To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
1A-4, *Cochlear and Auditory Brainstem Implants*
1A-27*, Electrodiagnostic Studies*
1H, *Telehealth, Virtual Communications and Remote Patient Monitoring*
3A, *Home Health Services*
5A-1, *Physical Rehabilitation Equipment and Supplies*
5B, *Orthotics & Prosthetics*
10C, *Local Education Agencies*
10D, *Independent Practitioners Respiratory Therapy Services*

1.0 Description of the Procedure, Product, or Service

Outpatient Specialized Therapy (OST) services are covered in all settings except hospital and rehabilitation inpatient facilities. The services consist of evaluations, re-evaluations, multidisciplinary evaluations, and treatments for the following:

a. Physical Therapy;
b. Occupational Therapy;
c. Speech-Language Therapy;
d. Respiratory Therapy; and
e. Audiology Therapy.

1.1 Definitions

Independent Practitioner Provider (IPP):
An individual or group of individuals in private practice who are licensed in their field to provide OST services. The IPP does not provide services through an institutional provider and is not employed by a physician's office.

Refer to Subsection 6.1 for the following definitions: Occupational Therapist, Physical Therapist, Speech-Language Pathologist, and Audiologist.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

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

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. **EPSDT and Prior Approval Requirements**

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

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

   EPSDT provider page**:** https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid 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.

3.1.1 Telehealth Services

As outlined in **Attachment A** and in **Subsection 3.2.1.3.e,** select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy, *1-H, Telehealth, Virtual Communications, and Remote Patient Monitoring,* on NC Medicaid's website at https://medicaid.ncdhhs.gov/

3.1.2 Ordering Practitioners

The OST service must be ordered by one of these NC Medicaid enrolled practitioners:

a. Medical Doctor (MD);
b. Doctor of Osteopathic Medicine (DO);
c. Doctor of Podiatric Medicine (DPM);
d. Certified Nurse Midwife (CNM);
e. Physician Assistant (PA); and
f. Nurse Practitioner (NP).

Note: Home Health OST services may be ordered by the practitioners specified in Clinical Coverage Policy 3A, *Home Health Services*. All documentation and services must adhere to Medicare and Medicaid requirements as outlined in Clinical Coverage Policy 3A, *Home Health Services.* The policy can be found at https://medicaid.ncdhhs.gov/

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover Outpatient Specialized Therapy (OST) when the beneficiary meets the following specific criteria:

3.2.1.1 Physical Therapy (PT)

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

Note: This policy does not address electrodiagnostic (EDX) evaluation services performed by licensed physical therapists. For coverage criteria for these services, refer to Clinical Coverage Policy 1A-27, *Electrodiagnostic Studies*, found on NC Medicaid's website https://medicaid.ncdhhs.gov/

3.2.1.2 Occupational Therapy (OT)

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

3.2.1.3 Speech-Language Therapy (ST)

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

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

J. Medical issues that affect feeding, swallowing, and nutrition; or

K. Oral function impairment or deficit that interferes with feeding.

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

b. For a beneficiary who is a minority language speaker, there is a continuum of proficiency in English.
   1. Determination of the minority language speaker's proficiency on the continuum must be documented as one of the following:
      A. **Bilingual English proficient:** a beneficiary who is bilingual and who is fluent in English or has greater control of English than the minority language;
      B. **Limited English proficient:** a bilingual or monolingual beneficiary who is proficient in his or her native language, but not English; or
      C. **Limited in both English and the minority language**: a beneficiary who is limited in both English and the minority language exhibits limited communication competence in both languages.
   2. Evaluation must contain both objective and subjective measures to determine if the beneficiary is more proficient in either the English language or the minority language.
   3. For speech and language therapy services to be medically necessary for a beneficiary who is a minority language speaker, ALL the following criteria must be met:
      A. All speech deficits must be present in the language in which the beneficiary has the highest proficiency;
      B. All language deficits must be present in the language in which the beneficiary has the highest proficiency;
      C. The delivery of services must be in the language in which the beneficiary has the highest receptive language proficiency; and
      D. If the use of interpreters or translators is the only alternative, the speech-language pathologist or audiologist must:
         i. Provide sufficient instruction to the interpreter or translator regarding the purposes, procedures and goals of the tests and therapy methods;

ii. For each date of service, the provider must ensure the interpreter or translator understands his or her role as it relates to the clinical procedures to be used and responses expected to address the goal;

iii. Use the same interpreter or translator with a given beneficiary as consistently as possible; and

iv. Use observation or other nonlinguistic measures as supplements to the translated measures, such as (1) beneficiary's interaction with parents, (2) beneficiary's interaction with peers, (3) pragmatic analysis.

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

Language Impairment Classifications for Beneficiaries from Birth to 20 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th to 15th percentile, **or** • A language quotient or standard score of 78 to 84, **or** • A delay measured by other methods for beneficiary age ranges: **Birth to 3 years**: A 20 to 24 percent delay on instruments that determine scores in months, **3 to 5 years**: If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12-month delay, **5 to 20 years**: If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1 year to 1 year, 6-month delay, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd to 6th percentile, **or** • A language quotient or standard score of 70 to 77, **or** • A delay measured by other methods for beneficiary age ranges: **Birth to 3 years**: 25 to 29 percent delay on instruments which determine scores in months, **3 to 5 years**: If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 13 to 18-month delay, **5 to 20 years**: If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 1 year, 7-month to 2-year delay, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Severe	• Standard scores more than 2 standard deviations below the mean, **or** • Scores below the 2nd percentile, **or** • A language quotient or standard score of 69 or lower, **or** • A delay measured by other methods for beneficiary age ranges: **Birth to 3 years**: A 30 percent or more delay on instruments that determine scores in months, **3 to 5 years**: If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 19 month or more delay, **5 to 20 years**: If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, **or** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Articulation/Phonology Impairment Classifications for Beneficiaries from Birth to 20 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **or** • Scores in the 7th to 15th percentile, **or** • One phonological process that is not developmentally appropriate, with a 20 percent occurrence, **or** • Additional documentation indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary is expected to have few articulation errors, generally characterized by typical substitutions, omissions, or distortions. Intelligibility is not greatly affected but errors are noticeable.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **or** • Scores in the 2nd to 6th percentile, **or** • Two or more phonological processes that are not developmentally appropriate, with a 20 percent occurrence, **or** • At least one phonological process that is not developmentally appropriate, with a 21 to 40 percent occurrence, **or** • Additional documentation 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 percent occurrence, **or** • At least one phonological process that is not developmentally appropriate, with more than 40 percent occurrence, **or**

	• Additional documentation indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Beneficiary typically has more than five sounds in error with a combination of error types. Inconsistent errors and lack of stimulability are evident. Conversational speech is generally unintelligible.

