North Carolina
Medicaid Special Bulletin

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Attention:

Area Mental Health Centers
Developmental Evaluation Centers
Head Start/Local Education Agencies
Home Health Providers
Hospital Outpatient Clinics
Independent Practitioner Providers
Local Health Departments
Physician Services

Outpatient Specialized Therapies

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Introduction

The N.C. Medicaid program has amended a contract with Medical Review of North Carolina (MRNC) to include prior approval of all outpatient specialized therapy services currently provided under Medicaid.

Effective October 1, 2002, this contract will encompass all outpatient treatment services for Occupational Therapy, Physical Therapy, Speech Therapy, Respiratory Therapy, and Audiological services (except schools) regardless of where the services are provided. MRNC will review these services and authorize care at designated trigger points. After these trigger points have been reached, claims will not process without prior approval.

In addition to obtaining prior approval, providers must follow the established guidelines for their respective programs. The Outpatient Specialized Therapy policy is not all inclusive of program requirements. Detailed information regarding coverage, limitations and exclusions can be found in individual program manuals.

Note: Local education agencies (LEAs), HMOs, and Medicare recipients are exempt from the MRNC process.

Outpatient Specialized Therapies

1.0 Description of Services

Outpatient Specialized Therapies include evaluations, re-evaluations, and/or multidisciplinary evaluations as well as therapeutic physical, occupational, speech, respiratory, and audiologic services provided by all provider types and in all settings except hospital/rehabilitation inpatient settings.

2.0 Eligible Recipients

Medicaid-eligible individuals with a need for specialized therapy services confirmed by a licensed physician, physician assistant or nurse practitioner are eligible to receive specialized therapies. This policy does not supercede eligibility restrictions or other governing program policies (ex., as in home health, federal regulations allow only a licensed physician to order a service).

Refer to **Section 5.0, Policy Guidelines**, for specific eligibility limitations.

3.0 When the Service is Covered

All services must be medically necessary. Specific criteria will be established at a later time based upon best practice guidelines for each discipline. Medically necessary services are covered for recipients over 21 only when provided by Home Health, hospital outpatient departments, physician offices, and area mental health centers.

4.0 When a Service is Not Covered

Specialized therapies are not covered when the following policy guidelines are not met.

5.0 Policy Guidelines

5.1 Patient's Location

A patient may receive specialized therapy in the setting allowed by the provider's type and specialty.

5.2 Treatment Services

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

1. All services must be provided according to a written plan.
2. The written plan for services must include defined goals for each therapeutic discipline.
3. Each plan must include a specific content, frequency and intensity of services for each therapeutic discipline.
4. A verbal or a written order must be obtained for services***** prior to the start of the services. If the order is written, there will be no payment for services rendered before the signature date. The signature date must be the date the physician signs the order. If the order is verbal, it must be countersigned within 30 calendar days

of the date of the verbal order. If not signed within 30 days, it is subject to recoupment effective with day 1 of the service. Backdating is not allowed.

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

5. Service providers must review and renew or revise plans and goals no less often than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than 6 months **after** the most recent physician order signature date **and before** the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.

6. Up to six unmanaged visits per discipline, per provider type are allowed without prior approval. Evaluations, re-evaluations, and/or multidisciplinary evaluations are **not** counted in the six unmanaged visits. If six therapy visits occur before six months from a physician's order for any specific discipline, and if services need to be continued for additional visits, Medical Review of North Carolina (MRNC) may approve continued services without an additional physician order under the following conditions:******

    a. The continued services must have a written plan with defined goals for each therapeutic discipline.

    b. The written plan must include a specific content, duration, frequency, and length of visits for each therapeutic discipline (e.g., PT services to include [list treatment modalities] for six weeks at three visits per week for 30 minutes each visit).

    c. The request for continuation of services must be accompanied by the documentation of the plan, goals and outcomes for the previous service interval.

    d. There will be no payment for services rendered in excess of six visits and before the date of the approval for continuation of services.

7. If a patient between birth and five years of age has had a Developmental Evaluation Center (DEC) or DEC-approved evaluation and has an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP), that will change the time for required MRNC approval for continued services from 6 visits to 6 months after the initial physician's order. The initial claim and the request for continued services must both include the DEC Medicaid provider number on the CMS-1500 (HCFA-1500) form to document that evaluation. If the DEC provider number is not included, the claim is subject to the same six visit approval requirement as all other claims.

8. 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.

****Note:** The screening thresholds (6 visits) being applied initially are designed to meet the prior approval requirements of the N.C. General Assembly while Medicaid collects data on which future, more clinically relevant and discipline-specific criteria will be based. The intention is to allow each discipline to assist in defining policy guidelines consistent with recommendations from the authoritative bodies for each discipline (national standards, best practice guidelines).

5.3 Prior Approval Process

After six unmanaged visits, prior approval is required for continued treatment. Please note that prior approval is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service. The prior approval process does not start until all six visits have been used. However, the prior approval request should be made at approximately the 2nd or 3rd visit to allow sufficient time for processing.

A prior approval request form signed by the provider must be faxed to MRNC for treatment to be continued. If appropriate, MRNC will authorize services for a specific number of units through a specific length of time. Units should be requested based on the CPT code billed. If the CPT code is billed by event then 1 unit should be requested. If the CPT code is billed in 15-minute increments with 15 minutes equaling 1 unit, then the number of units to be provided should be requested. Once these limits have been reached, prior approval must again be requested for continued treatment.

For local educational agencies (LEAs) the prior approval process is deemed met by the IEP process, however all of the requirements listed in **Section 7.0, Additional Requirements**, below must be followed.

Note:

- If a recipient has had a DEC evaluation, prior approval is not required for the first six months. Refer to **item #7, Section 5.2, Treatment Services**, for information on DEC evaluations.
- HMO and Medicare recipients are exempt from the prior approval process.

