a public school are eligible. Beneficiary eligibility for health-related services depends upon whether:

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

b. the beneficiary's need for treatment services has been confirmed by a licensed MD, DPM, DO, PA, NP or CNM;

c. the beneficiary receives the service(s) in the public school setting or a setting identified in an IEP or Individualized Family Service Plan (IFSP) and is receiving special education services as part of an IEP or IFSP; and

d. the beneficiary receives the service(s) in the public school setting or a setting identified in an IEP or IFSP and is receiving special education services as part of an IEP/IFSP.

NCHC

NCHC beneficiaries are not eligible for Outpatient Specialized Therapies when provided by Local Education Agencies.

2.2 Special Provisions

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

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

2.2.2 EPSDT does not apply to NCHC beneficiaries

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

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

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

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

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Service is covered when it is medically necessary and is outlined in an IEP or IFSP. All services must be medically necessary as defined by the policy guidelines (national standards, best practice guidelines, etc.) recommended by the authoritative bodies for each discipline and are outlined in an IEP or IFSP.

3.2.3 NCHC Additional Criteria Covered

None Apply.

3.3 Physical Therapy (PT)

Medicaid accepts the medical necessity criteria for physical therapy treatment as follows the American Physical Therapy Association (APTA), APTA official statements, APTA position papers, and current physical therapy research from peer reviewed journals.

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

3.4 Occupational Therapy (OT)

Medicaid accepts the medical necessity criteria for occupational therapy treatment as follows the American Occupational Therapy Association (AOTA) most recent edition of The Practice Framework, AOTA official statements, AOTA position papers, and current occupational therapy research from peer reviewed journals.

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

3.5 Speech/Language-Audiology Therapy

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

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

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

c. The following criteria for birth to 21 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 of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd–6th percentile, **or** • A language quotient or standard score of 70–77, **or** • A 25%–29% delay on instruments which determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A 30% or more delay on instruments that determine scores in months, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications Medicaid Beneficiaries 3 – 5 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th–15th percentile, **or** • A language quotient or standard score of 78–84, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6- to 12-month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd–6th percentile, **or** • A language quotient or standard score of 70–77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13- to 18-month delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 19-month or more delay, **or** • Additional documentation of examples indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications Medicaid Beneficiaries 5 through 20 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th–15th percentile, **or** • A language quotient or standard score of 78–84, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrate a 1-year to 1-year, 6-month delay, **or** • Additional documentation of examples indicating that the beneficiary exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics, or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd–6th percentile, **or** • A language quotient or standard score of 70–77, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1-year, 7-month to 2-year delay, or • Additional documentation of examples indicating that the beneficiary exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2-year or more delay, **or** • Additional documentation of examples indicating that the beneficiary exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

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

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

Phonology Treatment Goals Based on Age of Acquisition of Adult Phonological Rules	
Age of Acquisition	**Treatment Goal(s)**
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
When beneficiaries develop idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and should be addressed in therapy. Minor processes, or secondary patterns such as glottal replacement, apicalization and palatalization typically occur in conjunction with other major processes. These minor processes frequently correct on their own as those major processes are being targeted.	
After age 4 years, 0 months	Deaffrication, vowelization/vocalization, cluster reduction, 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 when the percentage of stuttered words fall in a lower severity rating and the duration and the presence of physical characteristics falls in a higher severity rating.	

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

Differential Diagnosis for Stuttering

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

More Usual (Typical Dysfluencies)

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

Crossover Behaviors

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

More Unusual (Atypical Dysfluencies)

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

d. **Augmentative and Alternative Communication** (AAC) standards for treatment from ASHA *Augmentative Communication Strategies*, volume II, 1988 and any subsequent editions. The criteria must:
   1. define parameters for involvement and services of the therapist for evaluation and treatment, not purchases of the devices or equipment; and
   2. not override or replace existing limits on coverage for services, either as dollar amounts or as acceptable billing codes.

"The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each person's preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual's initiative, independence, and sense of personal responsibility and self-worth."