Articulation Treatment Goals Based on Age of Acquisition	
Age of Acquisition	**Treatment Goal(s)**
Before Age 2	Vowel sounds
After Age 2, 0 months	/m/, /n/, /h/, /w/, /p/, /b/
After Age 3, 0 months	/f/, /k/, /g/, /t/, /d/
After Age 4, 0 months	/n/, /j/
After Age 5, 0 months	voiced th, sh, ch, /l/, /v/, j
After Age 6, 0 months	/s/, /r/, /z/, /s/ blends, /r/ blends, vowelized /r/, voiceless th, /l/ blends
In using these guidelines for determining eligibility, total number of errors and intelligibility must be considered. A 90 percent criterion is roughly in accord with accepted educational and psychometric practice that considers only the lowest 5 to10 percent of performances on a standardized instrument to be outside the normal range.	

Phonology Treatment Goals Based on Age of Acquisition of Phonological Rules	
Age of Acquisition	**Treatment Goal(s)**
After age 2 years, 0 months	Syllable reduplication
After age 2 years, 6 months	Backing, deletion of initial consonants, metathesis, labialization, assimilation
After age 3 years, 0 months	Final consonant devoicing, fronting of palatals and velars, final consonant deletion, weak syllable deletion /syllable reduction, stridency deletion/ stopping, prevocalic voicing, epenthesis
When a beneficiary develops idiosyncratic patterns, which exist after age 3 years, 0 months to 3 years, 5 months, they likely reflect a phonological disorder and must be addressed in therapy. Minor processes or secondary patterns including glottal replacement, apicalization and palatalization typically occur in conjunction with other major processes. These minor processes frequently correct on their own as those major processes are being targeted.	
After age 4 years, 0 months	Deaffrication, vowelization and vocalization, cluster reduction
After age 5 years, 0 months	Gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 to 10 sw/m or 3 to 10 percent stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total whole-word and part-word repetitions.
Moderate	More than 10 sw/m or 10 percent stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10 percent of stuttered words of words spoken,

	duration of dysfluencies lasting 3 or more seconds; secondary characteristics are conspicuous.

Note: The service delivery may be raised to the higher level when: the percentage of stuttered words and the duration fall in a lower severity rating, and the presence of physical characteristics falls in a higher severity rating.

Differential Diagnosis for Stuttering

Characteristics of normally dysfluent beneficiaries:

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

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

More Usual (Typical Dysfluencies)

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

Crossover Behaviors

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

More Unusual (Atypical Dysfluencies)

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

d. Medically necessary treatment for the use of augmentative and alternative communication (AAC) devices must meet the following criteria:

1. Selection of the device must meet ALL the criteria specified in clinical coverage policy 5A-1, *Physical Rehabilitation Equipment and Supplies:*
   A. Employ the use of a dedicated speech generating device that produces digitized speech output, using pre-recorded messages (these are typically classified by how much recording time they offer); or
   B. Employ the use of a dedicated speech-generating device that produces synthesized speech output, with messages formulated either by direct selection techniques or by any of multiple methods.
2. AAC therapy treatment programs consist of the following treatment services:
   A. Counseling;
   B. Product Dispensing;
   C. Product Repair and Modification;
   D. AAC Device Treatment and Orientation;
   E. Prosthetic and Adaptive Device Treatment and Orientation; and
   F. Speech and Language Instruction.
3. AAC treatment must be used for the following:
   A. Therapeutic intervention for device programming and development;
   B. Intervention with parent(s), legal guardian(s), family members, support workers, and the beneficiary for functional use of the device; and
   C. Therapeutic intervention with the beneficiary in discourse with communication partner using his or her device.
4. The above areas of treatment must be performed by a licensed speech-language pathologist with education and experience in augmentative communication to provide therapeutic intervention to help a beneficiary communicate effectively using his or her device in all areas pertinent to the beneficiary. Treatment may be authorized when the results of an authorized AAC evaluation recommend either a low-tech or a high-tech system. Possible reasons for additional treatment include:
   A. update of device;
   B. replacement of current device;
   C. significant revisions to the device and vocabulary; and
   D. medical changes.

e. Telehealth

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

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

3.2.1.4 Audiology Therapy (Aural Rehabilitation)

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

b. A beneficiary shall have one or more of the following deficits to initiate therapy:
   1. hearing loss (any type) with a pure tone average greater than 25dB in either ear;
   2. Standard Score more than one SD (standard deviation) below normal for chronological age on standardized tests of language, audition, speech, or auditory processing which must be documented on the basis of the results of a central auditory test battery; or
   3. less than 1-year gain in skills (auditory, speech, processing) during a period of 12-calendar months.

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

d. Evaluation for aural rehabilitation
   1. Service delivery requires ALL the following elements:
      A. The provider shall check the functioning of hearing aids, assistive listening systems and devices, and sensory aids prior to the evaluation.
      B. Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary's skills, in both clinical and natural environments, for the following:
         i. medical and audiological history;
         ii. reception, comprehension, and production of language in oral, or manual language modalities;
         iii. speech and voice production;
         iv. perception of speech and non-speech stimuli in multiple modalities;
         v. listening skills;
         vi. speech-reading; and
         vii. communication strategies.
      C. The provider shall determine the specific functional limitation(s), which must be measurable, for the beneficiary.

e. Evaluation for Central Auditory Processing Disorders (CAPD)
   1. CAPD evaluation is to be completed by an audiologist and consists of tests to evaluate the beneficiary's overall auditory function. Through interview, observation, and clinical testing, the provider shall evaluate the beneficiary for ALL the following:
      A. Communication, medical, and educational history;
      B. Medicaid shall cover the following Central auditory tests for the identification of CAPD:
         i. auditory discrimination test;
         ii. auditory temporal processing and patterning test;
         iii. dichotic speech test;
         iv. monaural low-redundancy speech test;
         v. binaural interaction test;
         vi. electroacoustic measures; and
         vii. electrophysiologic measures.

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

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

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

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

Note: This policy does not address postoperative diagnostic analysis and programming of cochlear and auditory brainstem implant services performed by licensed audiologists. For coverage criteria for these services, refer to Clinical Coverage Policy *1A-4, Cochlear and Auditory Brainstem Implants*, found on NC Medicaid's website https://medicaid.ncdhhs.gov/

3.2.1.5 Evaluation Services

Evaluation services are the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This evaluation protocol can contain interviews with parent(s), legal guardian(s), other family members, other service providers, and teachers to collect assessment data from inventories, surveys, and questionnaires. An evaluation visit also incorporates any immediate treatment warranted based on the evaluation results. No prior authorization is needed for evaluation visits or for treatment rendered as part of an evaluation visit.