6.0 Eligible Providers

Eligible providers are defined by each program type.

7.0 Additional Requirements

Documenting Services

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

- The patient name and Medicaid identification number.
- A copy of the treatment plan (IEP accepted for LEAs).
- A copy of the physician's order for treatment services. Date signed must precede treatment dates (verbal order must be signed within 30 days of the date of the order).
- Description of services (intervention and outcome/client response) performed and dates of service.
- The duration of service (i.e., length of assessment and/or treatment session **in minutes**).
- The signature of the person providing each service.
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form with the prior approval authorization.

8.0 Billing Guidelines

Claim Type

Outpatient therapy services delivered in accordance with the policy guidelines in **Section 5.0, Policy Guideline**s, on page 2 may be submitted for reimbursement. Separate CMS-1500 claim forms must be filed for assessment/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.

Claims for hospital and home health services are filed on a UB-92 form.

Providers billing services for recipients who had a DEC evaluation must enter the DEC Medicaid provider number on the CMS-1500 as a referral source since prior approval is not required for six months.

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

Refer to the **Basic Medicaid handout** for additional billing information.

Program Information

Independent Practitioners

1.0 Description of Service

The covered services are assessments and treatments performed by qualified Independent Practitioner (IP) service providers from the following disciplines:

1.1 Audiology Services

Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

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

Treatment

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

- auditory training
- speech reading
- augmentative and alternative communication training (including sign language and cued speech training)
- aural rehabilitation (hearing aid, FM system, assistive listening device, and/or cochlear implant device training)

1.2 Speech/Language (ST) Services

Assessment

Service must include testing and/or clinical observation, as appropriate for chronological or developmental age, for **all** the following areas, and shall yield a written evaluation report.

- expressive language
- receptive language
- auditory processing, discrimination, and memory
- augmentative and alternative communication
- vocal quality
- resonance patterns
- articulation/phonological development
- pragmatic language
- rhythm/fluency

- oral mechanism/swallowing
- hearing status based on pass/fail criteria

Note: Any of the above named areas of functioning may also be addressed as a specialized assessment, following performance of the overall evaluation of the child's speech/language skills.

Treatment
Service may include one or more of the following, as appropriate:

- articulation/phonological training
- language therapy
- augmentative and alternative communication training
- auditory processing/discrimination training
- fluency training
- voice therapy
- oral motor training; swallowing therapy
- speech reading

1.3 Occupational Therapy (OT) Services

Assessment
Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- activities of daily living assessment
- sensorimotor assessment
- neuromuscular assessment
- fine motor assessment
- feeding/oral motor assessment
- visual perceptual assessment
- perceptual motor development assessment
- musculo-skeletal assessment
- gross motor assessment
- functional mobility assessment
- pre-vocational assessment

Treatment
Service may include one or more of the following, as appropriate:

- activities of daily living training
- neuromuscular development
- muscle strengthening, endurance training
- feeding/oral motor training
- adaptive equipment application
- visual perceptual training

- facilitation of gross motor skills
- facilitation of fine motor skills
- fabrication and application of splinting and orthotic devices
- manual therapy techniques
- sensorimotor training
- pre-vocational training
- functional mobility training
- perceptual motor training

1.4 Physical Therapy (PT) Services

Assessment

Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and shall yield a written evaluation report.

- neuromotor assessment
- range of motion, joint integrity, functional mobility, and flexibility assessment
- gait, balance, and coordination assessment
- posture and body mechanics assessment
- soft tissue assessment
- pain assessment
- cranial nerve assessment
- clinical electromyographic assessment
- nerve conduction, latency and velocity assessment
- manual muscle test
- reflex integrity
- activities of daily living assessment
- cardiac assessment
- pulmonary assessment
- sensory motor assessment
- feeding/oral motor assessment

Treatment

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

- manual therapy techniques
- fabrication and application of orthotic device
- therapeutic exercise
- functional training
- facilitation of motor milestones
- sensory motor training
- cardiac training
- pulmonary enhancement

- adaptive equipment application
- feeding/oral motor training
- activities of daily living training
- gait training
- posture and body mechanics training
- muscle strengthening
- gross motor development
- modalities
- therapeutic procedures
- hydrotherapy
- manual manipulation
- wheelchair management

1.5 Respiratory Therapy (RT) Services

Assessment

Service may include testing and/or clinical observation, as appropriate for evaluation of pulmonary status, for one or more of the following areas; and shall yield a written evaluation report.

- collection of specimen for arterial blood gas analysis (ABGs)
- pulmonary function studies
- breath sounds
- acute and chronic lung disease patients
- ventilator dependent patients

Treatment

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

- bronchodilator and aerosol therapy
- oxygen therapy
- sterile and non-sterile suctioning techniques
- tracheostomy care
- chest vibrations, postural drainage, and breathing techniques
- ventilator care
- monitoring of respiratory status (ABGs, pulse oximetry, pulmonary function studies, sputum cultures, apnea-bradycardiac monitors, etc.)

2.0 Eligible Recipients

Recipients must be under the age of 21 and must be Medicaid-eligible when the services are provided.

Note: The IP program **cannot** be billed for Medicaid recipients who are enrolled through an HMO. These services are always classified as being "in-plan."

Note: There is a required referral process for a recipient who is enrolled through the Carolina ACCESS (CA) program.

3.0 When Service is Covered

All services must be medically necessary. Specific criteria will be established at a later time based upon best practice guidelines for each discipline.

4.0 When a Service is Not Covered

OT, PT, ST, and RT are not covered when the following policy guidelines are not met.

Note: The IP program **cannot** be billed for Medicaid recipients who are enrolled through an HMO. These services are always classified as being "in-plan."