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

a. counseling;
b. product dispensing;
c. product repair/modification;
d. AAC system and/or device treatment/orientation;
e. prosthetic/adaptive device treatment/orientation; and
f. speech/language instruction.

AAC treatment codes are used for the following:

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

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

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

a. update of device;
b. replacement of current device;
c. significant revisions to the device and/or vocabulary; or
d. medical changes.

3.6 Audiology Therapy (Aural Rehabilitation) Practice Guidelines

The basis for audiology referral is the presence of any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation assessment or presence of impaired or compromised auditory processing abilities on the basis of the results of a central auditory test battery.

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

a. Hearing loss (any type) >25 dBHL at 2 or more frequencies in either ear;
b. Standard Score more than 1 SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing;
c. Impaired or compromised auditory processing abilities as documented on the basis of the results of a central auditory test battery; or
d. Less than 1-year gain in skills (auditory, language, speech, processing) during a 12-month period of time.

3.6.1 Underlying Referral Premise

Aural rehabilitation includes:

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

3.6.2 Evaluation—Audiologic (Aural) Rehabilitation

Service delivery requires the following elements:

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

Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary's skills in both clinical and natural environments and the written evaluation report must include:

a. Medical and audiological history;
b. Reception, comprehension, and production of language in oral, signed or written modalities;
c. Speech and voice production;
d. Perception of speech and non-speech stimuli in multiple modalities;
e. Listening skills;
f. Speech reading; and
g. Communication strategies.

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

3.6.3 Evaluation—Central Auditory Processing Disorders (CAPD)

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

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

a. Communication, medical, educational history;
b. Central auditory behavioral tests. Types of central auditory behavioral tests include:
    1. Tests of temporal processes;
    2. Tests of dichotic listening;
    3. Low redundancy monaural speech tests; and
    4. Tests of binaural interaction.
c. Central auditory electrophysiologic tests include:
    1. Auditory brainstem response (ABR);
    2. Middle latency evoked response (MLR);
    3. N1 and P2 (late potentials) responses and P300;
    4. Mismatched negativity (MMN);
    5. Middle ear reflex; and
    6. Crossed suppression of otoacoustic emissions.

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

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

3.6.4 Functional Deficits

Functional deficits include a beneficiary's inability to:

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

3.6.5 Treatment Planning

The treatment plan is developed in conjunction with the beneficiary, caregiver and medical provider and considers performance in both clinical and natural environments. Language therapy treatments sessions shall not be billed concurrently with aural rehabilitation therapy treatment sessions. Treatment must be culturally appropriate. Short- and long-term functional communication goals and specific objectives are determined from assessment.

The amount of time, place(s), and professional or lay person(s) involved must be designated. Generalization of skills and strategies is enhanced by extending practice to the natural environment through collaboration among key professionals. Goals and objectives shall be reviewed periodically to determine appropriateness and relevance and shall include measurable targets within these areas.

a. Short-term Goals: Improve the overall communication process as defined in functional limitations.
b. Long-term Goals: Decrease or eliminate functional deficit.

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

3.6.6 Discharge

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

a. beneficiary has achieved functional goals and outcomes;
b. beneficiary's performance is Within Normal Limits, WNL for chronological age on standardized measures of language, speech, audition, and/or auditory processing (as applicable to the client); or
c. non-compliance with treatment plan (including caregiver).

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

3.6.7 Follow-Up

Re-admittance to audiologic (aural) rehabilitation can result from changes in:

a. Functional status;
b. Living situation;

c. School or childcare; or
d. Caregiver or personal interests.

3.7 Nursing Services

Medicaid accepts the medical necessity criteria for beginning, continuing, and terminating treatment as documented in an established POC ordered by a licensed MD, DPM, DO, PA, NP or CNM. Services must be within the scope of practice and comply with other licensure rules as outlined in the North Carolina Nursing Practice Act.