3.2.1.6 Treatment Plan (Plan of Care)

The treatment plan must be established once an evaluation has been administered and prior to the beginning of treatment services. The treatment plan is developed in conjunction with the medical provider, beneficiary, parent(s) or legal guardian(s) for children, and Authorized Representative for adults (if applicable). The treatment plan must consider performance in both clinical and natural environments. Treatment must be culturally appropriate. Short- and long-term functional goals and specific objectives must be determined from the evaluation. Goals and objectives must be reviewed periodically and must target functional and measurable outcomes. The treatment plan must be a specific document.

Each treatment plan in combination with the evaluation or re-evaluation written report must contain ALL the following:

a. duration of the therapy treatment plan consisting of the start and end date (no more than six months);
b. discipline specific treatment diagnosis and any related medical diagnoses;
c. rehabilitative or habilitative potential;
d. defined goals (specific and measurable goals that have reasonable expectation to be achieved within the duration of the therapy plan) for each therapeutic discipline;
e. skilled interventions, methodology, procedures and specific programs to be utilized;
f. frequency of services;
g. length of each treatment visit in minutes; and
h. name, credentials and signature of professional completing the Treatment Plan dated on or prior to the start date of the treatment plan.

3.2.1.7 Treatment Services

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

Treatment services must adhere to the following requirements:

a. A verbal or a written order must be obtained for services prior to the start of services. All verbal orders must report the date and signature of the person receiving the order, must be recorded in the beneficiary's health record and shall be countersigned by the physician within 60 calendar days. All verbal orders are valid up to six months from the documented date of **receipt**. All written orders are valid up to six months from the date of the physician's signature. Backdating is not allowed.

b. All services must be provided according to a treatment plan that meets the requirements in **Subsection 3.2.1.6.**
c. Service providers shall review and renew or revise treatment plans and goals at least every six calendar months.
d. Prior approval is required prior to the start of treatment services.
e. For a Local Education Agency (LEA), the prior approval process is deemed met by the Individualized Education Program (IEP), Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP), or 504 Plan processes. An LEA provider shall review, renew and revise the IEP, IFSP, IHP, BIP or 504 Plan annually along with obtaining a dated physician order with signature. The requirement of parent notification must occur at regular intervals throughout the year as stipulated by NC Department of Public Instruction. Such notification must detail how progress is sufficient to enable the child to achieve the goals by the end of the school year.
f. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or order sheet. Electronic signatures and printed dates are acceptable. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper or unauthorized use, and reconstruction of records in the event of a system breakdown. Stamped signatures are not permitted.

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

3.2.1.8 Re-evaluation Services

Re-evaluation services are the administration of an evaluation protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written evaluation report. This protocol contains interviews with parent(s), legal guardian(s), other family members, other service providers, and teachers to collect assessment data from inventories, surveys, and questionnaires. When continued treatment is medically necessary, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report.

3.2.1.9 Discharge and Follow-up

a. Discharge

1. The therapy must be discontinued when the beneficiary meets ONE of the following criteria:
   A. functional goals and outcomes are achieved;
   B. performance is within normal limits for chronological age on standardized measures;
   C. non-compliance with the treatment plan that is overt and consistent on the part of the beneficiary, parent(s), or legal guardian(s); or
   D. the treatment plan does not require the service of a licensed therapist to address the targeted improvement(s).
2. At discharge, the therapist shall identify indicators for potential follow-up care.

b. Follow-Up

Re-admittance of a beneficiary to therapy services may result from changes in the beneficiary's:

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

3.2.1.10 Respiratory Therapy (RT)

Refer to clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services* at https://medicaid.ncdhhs.gov/

3.2.2 Medicaid Additional Criteria Covered

None Apply.

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

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

4.1 General Criteria Not Covered

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

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover Outpatient Specialized Therapies when:

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

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall require prior approval for Outpatient Specialized Therapies.
The provider shall obtain prior approval before rendering Outpatient Specialized Therapies.

Note: Refer to **Subsections 3.2.1.5, 5.1.2, and 5.2** for prior authorization exclusions.

To obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required. Retroactive prior approval is considered when a beneficiary does not have Medicaid coverage at the time of the procedure and is later approved for Medicaid with a retroactive eligibility date. Medicaid does not guarantee approval of retroactive requests.

5.1.1 General

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

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

5.1.2 Specific

When granted, the approval is for medical approval only and does not guarantee payment or ensure beneficiary eligibility on the date of service.

For prior approval, a written evaluation report must be completed within three months of the requested treatment start date. When continued treatment is requested, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report. Each reauthorization request must document the efficacy of treatment.

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

5.2 Beneficiaries under the Age of 21 Years

Prior approval is required **prior to** the start of all treatment services. For a Local Education Agency (LEA), the prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes.

Detailed information and instructions for registering and submitting requests is available on the DHHS utilization review contractor's website https://choicepa.medicaidprograms.org/Account/Login.aspx?ReturnUrl=%2f

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

The provider shall submit information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

5.3 Visit Limitations Beneficiaries 21 Years of Age and Older

Prior approval is required at the start of all treatment services.

Detailed information and instructions for registering and submitting requests is available on the DHHS utilization review contractor's website https://choicepa.medicaidprograms.org/Account/Login.aspx?ReturnUrl=%2f

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

Prior Authorization (PA) can be obtained for up to 12 therapy treatment visits and six months in a single PA request. Each reauthorization request must document the efficacy of treatment. Annual treatment visits must be medically necessary and are available to beneficiaries 21 years and older as follows:

a. A total maximum of 30 treatment visits per calendar year combined across occupational and physical therapy habilitative services.
b. A total maximum of 30 treatment visits per calendar year combined across occupational and physical therapy rehabilitative services.
c. A total maximum of 30 treatment visits per calendar year for speech therapy habilitative services.
d. A total maximum of 30 treatment visits per calendar year for speech therapy rehabilitative services.

Habilitative and Rehabilitative Services are defined by U.S. Centers for Medicare & Medicaid Services: Glossary of Health Coverage and Medical Terms at https://www.healthcare.gov/sbc-glossary/ and 45 CFR § 156.115.

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

5.4.1 Physical and Occupational Therapy

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

5.4.2 Speech-Language-Audiology Therapy

a. Speech-Language and Audiology therapy services are limited to the need for services based upon the severity of the deficit:
   1. Mild Impairment range of visits: 6 to 26
   2. Moderate Impairment range of visits: Up to 46
   3. Severe Impairment range of visits: Up to 52
b. Speech-Language and Audiology therapy services are limited to the number of medically necessary visits within an authorization period. An authorization period cannot exceed a timeframe of six calendar months.
c. Audiology: 30- to 60-minute sessions, one to three times a week, in increments of six calendar months. Length of visit and duration are determined by the beneficiary's level of severity and rate of change.

5.4.3 Respiratory Therapy

Refer to clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services* at https://medicaid.ncdhhs.gov/

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

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

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice as defined by the appropriate licensing entity.