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

5.0 Policy Guidelines

5.1 Patient's Location

A patient may receive IP therapy services in the office, home, school, through the Head Start program, and/or child care (i.e., regular and developmental day care) settings.

5.2 Treatment Services

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

1. All services must be provided according to a written plan.
2. The written plan for services must include defined goals for each therapeutic discipline.
3. Each plan must include a specific content, frequency and intensity of services for each therapeutic discipline.
4. A verbal or a written order must be obtained for services***** prior to the start of the services. If the order is written there will be no payment for services rendered before the signature date. The signature date must be the date the physician signs the order. If the order is verbal, it must be countersigned within 30 calendar days of the date of the verbal order. If not signed within 30 days, it is subject to recoupment effective with day 1 of the service. Backdating is not allowed.

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

5. Service providers must review and renew or revise plans and goals no less often than every six months, to include obtaining another dated physician signature for the renewed or revised orders. There will be no payment for services rendered more than 6 months **after** the most recent physician order signature date **and before** the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed.

6. Up to six unmanaged visits per discipline, per provider type are allowed without prior approval. Evaluations, re-evaluations, and/or multidisciplinary evaluations are not counted in the six unmanaged visits. If six therapy visits occur before six months from a physician's order for any specific discipline, and if services need to be continued for additional visits, Medical Review of North Carolina (MRNC) may approve continued services without an additional physician order under the following conditions:******
   a. The continued services must have a written plan with defined goals for each therapeutic discipline.
   b. The written plan must include a specific content, duration, frequency and length of visits for each therapeutic discipline (e.g., PT services to include [list treatment modalities] for six weeks at three visits per week for 30 minutes each visit).
   c. The request for continuation of services must be accompanied by the documentation of the plan, goals and outcomes for the previous service interval.
   d. There will be no payment for services rendered in excess of six visits and before the date of the approval for continuation of services.
7. If a patient between birth and five years of age has had a Developmental Evaluation Center (DEC) or DEC-approved evaluation and has an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP), that will change the time for required MRNC approval for continued services from 6 visits to 6 months after the initial physician's order. The initial claim and the request for continued services must both include the DEC Medicaid provider number on the CMS-1500 (HCFA-1500) form to document that evaluation. If the DEC provider number is not included, the claim is subject to the same six visit approval requirement as all other claims.
8. 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.

****Note:** The screening thresholds (6 visits) being applied initially are designed to meet the prior approval requirements of the N.C. General Assembly while Medicaid collects data on which future, more clinically relevant and discipline-specific criteria will be based. The intention is to allow each discipline to assist in defining policy guidelines consistent with recommendations from the authoritative bodies for each discipline (national standards, best practice guidelines).

5.3 Prior Approval

After six unmanaged visits, prior approval is required for continued treatment. **Prior approval is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service.** The prior approval process does not start until all six visits have been used. However, the prior approval request should be made at approximately the 2nd or 3rd visit to allow sufficient time for processing.

A prior approval request form signed by the provider must be faxed to MRNC for treatment to be continued. If appropriate, MRNC will authorize services for a specific number of units through a specific length of time. Units should be requested based on the Y code or CPT code billed. If the CPT code is billed by event, then one unit should be requested. If the CPT code is billed in 15-minute increments with 15 minutes equaling one unit, then the number of units to be provided should be requested. Once these limits have been reached, prior approval must again be requested for continued treatment.

Prior approval authorizations do not transfer if the recipient changes IP providers.

Note: If a recipient has had a DEC evaluation, prior approval is not required for the first six months. Refer to **item #7, Section 5.2, Treatment Services**, for information on DEC evaluations.

Note: HMO and Medicare recipients are exempt from the prior approval process.

Refer to page 29 for a copy of the prior approval request form.

5.4 Amount of Service

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

5.5 Other Limitations

Assessment Services

For occupational therapy (OT), physical therapy (PT), and respiratory therapy (RT), a maximum of two hours of assessment services, for each type of service, is billable for each assessment. Each written evaluation report should contain a final summary listing the diagnosis/statement of the problem including the primary medical diagnosis, if known, and a secondary treatment-related diagnosis, as well as the recommendations for treatment. The diagnosis should include a statement concerning the degree of severity of each condition exhibited by the patient. The summary should also indicate whether the child has received any known assessments within the past six months for the type of service being billed. 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 submitted.

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

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

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 recipients) 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.

6.0 Eligible Providers

6.1 Audiology

Eligible providers must have:

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists,
2. a master's degree in Audiology, and
3. an ASHA Certificate of Clinical Competence (i.e., CCC) in Audiology, or there must be documentation that the service provider **has completed**:
    a. the requirements and work experience necessary for the Audiology CCC, or
    b. the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Audiology CCC.

6.2 Speech/Language

Eligible providers must have:

1. a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists,
2. a master's degree in Speech/Language Pathology, and
3. an ASHA Certificate of Clinical Competence (i.e., CCC) in Speech/Language Pathology, or there must be documentation that the service provider **has completed**:
    a. the requirements and work experience necessary for the Speech/Language Pathology CCC, or
    b. the academic master's degree program and is acquiring the supervised work experience necessary to qualify for the Speech/Language Pathology CCC.
4. Treatment services may be performed by a Speech/Language Pathology assistant who works under the supervision of an enrolled licensed practitioner.

6.3 Occupational Therapy

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

6.4 Physical Therapy

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

6.5 Respiratory Therapy

Assessment and treatment services must be provided by a respiratory therapist who holds the minimum credential of Certified Respiratory Therapist (CRT), issued by the National Board for Respiratory Care.