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

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

4.1 General Criteria Not Covered

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

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

OT, PT, speech/language-audiology, psychological/counseling services, and nursing services are not covered when the above medical criteria are not met. Medicaid reimburses for medically necessary services only.

4.2.3 NCHC Additional Criteria Not Covered

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

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

The prior approval process is deemed met by the IEP process.

5.2 Limitations or Requirements

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

Assessment services are billable only for students receiving assessment services prescribed through an IEP. Initial assessments done for the purpose of identification for Special Education Services are only reimbursable from Medicaid after the development of an IEP that lists the service as one being needed by the beneficiary. If the assessment does not reveal "medical necessity" for the services, the assessment cannot be billed. Medical necessity criteria outlined in **Section 3.0** of this policy must be met.

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

All treatment services shall be provided on an individualized face to face basis as outlined in an IEP 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 or monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and travel is not billable to Medicaid or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.

5.3 Location of Service

The service must be performed at the location identified on the IFSP or IEP.

5.4 Treatment Services

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

a. All services must be provided according to a documented treatment plan. The IEP can include many of the requirements of the treatment plan but does not sufficiently meet all the requirements.
b. The treatment plan for services must include defined goals for each therapeutic discipline.

c. The treatment plan must include anticipated skilled interventions, frequency of services, duration of the therapy plan and length of each treatment visit for each therapeutic discipline.

d. A licensed MD, DPM, DO, PA, NP or CNM verbal or a written order must be obtained for services* prior to the start of the services. Backdating is not allowed.

***Note:** *Services are all therapeutic PT, OT, S/L, psychological/counseling activities beyond the entry evaluations. This includes recommendations for specific programs, providers, methods, settings, frequency and intensity of services.*

e. Service providers shall review and renew or revise plans and goals no less often than annually, to include obtaining another dated signature for the renewed or revised orders. The IEP requirement of parent notification must occur at regular intervals throughout the year, and such notification must detail how progress is sufficient to enable the beneficiary to achieve the IEP goals by the end of the year. There will be no payment for services rendered more than a year **after** the annual IEP review. The signature date must be the date the order is signed. Backdating is not allowed.

f. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet. Electronic signatures and printed dates are acceptable. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper or of records in the event of a system breakdown. Stamped signatures are not permitted.

All treatment services must be provided on an individualized face to face basis except for speech/language services that include group speech therapy with a maximum total number of four (4) children per group. The group may contain both non-eligible and Medicaid-eligible beneficiaries. However, only the time spent with the Medicaid-eligible beneficiary is billable to Medicaid.

5.5 Amount of Service

Only medically necessary services documented in the IEP are covered.

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

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

a. meet Medicaid or NCHC qualifications for participation;

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

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

The physical therapist, occupational therapist, speech-language pathologist, and audiologist shall comply with their entire practice act for the discipline regarding providing quality services, supervision of services and billing of services. The provider

agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice.

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

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

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

Below are laws and regulations for each discipline, including:

Occupational Therapist

Qualified occupational therapist defined under 42 CFR § 440.110(b)(2) who meets the qualifications as specified under 42 CFR §484.4.

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

Title 21NCAC, Chapter 38 Occupational Therapy

Physical Therapist

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

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

Title 21 NCAC, Chapter 48 Physical Therapy Examiners

Speech-Language Pathologist

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

Speech-language pathologist requirements are specified under 42CFR § 484.4.

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

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

Audiologist

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

Audiologist qualifications specified under 42 CFR 484.4.

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

Licensure Act for Speech and Language Pathologists and Audiologists
Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists

Psychological/Counseling Services

Qualifications of Providers: Minimum qualifications for providing services are licensure as a psychological associate or practicing psychologist by the North Carolina State Board of Examiners of Practicing Psychologists, or licensure as a school psychologist by the NC Department of Public Instruction, and Licensed Clinical Social Workers. Licensed Clinical Social Workers and Licensed Psychologists shall provide documentation of appropriate training and experience, which qualifies them to work with students in an educational setting.