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

Medicaid covers medically necessary Outpatient Specialized Therapies for beneficiaries under 21 when provided by any allowable outpatient provider, and over 21 only when provided by home health providers, hospital outpatient departments, independent practitioner providers and physician offices.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

The physical therapist, occupational therapist, speech-language pathologist, and audiologist shall comply with their practice act for the discipline regarding providing quality services, supervision of services and billing of services. The provider agency shall verify that their staff is licensed by the appropriate licensing board, and that the license is current, active, unrevoked, unsuspended and unrestricted to practice.

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

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

Laws and Regulations for each therapy discipline:

Occupational Therapist

Qualified occupational therapist defined under 42 CFR § 440.110 (b)(2).

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

Title 21NCAC, Chapter 38 Occupational Therapy

Physical Therapist

A qualified physical therapist defined under 42 CFR § 440.110(a)(2).

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

Licensure Act for Speech and Language Pathologists and Audiologists

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

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

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

7.1 Compliance

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

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

7.1.1 Post-Payment Reviews

Medicaid and DHHS Utilization Review Contractor(s) shall perform reviews for monitoring utilization, quality, and appropriateness of all services rendered as well as compliance with all applicable clinical coverage policies. NC Medicaid Program Integrity conducts post-payment reviews in accordance with 10A NCAC 22F and N.C.G.S 108-C. Program Integrity post-payment reviews may be limited in scope to address specific complaints of provider aberrant practices or may be conducted using a statistically valid random sample of paid claims. Program Integrity and its authorized contractors also analyze and evaluate provider claim data to establish conclusions concerning provider practices. Data analysis results may instigate post- or pre-payment reviews.

Overpayments are determined from review of the paid claims data selected for review or based on the statistically valid random sampling methodology approved for use by NC Medicaid. The findings of the post payment review or utilization review are sent to the therapy provider who is the subject of the review in writing. Notices of error findings, Educational or Warning Letters and Tentative Notices of Overpayment findings contain a description of the findings, the basis for the findings, the tentative overpayment determination and information regarding the provider's appeal rights.

7.1.2 Prepayment Claims Review

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

7.2 Documenting Services

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

a. The beneficiary's name and identification number;
b. A copy of the treatment plan;
c. A copy of the order for OST services as specified in **Subsection 3.2.1**;

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

e. The duration of service (that is, length of evaluation or treatment session **in minutes**) must be present in a note for each billed date of service;

f. The signature and credentials of the person providing each service. Each billed date of service must be individually documented and signed by the person providing the service;

g. A copy of each test performed or a summary listing all test results, contained in the written evaluation report and the annual re-evaluation report when applicable;

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

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

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

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

8.0 Policy Implementation and History

Original Effective Date: October 1, 2002

History:

Date	Section Revised	Change
02/26/2003	5.2, Treatment Services, item #4 7.0, Documenting Services, 3rd bullet	Deleted text pertaining to verbal orders; effective with date of policy publication 10/01/02.
04/01/2003	5.2, Treatment Services, item #3 5.2, Treatment Services, item #4	The phrase "intensity of services" revised to "length of visits."
04/01/2003	5.3, Prior Approval	Prior approval criteria added for physical therapy, occupational therapy, and speech/language therapy.
04/01/2003	3.0, When the Service Is Covered	Coverage criteria added for physical therapy, occupational therapy, and speech/language therapy.
06/01/03	5.2, Treatment Services, item #7	Text was revised to conform to billing guidelines; effective with date of publication 10/01/02.
06/01/2003	8.0, Billing Guidelines	Addition of V code diagnosis for treatment services.
07/01/2003	3.4, Respiratory Therapy	Medical necessity criteria added for respiratory therapy.
07/01/2003	5.3, Prior Approval Process	Respiratory therapy guidelines were added.
07/01/2003	8.0, Billing Guidelines	Diagnosis code V57.2 was corrected to V57.21, effective with date of change 06/01/03
10/01/2003	Section 3.1.1, Home Health Maintenance Physical Therapy	Criteria were added for Home Health Maintenance Physical Therapy.
10/01/2003	Section 3.2, Occupational Therapy	A statement was added to indicate that Home Health Maintenance Occupational Therapy was not covered.
10/01/2003	Section 3.3, Speech/Language-Audiology Therapy	This section was expanded to include Audiology Therapy; the title of the section was changed to Speech/Language-Audiology Therapy. Augmentative and Alternative Communication (AAC) standards for treatment were also added.
10/01/2003	Section 3.3.1, Audiology Therapy (aural rehabilitation) Practice Guidelines	Section 3.3.1 was added to address audiology therapy practice guidelines.
10/01/2003	Section 5.3.1, item c, Physical and Occupational Therapy	Item c was added to address prior approval for physical therapy maintenance.
10/01/2003	Subsection 5.3.2, item c, Speech/Language-Audiology Therapy	Item c was added to address prior approval for audiology.
12/01/2003	Subsection 5.0	The section was renamed from Policy Guidelines to Requirements

		for and Limitations on Coverage.
07/01/2004	Subsection 5.2, Treatment Services	Added requirement for LEAs for annual review and order provided that parent notification occurs regularly and details how goals will be attained by year-end.
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Subsection 2.2	The Web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Subsection 5.2 and 7.2	These sections were updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
12/01/2006	Subsection 2.2	The special provision related to EPSDT was revised.
12/01/2006	Section 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
03/01/2007	Section 3.0	A reference was added to indicate that medical necessity is defined by the policy guidelines recommended by the authoritative bodies for each discipline.
03/01/2007	Subsection 3.3	A reference to ASHA guidelines regarding bilingual services was added as a source of medical necessity criteria for Speech/Language-Audiology therapy treatment for Spanish speaking recipients
03/01/2007	Subsection 5.2	Item 6.c. was updated to indicate that a request submitted for continuation of service must include documentation of the recipient's progress. Item 7 was corrected to comply with federal regulations. The note at the end of the section was deleted from the policy.
03/01/2007	Subsection 5.3	This section was updated to indicate that prior approval is required after six unmanaged visits or the end of the six-month period. A reference was also added to indicate the prior approval requests may be submitted electronically.
03/01/2007	Section 6.0	A reference to 42 CFR 440.110 and 440.185 was added to this section.
03/01/2007	Subsection 7.1	Item 3 Physicians order clarified
03/01/2007	Section 8.0	A reminder was added to this section to clarify that prior approval must be requested using the billing provider number and that services initiated through a CDSA are exempt from the prior approval requirement for six months and must, therefore, enter the date of the physician's order on the claim form.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
05/01/2007	Section 8	Added UB-04 as an accepted claims form.
12/01/2009	Subsection 2.1	Moved first paragraph ("recipients with a need for specialized therapy services") to follow standard statement.
12/01/2009	Subsection 2.2	Added legal citation for EPSDT.
12/01/2009	Sections 3.0, 4.0, & 6.0	Updated section titles to standard phrasing.
12/01/2009	Subsection 3.1	Added standard section.
12/01/2009	Subsection 3.2	Added title to existing criteria; changed "services" to "outpatient specialized therapies"; deleted Note on home health maintenance.
12/01/2009	Subsection 3.2.2 (was 3.1.1)	Deleted this section on home health maintenance physical therapy.