7.0 Additional Requirements

7.1 Documenting Services

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

- The patient name and Medicaid identification number.
- A copy of the treatment plan (IEP accepted for LEAs).
- A copy of the physician's order for treatment services. Date signed must precede treatment dates (verbal order must be signed within 30 days of the date of the order).
- Description of services (intervention and outcome/client response) performed and dates of service.
- The duration of service (i.e., length of assessment and/or treatment session **in minutes**).
- The signature of the person providing each service. Treatment documentation must be signed by licensed therapist (e.g., PT co-signs for LPTA).
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form with the prior approval authorization number.

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

If treatment services provided by the IP are the same type of health-related services the patient concurrently receives as part of the public school's special education program, a copy of the patient's current Individualized Education Plan (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 IFSP should be obtained by the billing provider and maintained in the patient's file.

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

Note: The requirement to obtain a copy of the patient's IEP or IFSP does not apply to respiratory therapy services nor to other treatment services that do not extend beyond a maximum of four weeks of treatment.

8.0 Billing Guidelines

8.1 What May Be Billed

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 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 recipients) 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.

8.2 Units of Service

The unit of service is determined by the Y code or CPT code used.

Service Code	Description of Service
Y2401	Audiology Assessment
Y2402	Audiology Treatment
Y2405	Occupational Therapist Assessment
Y2406	Occupational Therapist Treatment
Y2407	Physical Therapy Assessment
Y2408	Physical Therapy Treatment
Y2415	Respiratory Assessment
Y2416	Respiratory Treatment
Y2403	Speech/Language Assessment
Speech/Language Treatment	
Y2404	Individual Student
Y2411	Group of Two Students
Y2412	Group of Three Students
Y2413	Group of Four Students

Note: Y code services will be converted to CPT billing codes in January 2003.

8.3 Payment Rate

Payment is calculated based on the lower of the billed usual and customary charges and Medicaid's maximum allowable rate.

8.4 Filing a Claim

Separate CMS-1500 claim forms must be filed for assessment and treatment services, and separate claim forms must be filed for each type of service provided**.** It should be noted that individual and group speech therapy, being the same type of service, can be listed on the same claim form. All claims should be sent electronically or mailed directly to EDS.

Refer to the **Basic Medicaid handout** for details regarding billing issues.

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

Refer to **Section 3.0, When a Service is Covered**, and **Section 5.2, Treatment Services**, for additional information.

Local Education Agencies (LEAs)

Covered Services

- Audiology Services
- Speech/Language Services
- Occupational Therapy Services
- Physical Therapy Services
- Psychological Services

For LEAs, the prior approval process is deemed met by the IEP process. However, other aspects of the Outpatient Specialized Therapy Policy must be followed. Refer to **Outpatient Specialized Therapies** on page 2 for additional information.

Documenting Services

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

- The patient name and Medicaid identification number.
- A copy of the treatment plan (IEP accepted for LEAs).
- A copy of the physician's signed order for treatment services. Date signed must precede treatment dates (verbal order must be signed within 30 days of the date of the order).
- Description of services (intervention and outcome/client response) performed and dates of service.
- The duration of service (i.e., length of assessment and/or treatment session in minutes).
- The signature of the person providing each service. Treatment documentation must be signed by licensed therapist, (e.g., PT co-signs for LPTA).
- A copy of each test performed or a summary listing all test results, and the written evaluation report.

Units of Service

The unit of service is determined by the Y code or CPT code used.

Service Code	Description of Service
Y2401	Audiology
Y2402	Audiology
Y2405	Occupational Therapy
Y2406	Occupational Therapy
Y2407	Physical Therapy
Y2408	Physical Therapy
Y2409	Psychological
Y2410	Psychological
Y2403	Speech/Language, Assessment Speech /Language Treatment
Y2404	Individual student
Y2411	Group of Two Students
Y2412	Group of Three Students

Note: Y code services will be converted to CPT billing codes in January 2003.

Developmental Evaluation Centers

Covered Services and Provider Qualifications

Audiology Diagnosis and Assessment

Service is provided by an audiologist licensed in the State of North Carolina, in accordance with the N.C. Licensure Act for Speech and Language Pathologists and Audiologists.

Service Code	Description of Service
92551	***Pure tone screening***
92552	***Pure tone audiometry (threshold); air only***
92553	***Pure tone audiometry (threshold); air and bone***
92555	***Speech audiometry threshold;***
92556	***Speech audiometry threshold; with speech recognition***
92557	***Comprehensive audiometry threshold evaluation***
92567	***Tympanometry***
92568	***Acoustic reflex testing***
92569	***Acoustic reflex decay test***
92579	***Visual reinforcement audiometry (VRA)***
92582	***Conditioning play audiometry***
92583	***Select picture audiometry***
92585	***Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive***
92588	***Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)***
92589	***Central auditory function test(s)***
92590	***Hearing aid examination and selection; monaural***
92591	***Hearing aid examination and selection; binaural***
92592	***Hearing aid check; monaural***
92593	***Hearing aid check; binaural***
92594	***Electroacoustic evaluation for hearing aid; monaural***
92595	***Electroacoustic evaluation for hearing aid; binaural***

Audiology Treatment and Patient Instruction

Service is provided by an audiologist licensed by the State of North Carolina, in accordance with the N.C. Licensure Act for Speech and Language Pathologists and Audiologists.

Service Code	Description of Service
92507	***Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual***
92508	***Treatment: group, two or more individuals***
92510	***Aural rehabilitation following cochlear implant***

Occupational Therapy Diagnosis and Assessment
Service is provided by an occupational therapist working within the scope of the North Carolina Occupational Therapy Practice Act.