G.S. 115C-316.1.(a)(2) Duties of school counselors
G.S. 90-332.1.(a)(2) Exemptions from licensure

Nursing Services

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

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

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

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

Provider Certifications

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

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 must maintain and allow DMA to access the following documentation for each individual:

a. The patient name and Medicaid identification number;
b. A copy of the treatment plan (IEP accepted for LEAs);
c. A copy of the MD, DO, DPM, CNM, PA, or NP's order for treatment services. Date signed must precede treatment dates;
d. Description of services (intervention and outcome/client response) performed and dates of service. This element must be present in a note for each billed date of service;
e. The duration of service (i.e., length of assessment and/or treatment session **in minutes**). This element must be present in a note for each billed date of service;
f. The signature and credentials of the person providing each service. Each billed date of service must be individually documented and signed by the person providing the service;
g. A copy of each test performed or a summary listing all test results included in the written evaluation report;
h. For medication administration under nursing services, a flow sheet or equivalent documentation must be used by the nurse or delegated individual. The documentation must show the nurse's/delegated individual's full name and title. The date and time administered as well as nurse's/individual's initials and title must be written after each medication given. A narrative note summarizing the medication administered must be completed at least weekly by the RN with (if appropriate) input from the delegated person administering medication. This note should document results from the medication, side effects of the medication, and any other pertinent data;
i. Other nursing services outlined in the POC require the same documentation as all IEP services;
j. For delegated services, there must be documentation of training and validation of competency by the RN of the person who will be performing the procedure. In addition, documentation, at a minimum monthly, that the RN monitors the care of the student to ensure that the procedure is being performed safely and effectively.

The documentation usually is a form in which the school nurse and the assistant sign and date that the procedure is being done correctly; and

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

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

Because services provided in schools may be unique and differ from those provided in other settings, documentation to justify medical necessity could be more like progress notes identifying the services provided with an assessment of results and goals for the next treatment. Such documentation does not have to be lengthy and can be accomplished in a couple of sentences. It does, however, have to be clear to a reviewer to support the services billed.

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

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

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

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

7.3 Post-Payment Validation Reviews

Medicaid or agents acting on behalf of Medicaid will perform reviews for monitoring utilization, quality, and appropriateness of all services rendered. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider. While services provided by LEAs are excluded from prior authorization, they will be subject to post-payment review.

8.0 Policy Implementation and History

Original Effective Date: Month Day, Year

History:

Date	Section Revised	Change
10/01/2003	Subsection 3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/2003	Subsection 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/2003	Appendix A	The mailing address for the form was changed.
12/01/2003	Section 5.0	The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
07/01/2004	All sections and attachment(s)	Psychological changed to Psychological/Counseling
07/01/2004	Subsection 1.5, Psychological/Counseling Services Treatment services	Sociodrama and social skills training changed to individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy
07/01/2004	Subsection 5.2, Treatment Services # 5	Requirement for six month plan review and physician's order changed to annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
07/01/2004	Subsection 5.2, Treatment Services # 4 Subsection 7.1, Documenting Services	Extended through school year 2005 that the order must be obtained prior to services being billed, not before treatment rendered.
07/01/2004	Subsection 5.5, Other Limitations Subsection 8.1, Billing Guidelines	Added reimbursement for initial assessments if the service is an identified need in the IEP
07/01/2004	Subsection 6.1, Audiology Subsection 6.2, Speech/Language	Changed provider qualifications to allow CCC equivalency
01/01/2005	Subsection 8.2, Audiology Assessment	CPT code92589 was end-dated and replaced with 92620 and 92621