12/01/2009	Subsections 3.2.3 and 3.2.5	Deleted mentions of home health maintenance occupational and audiology therapy.
12/01/2009	Subsection 3.2.4 (was 3.3), letter c	Changed the word "patients" to "recipients" and rephrased.
12/01/2009	Subsection 3.2.5	In "Underlying Referral Premise," letter a, changed "individuals" to "recipients." In "Discharge/Follow-up," changed "client" to "recipient"; spelled out "within normal limits."
12/01/2009	Subsection 3.2.6	Spelled out first appearance of IPP (Independent Practitioner Program); corrected age range.
12/01/2009	Subsection 4.1	Added standard section.
12/01/2009	Subsection 4.2	Added title to existing criteria; added the word "outpatient" before the phrase "specialized therapies"; deleted the word "following" from "policy guidelines."
12/01/2009	Subsection 5.1 (Place of Service)	Moved this statement to Attachment A, letter F.
12/01/2009	New Subsection 5.1	Added statement that prior approval is required at start of treatment services. Deleted the word "initial" from the introductory statement. Deleted letters f and g (information about 6 unmanaged visits vs. 6 months of service; information about evaluation and prior approval by Children's Developmental Services Agency).
12/01/2009	Subsection 5.2	Changed section title to "Recipients under the Age of 21 Years"; deleted The Carolinas Center for Medical Excellence; changed criteria from 6 visits or 6 months to 52 visits in 6 months; deleted paragraph on Medicaid's initial authorization; added instructions on requesting approval for additional visits. Added: "Medicare recipients are exempt from this policy."
12/01/2009	Subsection 5.3	Added new section on visit limitations for adults.
12/01/2009	Subsection 5.4	Added section title.
12/01/2009	Subsection 5.4.1	Deleted information on home health maintenance physical therapy; added "medically necessary" before the word "visits"; deleted "requested by the therapist."
12/01/2009	Subsection 5.4.2	Deleted reference to 52 visits; deleted "requested by the therapist."
12/01/2009	Subsection 5.4.3	Deleted 52-visit cap in this location; deleted paragraph that LEAs meet requirement by IEP process; deleted note that prior approval is not required for recipients with a CDSA evaluation; deleted "Medicare recipients are exempt from the prior approval process"
12/01/2009	Section 6.0	Added standard paragraph about providers; updated and clarified language.
12/01/2009	Subsection 7.1	Added standard statement about compliance and renumbered subsequent headings.
12/01/2009	Subsection 7.2 (was 7.1)	Added DO and DPM as providers who may issue orders; changed "patient" to "recipient"; deleted requirement to keep copy of prior approval form.
12/01/2009	Subsection 7.3 (was 7.2)	Changed title from "Utilization Reviews" to "Post-Payment Validation Reviews"; deleted "CCME," changed "may" to "will," and added the word "all"; added statement on post-payment

		reviews and follow-up; deleted examples of review topics.
12/01/2009	Section 8.0	Moved to Attachment A, reorganized, and renamed "Claims-Related Information."
12/01/2009	Section 9.0	Renumbered to Section 8.0.
12/05/2011	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 10A under Session Law 2011-145, § 10.41.(b)
01/01/2012	Subsections 2.1 and 5.4.3	Changed "Medicare recipients are exempt from this policy." to "Medicare recipients are exempt from prior approval process and visit limits in this policy"
01/01/2012	Subsection 5.1	Added clarification regarding acceptable orders.
01/01/2012	Subsection 5.3	Change the number of visits and evaluations. Remove additional visit allowance
01/01/2012	Subsection 5.4	Change title from all recipients to Under 21
01/01/2012	Section 6.0	Clarify who "can work under the direction/supervision of"
01/01/2012	Subsection 7.2	Add credentials to requirement
01/01/2012	Attachment A	Added diagnosis codes for evaluations
02/13/2012	Subsection 5.3	Technical correction to clarify visits
03/12/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
06/01/2012	Attachment A	Added additional diagnosis codes for evaluations
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
12/01/2013	Subsection 6.1	Removed statement, "Only therapy assistants may work under the direction of the licensed therapist."
01/01/2014	Subsection 4.2.3	Deleted statement, "**Note**: Subsection 4.2.3(b) applies to NCHC only."
01/01/2014	Subsection 6.1	Added statement, "An Independent Practitioner Provider is an individual or group of individuals who are licensed in the field of occupational therapy, physical therapy, audiology, respiratory therapy, or speech/language pathology and who are not providing services through an institutional provider (CDSA, Home Health Agency, Hospital, LEA) or are not employed by a physician's office. "
01/01/2014	Subsection 7.2	Added statement, "h. All missed dates of service must be made up within 30 calendar days and within the same prior authorization period. Make up sessions must be a separate date of service. When billing in timed units, additional units of time must **not** be added to subsequent date(s) of service that will then differ from the treatment time specified on the treatment plan or on the PA request."
01/01/2014	Subsection 7.2	Replace the word "and" with "included in".
06/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
06/01/2014	Subsection 1.1	Definition removed, " Respiratory therapy services in this policy refer to services by independently enrolled respiratory therapists, not the treatments and services provided in the physician's office for respiratory care"