Service Code	Description of Service
97003	Occupational therapy evaluation
97004	***Occupational therapy reevaluation (used for children treated directly or consultatively by the DEC)***
97703	***Checkout for orthotic/prosthetic use, established patient, each 15 minutes***
97750	***Physical performance test or measurement eg. musculoskeletal, functional capacity with written report, each 15 minutes***
92525	***Evaluation of swallowing dysfunction and/or oral motor function for feeding***

Occupational Therapy Treatment and Patient Instruction
Service is provided by an occupational therapist working within the scope of the North Carolina Occupational Therapy Practice Act.

Service Code	Description of Service
97010	***Application of a modality to one or more areas; hot or cold packs***
97032	***Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes***
97110	***Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility***
97112	***Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception***
97113	***Aquatic therapy with therapeutic exercises***
97124	***Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)***
97140	***Manual therapy techniques (eg., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes***
97520	***Prosthetic training, upper and/or lower extremities, each 15 minutes (preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider, each 15 minutes***
97530	***Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes***
92526	***Treatment of swallowing dysfunction and/or oral function for feeding***

Physical Therapy Diagnosis and Assessment
Service is provided by a physical therapist licensed by the N.C. Board of Physical Therapy Examiners.

Service Code	Description of Service
97001	***Physical therapy evaluation***
97002	***Physical therapy reevaluation (used for children treated directly or consultatively by the DEC)***
97703	***Checkout for orthotic/prosthetic use, established patient, each 15 minutes***
97750	***Physical performance test or measurement eg., musculoskeletal, functional capacity with written report, each 15 minutes***

Physical Therapy Treatment and Patient Instruction
Service is provided by a physical therapist licensed by the N.C. Board of Physical Therapy Examiners.

Service Code	Description of Service
97010	***Application of a modality to one or more areas; hot or cold packs***
97032	***Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes***
97110	***Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility***
97112	***Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception, each 15 minutes***
97113	***Aquatic therapy with therapeutic exercises, each 15 minutes***
97116	***Gait training (includes stair climbing), each 15 minutes***
97124	***Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion), each 15 minutes***
97140	***Manual therapy techniques (eg., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes***
97520	***Prosthetic training, upper and/or lower extremities, each 15 minutes***
97530	***Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes***

Speech/Language Diagnosis and Assessment
Service is provided by a speech and language pathologist licensed by the State of North Carolina in accordance with the N.C. Licensure Act for Speech and Language Pathologists and Audiologists. Service may include testing and/or clinical observation as appropriate for chronological or mental age.

Service Code	Description of Service
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92525	***Evaluation of swallowing dysfunction and/or oral motor function for feeding***
92551	***Pure tone screening***
92567	***Tympanometry***

Speech/Language Treatment and Patient Instruction
Service is provided by a speech and language pathologist licensed by the State of North Carolina in accordance with the N.C. Licensure Act for Speech and Language Pathologists and Audiologists.

Service Code	Description of Service
92507	***Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual***
92508	***Treatment: group, two or more individuals***
92510	***Aural rehabilitation following cochlear implant***
92526	***Treatment of swallowing dysfunction and/or oral function for feeding***
97530	***Therapeutic Activities- (Development of cognitive skills), each 15 minutes***

Documenting Services
Each provider (i.e., biller) shall maintain the following documentation for each individual, readily accessible to the State:

- The patient name and Medicaid identification number.
- A copy of the treatment plan with clearly defined goals and measurable baselines.
- A copy of the physician's order for treatment services. Date signed must precede treatment dates (verbal order must be signed within 30 days of the date of the order).
- Progress notes with achievements or measurable progress; description of services performed and dates of service.
- The duration of service (i.e., length of assessment and/or treatment session **in minutes**).
- The signature of the person providing each service.
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form with the prior approval authorization number.

Local Health Departments

Specialized therapies can be provided in local health departments through home health agencies or Children's Special Health Service (CSHS) clinics affiliated with the health department. These therapists follow the guidelines specific to their agency.

For **Home Health Services**, follow the guidelines on page 22. CSHS clinics follow the **Outpatient Hospital Clinics and Physician Services** guidelines on page 25.

Home Health Services

The Medicaid prior approval requirement for therapies applies to physical therapy, speech/language pathology services, and occupational therapy covered under Medicaid Home Health Services. Home health agencies follow the policies and procedures in **Section 5** of the ***N.C. Medicaid Community Care Manual*** as amended in the following to meet the requirements in this special bulletin.

Overall, the Medicaid prior approval requirement and the amended Home Health Services requirements do the following:

- Require a distinction between therapy visits for the purpose of the evaluation and re-evaluation of the patient, and therapy visits for treatment. Home health agencies will have to be sure that the distinction is made in orders, documentation, and billing. Revenue codes are added to bill for therapy evaluation visits.
- Add a prior approval requirement for over six treatment visits per type of therapy under Home Health Services.
  - Any therapy provided outside of the Home Health Services coverage does not count towards the limit.
  - The limit applies across home health providers. For example, if one agency provides four PT treatment visits to a patient and a second agency later gets an order for five PT treatment visits, the second agency must get prior approval for the third through fifth treatment visits in order to be paid by Medicaid.
  - The prior approval is for a specified number of visits within a stated time period. The PA is for only the home health agency given the prior approval. For example, if a home health agency has PA for six PT visits for a patient, and the patient changes agencies after three visits, the new agency will have to obtain PA to continue Medicaid coverage of the PT visits – the PA for the remaining visits in the PA approval does not transfer to the new agency.

The following describes how the prior approval requirements apply to therapies under Home Health Services.

1.0 Description of Services

This special bulletin does not change the description of each therapy covered under Medicaid Home Health Services or add additional therapies. Medicaid home health therapies are described in **Section 5.1, What Home Health Covers**, in the ***N.C. Medicaid Community Care Manual***. The **MEDICARE-*Medicaid* Skilled Services Billing Guide** provides additional details about what is included in the coverage of each therapy.