Date	Section Revised	Change
07/01/2005	Subsection 5.2, Treatment Services # 4 Subsection 7.1, Documenting Services	Extended through school year 2006 that the order must be obtained prior to services being billed, not before treatment rendered.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.3	The web address for DMA's EDPST policy instructions was added to this section.
12/01/2005	Subsection 8.3	The Place of Service code was converted to 03.
01/01/2006	Subsection 8.2	CPT procedure code 95210 was end-dated and replaced with 92626, 92627, 92630 and 92633; 97504 was end-dated and replaced with 97760; 97520 was end-dated and replaced with 97761; 97703 was end-dated and replaced with 97762; 96100 was end-dated and replaced with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
06/01/2006	Subsection 5.2, Treatment Services # 4 Subsection 7.1, Documenting Services	Extended through school year 2007 that the order must be obtained prior to services being billed, not before treatment rendered.
06/01/2006	Subsection 8.2	CPT procedure codes 92626 and 92627 were deleted from the list of codes for Speech/Language Treatment and added to the list of codes for Speech/Language Assessment and Audiology Assessment.
07/01/2006	Attachment A	The Certification of Non-Federal Match Form was replaced with a new version of the form.
10/01/2006	Attachment A	The Certification of Non-Federal Match Form was replaced with a new version of the form.
12/01/2006	Subsection 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
03/01/2007	Section 3.0	A reference was added to indicate that medical necessity is defined by the policy guidelines recommended by the authoritative bodies for each discipline.
03/01/2007	Subsection 3.3	A reference to ASHA guidelines regarding bilingual services was added as a source of medical necessity criteria for Speech/Language-Audiology therapy treatment for Spanish speaking recipients
03/01/2007	Section 6.0	A reference to 42 CFR 440.110 and 440.60 was added to this section.
04/01/2007	Section 6.0	Clarified that online verification of staff credentials is acceptable.
04/01/2007	Subsection 2.3, and Sections 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.

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

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

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

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

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

Date	Section Revised	Change
06/01/2014	Attachment A (E)	Added: Timed units billed must meet CMS regulations: 1 unit: ≥8 minutes through 22 minutes 2 units: ≥23 minutes through 37 minutes 3 units: ≥38 minutes through 52 minutes 4 units: ≥53 minutes through 67 minutes 5 units: ≥68 minutes through 82 minutes 6 units: ≥83 minutes through 97 minutes 7 units: ≥98 minutes through 112 minutes 8 units: ≥113 minutes through 127 minutes
07/01/2015	Attachment A	Removed CPT Code 92507 under Audiology Treatment procedures
07/01/2015	Attachment A	Added CPT Codes 92630 and 92633 under Audiology Treatment procedures
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/01/2015	All Sections and Attachments	Removed all references to the discipline specific ICD-9-CM aftercare codes V57.

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)

Separate CMS-1500 claim forms must be filed for assessment and treatment services, and separate forms must be filed for each type of service provided. It should be noted that individual and group speech therapy, being the same type of service, can be listed on the same claim form. All claims must be sent electronically or mailed directly to FISCAL AGENT. Refer to the *Basic Medicaid and NC Health Choice Billing Guide* for general billing information at http://www.ncdhhs.gov/dma/basicmed/.

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

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

All claims must be sent directly to FISCAL AGENT. Refer to the *Basic Medicaid and NC Health Choice Billing Guide* for instructions.

Refer to the *Basic Medicaid and NC Health Choice Billing Guide* for details regarding billing issues.

Refer to **Section 3.0, When the Product, Procedure, or Service is Covered,** and **Subsection 5.4, Treatment Services,** for additional information.

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

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

C. Code(s)

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

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

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

Audiology Therapy Assessment

CPT Code	Unit of Service
92550	(1 unit = 1 test)
92551	(1 unit = 1 test)
92552	(1 unit = 1 test)
92553	(1 unit = 1 test)
92555	(1 unit = 1 test)
92556	(1 unit = 1 test)
92557	(1 unit = 1 test)
92567	(1 unit = 1 test)
92568	(1 unit = 1 test)
92569	(1 unit = 1 test)
92570	(1 unit = 1 test)
92571	(1 unit = 1 test)
92572	(1 unit = 1 test)
92576	(1 unit = 1 test)
92579	(1 unit = 1 test)
92582	(1 unit = 1 test)
92583	(1 unit = 1 test)
92585	(1 unit = 1 test)
92587	(1 unit = 1 test)
92588	(1 unit = 1 test)
92590	(1 unit = 1 test)
92591	(1 unit = 1 test)
92592	(1 unit = 1 test)
92593	(1 unit = 1 test)
92594	(1 unit = 1 test)
92595	(1 unit = 1 test)
92620	(1 unit = 60 min)
92621	Each additional 15 minutes (1 unit = 1 test) must be used with 92620
92626	(1 unit = 60 min)
92627	Each additional 15 minutes (1 unit = 15 minutes) must be used with 92626