06/01/2014	Subsection 3.2.1.5 and 3.2.1.6. All section(s) and attachment(s) related to respiratory therapy services	*Respiratory Therapy* Services removed from this policy as they are covered in 10 D, *Independent Practitioners Respiratory Therapy.*
06/01/2014	Subsection 3.2.1	The following removed, "Prior approval is required for all treatment services. For Local Education Agencies' (LEA)'s, the prior approval process is deemed met by the Individualized Education Program IEP process."
06/01/2014	Subsection 3.2.1.3	Age ranges of groups more clearly defined in tables.
06/01/2014	Subsection 3.2.1.3	The following was removed: "The primary purpose of an augmentative communication program is to enhance the quality of life for persons with severe speech and language impairments in accordance with each person's preferences, abilities, and life style. Augmentative communication programs perform the continuing, vital, and unique task of helping these individuals develop communication skills they will need throughout the course of their lives. The programs also encourage the development of each individual's initiative, independence, and sense of personal responsibility and self-worth."
06/01/2014	Subsection 3.2.2	"Medicaid covers medically necessary outpatient specialized therapies for beneficiaries under 21 when provided by any allowable outpatient provider and over 21 only when provided by home health providers, hospital outpatient departments, physician offices, and area mental health centers. Changed to "None Apply."
06/01/2014	Subsection 3.2.3	"NCHC covers medically necessary outpatient specialized therapies when provided by any allowable outpatient provider." Changed to "None Apply."
06/01/2014	Subsection 5.2.2	Removed "None" and added: "In addition to Subsection 5.2.1, for beneficiaries over 21 years of age, the provider shall use on the prior authorization request, the applicable diagnosis or procedure code, found in Attachment A of the policy." Added: Medicare beneficiaries are exempt from this policy.
06/01/2014	Subsection 5.5	Removed: A beneficiary 21 years of age or older may have 3 combined treatment visits and 1 evaluation visit of all therapies combined (PT, OT, SLP) per calendar year, from all therapy providers, in any outpatient setting. Treatment by multiple disciplines in the same visit will each count separately toward the total visit limit.
06/01/2014	Subsection 5.5	Added: Beneficiaries 21 years of age and older are restricted to annual and episodic visit limits. Limits on visits refer to combined PT, OT, and ST visits from all therapy providers in any outpatient setting. Specific diagnoses and procedures covered by the provisions of each visit limit group are listed in Attachment A, Section (B) of this policy. Specific diagnoses and procedures are required for prior authorization review (refer to **Subsection 5.2.1** If multiple disciplines treat on the same date of service, each count separately toward the total visit limit.

		All beneficiaries 21 years of age and older may have one (1) therapy evaluation per calendar year.
06/01/2014	Subsection 5.5	Added: A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit per calendar year, if the beneficiary has: a. a neurodegenerative or lymphedema diagnosis; b. is within 60 calendar days post musculoskeletal or neurological surgical procedure.
06/01/2014	Subsection 5.5	Changed the limit for beneficiaries who have had an amputation, joint replacement or post-op hip fracture from 10 to 8 treatments.
06/01/2014	Subsection 5.5	Changed the limit for beneficiaries who have had a stroke, traumatic brain injury or spinal cord injury from 30 to 24 treatments.
06/01/2014	Subsection 5.5	Added: “Refer to Attachment A for qualifying ICD9, ICD10, and CPT codes.”
06/01/2014	Subsection 6.1	Deleted: " Respiratory therapists shall follow 42 CFR 440.185"
06/01/2014	Subsection 6.1	Deleted; "Physical therapists, occupational therapists, speech–language pathologists, and audiologists shall meet the qualifications according to 42 CFR 440.110" Added: "484.4. The physical therapist, occupational therapist, speech-language pathologist, … and audiologist shall comply with their entire practice act for the discipline regarding providing quality services, supervision of services and billing of services."
06/01/2014	Subsection 6.1	Replaced “are defined by the following program types” with “include.” Replaced “qualified” with “licensed.” Changed “42 CFR 440.110” to “42 CFR 484.4”/ Replaced “follow” with “comply with.” Added: “The physical therapist, occupational therapist, pathologist, respiratory therapist, and audiologist shall comply with the entire practice act for the discipline regarding providing quality services, supervision of services and billing of services. The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice. Eligible providers may only bill for procedures, products, and services that are within the scope of their clinical practice (the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience practices in their specifically defined field), as defined by the appropriate licensing entity. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of a licensed therapist, physician, or qualified personnel. Speech language pathologists in their clinical fellowship year may

		work under the supervision of the licensed therapist. The supervising therapist is the biller of the service. Added: "unrevoked and unsuspended"
06/01/2014	Subsection 6.1	Added: **Occupation Therapist** Qualified occupational therapist defined under 42 CFR § 440.110(b)(2) who meets the qualifications as specified under 42 CFR §484.4. The occupational therapist shall comply with G.S. Chapter 90, Article 18D Occupational Therapy also known as North Carolina Occupational Therapy Practice Act. Title 21NCAC, Chapter 38 Occupational Therapy **Physical Therapist** A qualified physical therapist defined under 42 CFR § 440.110(a)(2), who meets the qualifications as specified under 42CFR § 484.4. G.S. Chapter 90, Article 18B Physical Therapy Title 21 NCAC, Chapter 48 Physical Therapy Examiners **Speech-Language Pathologist** Speech Pathologist defined under 42 CFR § 440.110(c (2)(i)(ii)(iii). Speech-language pathologist requirements are specified under 42CFR § 484.4. Speech-Language Pathologist defined in G.S. 293(5). Speech-Language Pathologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists **Audiologist** Qualified audiologist defined under 42 CFR§ 440.110(c) (3)(i)(ii)(A)(B) Audiologist qualifications specified under 42 CFR 484.4 Audiologist shall comply with G.S. Chapter 90, Article 22, Licensure Act for Speech and Language Pathologists and Audiologists Title 21 NCAC, Chapter 64 Speech and Language Pathologists and Audiologists
06/01/2014	Subsection 6.1	Eligible providers may only bill for procedures, products, and services that are within the scope of their clinical practice (the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience practices in their specifically defined field), as defined by the appropriate licensing entity. Speech language pathologists in their clinical fellowship year may work under the supervision of the licensed therapist. The

		supervising therapist is the biller of the service. The provider agency shall verify that their staff is licensed by the appropriate board and that the license is current, active, unrevoked, unsuspended and unrestricted to practice.
06/01/2014	Subsection 7.4	Added: Requirements When the Type of Treatment Services Are the Same as Those Provided by the Child's Public School or Early Intervention Program If treatment services provided by any provider are the same type of health-related services the beneficiary concurrently receives as part of the public school's special education program, a copy of the patient's current IEP should also be obtained by the billing provider and maintained in the patient's file. Likewise, if the patient is concurrently receiving the same type of treatment service as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program), a copy of the current Individualized Family Service Plan (IFSP) should be obtained by the billing provider and maintained in the patient's file. All services combined cannot exceed medical necessity criteria. Services should not be provided on the same day. Furthermore, a copy of the patient's current IEP or IFSP should be obtained by the billing provider when the provider is providing services, under a contractual agreement, for the special education or early intervention program. **Note:** The requirement to obtain a copy of the patient's IEP or IFSP does not apply to treatment services that do not extend beyond a maximum of four weeks of treatment.
06/01/2014	Attachment A	Added: "Independent practitioner providers may only bill for services rendered to Medicaid beneficiaries under 21 years of age and NCHC beneficiaries under 19 years of age."
06/01/2014	Attachment A	Added: "In order for a Medicaid beneficiary 21 years and older to have treatments or evaluations as outlined in **Subsection 5.5,** the following diagnosis codes must apply to the beneficiary and must be included on the billed therapy claim. There is a time element involved in qualifying for services."
06/01/2014	Attachment A	Added ICD-9 and CPT codes
06/01/2014	Attachment A (E)	Added: Timed units billed must meet CMS regulations: 1 unit: ≥8 minutes through 22 minutes 2 units: ≥23 minutes through 37 minutes 3 units: ≥38 minutes through 52 minutes 4 units: ≥53 minutes through 67 minutes 5 units: ≥68 minutes through 82 minutes 6 units: ≥83 minutes through 97 minutes 7 units: ≥98 minutes through 112 minutes 8 units: ≥113 minutes through 127 minutes
06/01/2014	Attachment A (E)	Added: **Assessment services** are defined as the administration of an evaluation protocol, involving testing and/or clinical observation as appropriate for chronological or developmental age,