2.0 Eligible Recipients

This special bulletin does not change who is eligible for a therapy under Home Health Services. An individual must meet the requirements listed in **Section 5.2, Who's Covered**, in the ***N.C. Medicaid Community Care Manual***. Please note that individuals with Pregnant Women (MPW) coverage continue to require prior approval for **all** home health services. Refer to **Section 5.3.1, Prior Approval**, in the ***N.C. Medicaid Community Care Manual***.

3.0 When the Service is Covered

This special bulletin adds a prior approval requirement for therapies to the prior approval requirements listed in **Section 5.3.1, Prior Approval**, in the ***N.C. Medicaid Community Care Manual***. Otherwise, it does not change when a service is covered or the criteria for a service. Home health therapy services must be medically necessary and the patient's home must be the most appropriate setting for the care. Refer to **Section 5.2, Who's Covered**, in the ***N.C. Medicaid Community Care Manual*** and the details on therapies in the **MEDICARE-*Medicaid* Skilled Services Billing Guide** for all of the requirements.

4.0 When a Service is Not Covered

A therapy is not covered when the policies and procedures in the ***N.C. Medicaid Community Care Manual*** as amended by the content of this special bulletin are not met.

5.0 Policy Guidelines

5.1 Patient's Location

Home health therapies may be provided only at the patient's residence. This special bulletin does not modify the policy. Refer to **sections 5.1, What Home Health Covers**, and **5.2.3, Whether the Service is Medically Necessary and Appropriate in the Home**, in the ***N.C. Medicaid Community Care Manual***.

5.2 Obtaining Services

The process for initiating a therapy service under Home Health Services as described in **Section 5.5, Getting Coverage**, in the ***N.C. Medicaid Community Care Manual*** is modified as noted below to meet the requirements in this special bulletin.

1. The HCFA-485 continues to be used for documenting the physician's orders and the written plan of care. It must include defined goals for each therapeutic discipline and the specific content, duration and intensity of services for each therapeutic discipline as well as the information noted in **Step 1, Section 5.5 Getting Coverage**, in the ***N.C. Medicaid Community Care Manual***. The HCFA-485 content must delineate visits according to whether they are an evaluation visit or for treatment.

2. A verbal or a written order documented on a HCFA-485 must be obtained for services***** prior to the start of treatment services – that is, any visits beyond an evaluation visit. If the order is written, there will be no payment for services rendered before the signature date. The signature date must be the date the physician signs the order. If the order is verbal, it must be countersigned within 30 calendar days of the date of the verbal order. If not signed within 30 days, it is subject to recoupment effective with day 1 of the service. Backdating is not allowed.

   *(*Services are all therapeutic activities <u>beyond</u> the entry evaluations. An evaluation visit may be conducted based on a verbal order according to the requirements in* **Step 1, Section 5.5, Getting Coverage**, *in the* ***N.C. Medicaid Community Care Manual****.)* The acceptance of faxed orders is in accordance with DMA's overall policy on the use of facsimile copies for documentation.

3. The requirement for the physician to recertify the need for care at least every 60 days continues. Refer to **Section 5.9, Recertification Review**, in the ***N.C. Medicaid Community Care Manual***.

5.3 Prior Approval Process

After six unmanaged visits, prior approval is required for continued treatment. Please note that prior approval is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service. The prior approval request should be initiated as soon as the agency has a physician order for treatment visits that will exceed the six-visit threshold.

Medical Review of North Carolina (MRNC) is the contractor handling this prior approval process for DMA. A home health agency requests prior approval by faxing the following to MRNC at the fax number on the form:

1. A completed prior approval request form signed by the provider.
2. Copies of all applicable HCFA-485(s) for the current course of treatment.
3. A copy of each applicable evaluation and progress summary.

If MRNC approves the request, it will authorize the agency that initiated the request to provide a specific number of visits through a specific length of time. If it appears that more visits will be required and/or the time period needs to be extended, the agency must submit another request with the required supporting documentation to MRNC for approval.

5.3 Documenting Services

Overall, Medicaid record keeping requirements for Home Health Services are contained in **Section 4.7, Record Keeping**, in the ***N.C. Medicaid Community Care Manual***. For the therapy visits, each provider must maintain and allow DMA to access the following documentation for each individual:

- The patient name and Medicaid identification number.
- All HCFA-485s related to the therapies. They must be signed by the physician according to the requirements in this special bulletin.
- A description of the services performed (intervention and outcome/client response) on each date of service signed by the person providing the service. The signature(s) must be according to the applicable standard of practice.
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form with the prior approval authorization number.

8.0 Billing Guidelines

Effective with date of service October 1, 2002, the billing instructions in the ***N.C. Medicaid Community Care Manual*** are amended to allow for the billing of evaluation visits for each therapy. The use of the revenue codes for home health therapies described in **Section 5.10, Getting Paid Coverage**, **Section 5, MEDICARE-*Medicaid* Skilled Services Billing Guide**, and the UB-92 instructions for form locator 42 "REV CODE" in **illustration 14-3, Section 14, Filing Claims**, are revised as follows:

- ***If the purpose of a visit is the evaluation or re-evaluation*** of a patient's need for therapy, the provider bills with the following revenue codes:
  424 Physical Therapy Evaluation
  434 Occupational Therapy Evaluation
  444 Speech-Language Pathology Services Evaluation
- ***If the purpose of a visit is treatment***, the provider bills with the following revenue codes:
  420 Physical Therapy
  430 Occupational Therapy
  440 Speech-Language Pathology Services

Home health agencies should consult the referenced portions of the ***N.C. Medicaid Community Care Manual*** for complete billing instructions.