Audiology Therapy Treatment

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

Speech/Language Therapy Assessment

CPT Code	Unit of Service
92521	(1 unit = 1 test)
92522	(1 unit = 1 test)
92523	(1 unit = 2 tests)
92524	(1 unit = 1 test)
92607	(1 unit = 1 test)
92608	Each additional 30 minutes (1 unit = 1 test) must be used with 92607
92551	(1 unit = 1 test)
92610	(1 unit = 1 test)
92612	(1 unit = 1 test)
92626	(1 unit = 60 min)
92627	Each additional 15 minutes (1 unit = 15 minutes) must be used with 92626
96125	(1 unit = 1 hour)

Speech/Language Therapy Treatment

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

Occupational Therapy Assessment

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

Occupational Therapy Treatment

CPT Code	Unit of Service
29075	(1 unit = 1 event)
29085	(1 unit = 1 event)
29105	(1 unit = 1 event)
29125	(1 unit = 1 event)
29126	(1 unit = 1 event)
29130	(1 unit = 1 event)
29131	(1 unit = 1 event)
29240	(1 unit = 1 event)
29260	(1 unit = 1 event)

29280	(1 unit = 1 event)
29530	(1 unit = 1 event)
29540	(1 unit = 1 event)
92065	(1 unit = 1 event)
92526	(1 unit = 1 event)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

Physical Therapy Assessment

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

Physical Therapy Treatment

CPT Code	Unit of Service
29075	(1 unit = 1 event)
29085	(1 unit = 1 event)
29105	(1 unit = 1 event)
29125	(1 unit = 1 event)
29126	(1 unit = 1 event)
29130	(1 unit = 1 event)
29131	(1 unit = 1 event)
29240	(1 unit = 1 event)
29260	(1 unit = 1 event)
29280	(1 unit = 1 event)
29405	(1 unit = 1 event)
29505	(1 unit = 1 event)
29515	(1 unit = 1 event)
29530	(1 unit = 1 event)
29540	(1 unit = 1 event)
92526	(1 unit = 1 event)
95992	(1 unit = 1 event)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)

97116	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)

Psychological/Counseling Services Assessment

CPT Code	Unit of Service
90801	(1 unit = 1 visit)
90802	(1 unit = 1 visit)
96101	(1 unit = 1 hour)
96110	(1 unit = 1 hour)
96111	(1 unit = 1 hour)
96116	(1 unit = 1 hour)
96118	(1 unit = 1 hour)

Psychological/Counseling Services Treatment

CPT Code	Unit of Service
90804	(1 unit = 20–30 minutes)
90806	(1 unit = 45–50 minutes)
90808	(1 unit = 75–80 minutes)
90810	(1 unit = 20–30 minutes)
90812	(1 unit = 45–50 minutes)
90814	(1 unit = 75–80 minutes)
90846	(1 unit = 1 visit)
90853	(1 unit = 1 visit)

Nursing Services

HCPCS Procedure Code	Unit of Service
T1002	(1 unit = 15 minutes)
T1003	(1 unit = 15 minutes)
S5125	(1 unit = 15 minutes)

Unlisted Procedure or Service

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

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

Third-Party Liability

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

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

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

Refer to the Basic Medicaid and NC Health Choice Billing Guide for additional information.

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

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

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

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

F. Place of Service

The service must be performed at the location identified on the IEP.

G. Co-payments

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

Co-payments are not required for Local Education Agencies

H. Reimbursement

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

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