		which results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service providers, and/or teachers as a means to collect assessment data from inventories, surveys, and/or questionnaires. Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, report writing, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid or NCHC program, or to any other payment source since it is a part of the assessment process that was considered in the determination of the rate per unit of service. **Treatment services** are defined as therapeutic procedures addressing the observed needs of the patient, which are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, and/or teachers **should be included** in order to facilitate carry-over of treatment objectives into the child's daily routine. All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible beneficiaries) of four children per group. Treatment services **do not include** consultation activities, specific objectives involving English as a second language or a treatment plan primarily dealing with maintenance/monitoring activities. Time spent for preparation, processing of claims, documentation regarding billing or service provision, and/or travel is not billable to the Medicaid program or to any other payment source, since it is a part of the treatment process which was considered in the determination of the rate per unit of service.
06/01/2014	Attachment A	Added applicable ICD-10 codes, effective 10/1/2015
07/01/2014	Subsection 5.5	Removed "A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit per calendar year, if the beneficiary has: a) a neurodegenerative or lymphedema diagnosis; or b) is within 60 calendar days post musculoskeletal or neurological surgical procedure." Added: "A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit per calendar year, if the beneficiary has a neurodegenerative or lymphedema diagnosis. A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit if the beneficiary is within 60 calendar days post musculoskeletal or neurological surgical procedure. A different musculoskeletal or neurological surgical procedure allows for a new episode of one

		(1) evaluation and three (3) therapy treatment visits."
07/01/2014	Attachment A	Removed V54.89 from ICD-9-CM List for 2 evaluations and 8 treatments
07/01/2014	Attachment A	Revised ICD-9-CM List for 3 evaluations and 24 treatments to be chronological and added 432.0, 432.1, and 432.9 ICD-9 codes.
07/01/2014	Attachment A	Added Musculoskeletal surgical procedure codes 22532-22865 and 27126-27187.
08/15/2014	Attachment A	Added to the ICD-9-CM Table for 3 treatments the codes 741.0 and 741.9. Added codes for open treatment of fractures to the table of Musculoskeletal CPT Codes for 3 treatments. Added codes for arthroplasty and hemiarthroplasty to the table for Musculoskeletal CPT Codes for 2 evaluations and 8 treatments. Added corresponding ICD-10-CM codes for 432.0, 432.1, 432.9, 741.0, 741.9.
10/01/2014	Subsection 7.2	Added to item (i): Date of service documentation must include objective measures of any change in status associated with the missed visit(s) and medical necessity rationale for the make-up session(s).
10/01/2014	Attachment A	Removed the Codes 953.0, 953.1, 953.2, 953.3, 953.4, 953.5, 953.8 and 953.9 from the table for 3 evaluations and 24 treatments.
10/01/2014	Attachment A	Removed the Codes S14, S24 and S34 from the table for 1 evaluation and 3 treatments.
12/01/2014	Subsection 5.4 and 5.5	Added correct hyperlink for requesting PA: https://www.medicaidprograms.org/NC/ChoicePA
12/01/2014	Subsection 7.2	Remove from Section 7.2 (i): "Date of service documentation must include objective measures of any change in status associated with the missed visit(s) and medical necessity rationale for the make-up session(s)." Add to Section 7.2 (i): "The rescheduled date of service documentation must reference the missed date of service."
12/01/2014	Attachment A	Removed ICD-10 code references
04/01/2015	Subsection 3.2.1.3	Removed the word "adult" from the phonological rules table
04/01/2015	Subsection 7.3	Clarified information regarding Post Payment Reviews
04/01/2015	Subsection 7.4	Added section regarding Pre-Payment Reviews
04/01/2015	Attachment A	Added CPT Codes 27440 - 27447 to chart for 2 evaluations and 8 treatments
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
10/06/2015	Attachment A	Removed time-frame specifications from ICD-10 tables. Time frames are specified in Subsection 5.5.
04/01/2016	Subsection 3.2.1	Added: Medicaid and NCHC shall cover medically necessary outpatient specialized therapies when the service is ordered by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM), Certified Nurse Midwife (CNM), Physician Assistant (PA), or Nurse Practitioner (NP)'s **and** when prior authorization is received. Home Health services

		may only be ordered by an MD or DO.
04/01/2016	Subsection 3.2.1.1	Added: Medicaid and NCHC may cover medically necessary outpatient physical therapy treatment if prior authorization is received. Refer to Section 5.0.
04/01/2016	Subsection 3.2.1.2	Added: Medicaid and NCHC may cover medically necessary occupational therapy treatment if prior authorization is received. Refer to Section 5.0.
04/01/2016	Subsection 3.2.1.3	Added: Medicaid and NCHC may cover medically necessary outpatient speech-language and audiology therapy treatment if prior authorization is received. Refer to Section 5.0.
04/01/2016	Subsection 3.2.1.3	Removed: CMS Publication 100-3 Medicare National Coverage Determinations Manual 170.3-Speech Language Pathology Services for the Treatment of Dysphagia (Rev.55, Issued: 05-05-06, Effective:10-01-06, Implementation: 10-2-06, and subsequent updates) and Publication 100-2 The Medicare Benefit Policy, Chapter 15, Covered Medical and Other Health Services, Sections 220 and 230.3 (Rev 36, Issued:06-24-05, Effective: 06-06-05, Implementation:06-06-05, and subsequent updates) These publications can be found at http://www.cms.hhs.gov/manuals/IOM/list.asp
04/01/2016	Subsection 3.2.1.3	Added specific guidelines for dysphagia therapy and speech therapy services for minority language speakers. Added guidelines for augmentative communication therapy and aural rehabilitation therapy.
04/01/2016	Subsection 3.2.1.5	Subsection added: “Evaluation Services”
04/01/2016	Subsection 3.2.1.6	Defined the components of the Treatment Plan
04/01/2016	Subsection 3.2.1.7	Subsection added: “Treatment Services”
04/01/2016	Subsection 3.2.1.8	Subsection added: “Re-Evaluation Services”
04/01/2016	Subsection 3.2.1.9	Removed: c. non-compliance with treatment plan (including caregiver). Added: C. overt and consistent non-compliance with treatment plan on the part of the beneficiary; or D. overt and consistent non-compliance with treatment plan on the part of parent(s) or legal guardian(s).
04/01/2016	Subsection 5.1	Added: In order to obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required.
04/01/2016	Subsection 5.2.2	Removed: For occupational therapy (OT) and physical therapy (PT), an assessment must occur within 12 months of the requested beginning date of treatment. When continued treatment is requested, an annual reassessment summary of the child’s status and performance must be documented.
04/01/2016	Subsection 5.2.2	Added: For occupational therapy (OT) and physical therapy (PT), an evaluation must occur within **6 months** of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation summary of the child’s status and performance must be documented. The re-evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public