Outpatient Hospital Clinics and Physician Services

The N.C. Medicaid program covers specialized therapies performed by qualified therapists when provided in a physician's office and in an outpatient hospital clinic. If at any time during the course of the therapy it is determined that the recipient's condition is unlikely to improve, the therapy service is no longer considered medically necessary and Medicaid must not be billed. Medicaid does not cover maintenance programs.

Specialized therapy services performed in the physician's office are covered under the "Incident To " policy.

Area Mental Health Centers

Patient's Location
A patient may receive Outpatient Specialized Therapy services in the office, home, school, and/or child care (i.e., regular and developmental day).

Covered Services

Speech Therapy	
Speech therapy codes require a relevant ICD-9-CM diagnosis to support the need for therapy. These codes are not time-based. Reimbursement is on the basis of one (1) unit per session regardless of the amount of time spent with the client.	
Service Code	**Description of Service**
92506	***Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status***
92507	***Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual***
92508	***Speech Therapy Group, with two or more individuals***

Physical Medicine and Rehabilitation	
PT and OT services require an ICD-9-CM diagnosis pertinent to the type therapy provided. The diagnosis should be descriptive of the physical and functional limitations that the therapy addresses. Physical medicine and rehabilitation codes are time-based. One (1) unit equals 15 minutes of therapy.	
Service Code	**Description of Code**
97001	***Physical Therapy – Evaluation***
97002	***Physical Therapy - Re-evaluation***
97003	***Occupational Therapy – Evaluation***
97004	***Occupational Therapy - Re-evaluation***
97110	***Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility***
97112	***Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception (15 minutes = 1 unit)***
97113	***Aquatic therapy with therapeutic exercises (15 minutes = 1 unit)***
97116	***Gait training (includes stair climbing) (15 minutes = 1 unit)***
97124	***Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) (15 minutes = 1 unit)***
97140	***Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions (15 minutes = 1 unit)***
97520	***Prosthetic training; initial 30 minutes, each visit***
97530	***Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) (15 minutes = 1 unit)***

Service Code	Description of Code
97703	***Checkout for orthotic/prosthetic use, established patient (15 minutes = 1 unit)***
97750	***Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report (15 minutes = 1 unit)***

Provider Qualifications

Outpatient Specialized Therapy and Evaluation services are provided by therapists licensed in the State of North Carolina who are working within the scope of their professional discipline. Specific academic and licensure requirements for speech and language pathologists and audiologists, for licensed occupational therapists and licensed physical therapists and the supervision requirements for licensed OT and PT assistants can be found in the guidelines for **Independent Practitioner, Section 6.0, Eligible Providers** on page 13.

Service	Service Code	Provider Type
Speech Evaluation	92506	Speech Therapists
Speech Therapy: Individual	92507	Speech Therapists
Speech Therapy: Group	92508	Speech Therapists
Assessment of Aphasia	96105	Psychologists/Neuropsychologists Speech Therapists
Physical Medicine and Rehabilitation		
PT Evaluation	97001	Licensed Physical Therapist
PT Evaluation – Re-Evaluation	97002	Licensed Physical Therapist
OT Evaluation	97003	Licensed Occupational Therapist
OT Evaluation – Re-Evaluation	97004	Licensed Occupational Therapist
Therapeutic Procedures and Testing PT and OT		
Therapeutic procedure, one or more areas, therapeutic exercises to develop strength and endurance, range of motion and flexibility	97110	MD or Licensed PT or OT Assistant as licensure regs allow
Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	97112	MD or Licensed PT or OT Assistant as licensure regs allow
Aquatic Therapy with therapeutic exercise	97113	MD or Licensed PT or OT Assistant as licensure regs allow
Gait Training (includes stair climbing)	97116	MD or Licensed PT or OT Assistant as licensure regs allow
Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	97124	MD or licensed PT or OT Assistant as licensure regs allow
Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions.	97140	MD or licensed PT or OT Assistant as licensure regs allow
Prosthetic training, upper and/or lower extremities	97520	MD or licensed PT or OT Assistant as licensure regs allow
Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance)	97530	MD or licensed PT or OT Assistant as licensure regs allow

Service	Service Code	Provider Type
Checkout for orthotic/prosthetic use, established patient	97703	MD or licensed PT or OT Assistant as licensure regs allow
Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report	97750	MD or licensed PT or OT Assistant as licensure regs allow

Documenting Services
Each provider (i.e., biller) shall maintain the following documentation for each individual, readily accessible to the State:

- The patient's name and Medicaid identification number.
- A copy of the treatment plan with clearly defined goals and measurable baselines.
- A copy of the area mental health center's standing order for assessment services.
- A copy of the physician's order for treatment services. Date signed must precede treatment dates (verbal order must be signed within 30 days of the date of the order).
- Progress notes with dates of service and a description of services performed as they relate to goals in the treatment, with a discusssion of achievements or measurable progress.
- The duration of service (i.e., length of assessment and/or treatment session **in minutes**).
- The signature of the person providing each service.
- A copy of each test performed or a summary listing all test results, and the written evaluation report.
- A copy of the completed prior approval form with the prior approval authorization number.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

PRIOR AUTHORIZATION REQUEST FOR OUTPATIENT SPECIALIZED THERAPY SERVICES

For an authorization request to be considered, a **SIGNED AND DATED** Physician order, and the most current treatment plan, goals and updated progress summary or notes must be attached. If this is an initial authorization request, also attach evaluation. Include all other applicable documentation to support authorization request.

Initial Authorization Request _____ **Reauthorization Request** _____ _____ _____

Recipient Medicaid ID # _____ **Date of Birth: (MM/DD/YYYY)** _____ **Male:** _____ **Female:** _____

Recipient Name: (As shown on Medicaid card) Last: _____ **First:** _____ **MI** _____

Recipient County of Residence: _____

Parent/Guardian Name (If applicable): _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Billing Provider Name: _____ **Medicaid Group Provider #:** _____

Address: _____ **DEC# (if applicable):** _____

City: _____ **State:** _____ **Zip:** _____

Contact Name: _____ **Phone:** (____)_____ **Fax:** (____)_____

Provider Type (Check Appropriate): IPP _____ **DEC** _____ **HHA** _____ **Other Public Health Agency** _____

MD Services _____ **Hospital Outpatient Clinic** _____ **Area Mental Health Center** _____

Requesting Therapist Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: (____)_____ **Fax:** (____)_____

Type of therapy request: OT _____ **PT** _____ **ST** _____ **RT** _____ **Audiology** _____

Dates of Service (MM/DD/YYYY) Start	Stop	ICD-9-CM DX Codes (List Treatment First)	Number of Units Requested	Date Requested (MM/DD/YYYY)

Authorized Signature : _____

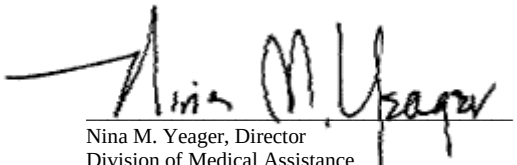
FAX to Medical Review of North Carolina, Inc. (MRNC) at 1-800-228-1437
For Authorization Request questions, contact MRNC at 1-800-228-3365

Instructions for Completing the Outpatient Specialized Therapies Prior Authorization (PA) Request Form

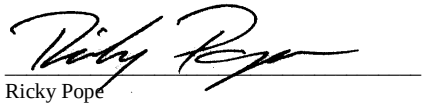
1. Initial Authorization Request
   Place a check mark on the line to indicate that this is the initial PA request for this recipient for this type of therapy. If this client was previously treated and discharged from therapy services, but it has been over 6 months since the last date of service, place a check mark on this line.
2. Reauthorization Request
   Place a check mark on the line to indicate that this is a PA request for continued services. If this client was previously treated and discharged from therapy services less than 6 months prior to this request, place a check mark on this line. Note: A maximum of 3 reauthorizations may be requested on this form. If more than 3 reauthorizations are required, a new form must be initiated.
3. Recipient Medicaid ID#
   Enter the nine digit and alpha suffix Medicaid number. If a Medicaid number has not been assigned, enter "Pending".
4. Date of Birth
   Enter the recipient's date of birth as a 2 digit month, 2 digit day and 4 digit year.
5. Male/Female
   Place a check mark next to the recipient's gender.
6. Recipient Name
   Enter the recipient's last name, first name and middle initial. If no middle name, enter "NMN".
7. Recipient County of Residence
   Enter the name of the county in which the recipient resides.
8. Parent/Guardian Name
   If the PA request is for a recipient under 18 years of age, or if the recipient is over 18 years of age and has an appointed guardian, enter the parent or guardian's complete name.
9. Mailing Address
   Enter the recipient's complete address.
10. Billing Provider Name
    Enter the complete name of the billing provider.
11. Medicaid Group Provider #
    Enter the 7digit Medicaid group provider number for the billing provider. If the billing provider is not part of a group, enter the billing provider's 7digit individual Medicaid provider number.
12. Address
    Enter the billing provider's complete mailing address.
13. DEC#
    Enter the 7digit DEC provider or referral number, if applicable.
14. Contact Name
    Enter the name of the person to who review correspondence and review questions should be addressed.
15. Phone
    Enter the telephone number, including area code, at which the contact person can be reached.
16. Fax
    Enter the fax number, including area code, to which review correspondence or review questions may be sent to the contact person.
17. Provider Type
    Place a check mark next to the provider type that will be rendering therapy services to the recipient.
18. Requesting Therapist Name
    Enter the complete name of the therapist requesting PA for this recipient. If the requesting therapist name is the same as the billing provider name, enter "Same".
19. Address
    Enter the complete mailing address of the requesting therapist. If the address is the same as the billing provider, enter "Same".
20. Phone/Fax
    Enter the telephone number and fax number, including area codes, of the requesting therapist. If the phone and/or fax numbers are the same as the billing provider, enter "Same".
21. Type of Therapy Request
    Place a check mark next to the type of therapy that is to be provided to the recipient.
22. Dates of Service
    Enter the Start and Stop dates for which PA is being requested, as a 2 digit month, 2 digit day and 4 digit year.
23. ICD-9-CM DX Codes
    Enter the ICD-9-CM diagnosis codes that accurately reflect the recipient's condition/reason for therapy. The diagnosis code(s) reflecting the reason for treatment should be listed first. Diagnosis codes should be entered on **one line** of the table, separated by a comma, **for each PA request**.
24. Number of Units Requested
    Enter the number of units that are being requested.
25. Date Requested
    Enter the date that the PA form was completed, in a 2 digit month, 2 digit day and 4 digit year format.
26. Authorized Signature
    The request for PA must be validated by the individual authorized by the provider to sign the form.

Contact List
DMA Website – http://www.dhhs.state.nc.us/dma

Issue	Contact
Processing of Prior Approval Forms	MRNC 1-800-228-3365 http://www.MRNC.org
Appeal of Decisions made by MRNC	Follow instructions outlined in the denial letter
Information/Questions Concerning Procedural Requirements addressed in these policies for * - Area Mental Health Centers * - IPP * - DEC * - LEA/ Head Start	Specialized Therapy Services Division of Medical Assistance 919-857-4040
Information/Questions Concerning Procedural Requirements addressed in these policies for * - Home Health Agency	Community Care/Home Health Services Division of Medical Assistance 919-857-4021
Information/Questions Concerning Procedural Requirements addressed in these policies for * - Public Health Agencies * - Outpatient Hospital Clinics * - Physician's Offices	Practitioner/Clinic Services Division of Medical Assistance 919-857-4020



Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

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