		school's special education program or as part of an early intervention program when applicable. Added: **For audiology services (AUD) and speech/language services (ST) prior approval:** The re-evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.
04/01/2016	Subsection 5.3	Subsection 5.3, Treatment Services – Moved to Subsection 3.2.1.7
04/01/2016	Subsection 5.5	Removed "A beneficiary 21 years of age and older may have a total of three (3) therapy treatment visits and one (1) evaluation visit if the beneficiary is within 60 calendar days post musculoskeletal or neurological surgical procedure. A different musculoskeletal or neurological surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits."
04/01/2016	Subsection 5.4	Added: "A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within 60 calendar days following a qualifying neurological surgical procedure. A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within 60 calendar days following a qualifying musculoskeletal surgical procedure, **or** within 30 calendar days of cast removal, hardware removal or both or elimination of weight bearing restrictions post musculoskeletal surgical procedure. A different neurological surgical procedure or musculoskeletal surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits."
04/01/2016	Subsection 7.5	If treatment services provided by any provider are the same type of health-related services the beneficiary concurrently receives as part of the public school's special education program, or as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program), the combined frequency of services must be medically necessary to address the beneficiary's deficits. The provider must document on the PA request as well as on the Treatment Plan the frequency at which the beneficiary receives the same type of health-related treatment services provided as part of the public school's special education program or as part of an early intervention program (i.e., Head Start, early childhood intervention service or developmental day care program). Services may not be provided on the same day.
04/01/2016	Attachment A:	Moved codes 20930, 20931, 20936, 20937, 20938, 20975 from Neurosurgical CPT Codes for 3 treatments, to Musculoskeletal Surgical CPT Codes for 3 treatments.

06/01/2016	Subsection 3.2.1.3	Removed: **If** the targeted speech sound(s) is age appropriate (see age of acquisition under articulation). And removed the phonological process of gliding from 4 years and 0 months. Added a new column "After age 5 years, 0 months and inserted the phonological process of gliding.
05/15/2016	Subsection 3.2.1.4	b. Removed: hearing loss (any type) >25 dBHL at two (2) or more frequencies in either ear; Added: hearing loss (any type) with a pure tone average greater than 25dB in either ear; c. Added "auditory memory" to the sentence, "improving auditory processing, listening, spoken language processing, auditory memory, overall communication process;". d. Removed: "signed or written and added manual language in the sentence, "reception, comprehension, and production of language in oral, or manual language modalities; e. Removed the sentence, "CAPD evaluation is to be interdisciplinary (involving audiologist and speech-language pathologist) completed by an audiologist and consists of tests to evaluate the overall communication behavior, such as spoken language processing and production." And added the sentence, "CAPD evaluation is to be completed by an audiologist and consists of tests to evaluate the beneficiary's overall auditory function." e.F. Removed the sentence, "read on grade level (as result of auditory processing difficulty);" and added the sentence, "hear and process the super-segmental aspects of speech or the phonemes of speech;".
05/15/2016	Subsection 5.4	Added "or immobilization" to the sentence, "A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within 60 calendar days following a musculoskeletal surgical procedure listed in Attachment A of this policy, **or** within 30 calendar days of cast removal, hardware removal or both or elimination of weight bearing restrictions or immobilization post musculoskeletal surgical procedure listed in Attachment A of this policy."
05/15/2016	Attachment A: E	Replaced statement, "All treatment services shall be provided on an individualized basis with the exception of speech/language services, which include group speech therapy with a maximum total number (i.e., both non-eligible and Medicaid-eligible beneficiaries) of four children per group." – which was inadvertently left out during revision process.
11/01/2016	Attachment A: C	Added the following musculoskeletal surgical codes to the table **Musculoskeletal Surgical CPT Codes for 3 treatments: 27236, 27244, 27248, 27253, 27254, 27258, 27259, 27269, 27280, 27282, 27284 and 27286.**

11/01/2016	Attachment A: B	Added the following ICD-10-CM diagnosis codes to the table, **ICD-10-CM Cerebrovascular Diseases and Diseases of Lymphatic Vessels and Lymph Nodes Diagnoses which allow for a maximum of 3 treatment visits:** G46.0. G46.1, G46.2, G46.5, G46.6, G46.7 and G46.8
11/01/2016	Attachment A: B	Added the following ICD-10-CM diagnosis codes to the table, **ICD-10-CM Intracranial Injuries Diagnoses which allow for a maximum of 3 treatment visits:** S06.1X0D, S06.1X0S, S06.1X1D, S06.1X1S, S06.1X2D, S06.1X2S, S06.1X3D, S06.1X3S, S06.1X4D, S06.1X4S, S06.1X5D, S06.1X5S, S06.1X6D, S06.1X6S, S06.1X7D, S06.1X7S, S06.1X8D, S06.1X8D, S06.1X9D and S06.1X9S
11/01/2016	Attachment A: B	Corrected codes in table "ICD-10-CM Vascular Syndromes in Cerebrovascular Disease, Non-traumatic Subarachnoid Hemorrhage and Unspecified Non-traumatic Intracranial Hemorrhage Diagnoses which allow for a maximum of 3 evaluations and 24 treatments"
06/01/2017	Subsection 5.4 and Attachment A	Added: the beneficiary is within three (3) calendar months of discharge from inpatient services for a laryngectomy surgical procedure listed in **Attachment A** of this policy.
06/01/2017	Attachment A	Codes were added, 31360 31365, R47.1 R49.0 and R49.1.
09/01/2017	Attachment A	CPT codes 27700 and 27702 were moved to the chart: Musculoskeletal Surgical CPT Codes for 2 evaluations and 8 treatments (Multiple CPT codes performed as a single procedure on the same date of service do not qualify for more than 8 treatment visits.)
09/07/2017	Section 8.0 and Attachment A	Corrected minor format issues. No change to policy scope or coverage and no change to Amended Date.
10/01/2017	Section 5.4	Clarify annual and episodic therapy visits and adjust specified time frames to request prior approval for therapy.
10/15/2015	Attachment A	Removed end-dated ICD-10-CM Codes
12/15/2017	Attachment A	Corrected the charts containing codes that had errors and that were out of order.
9/15/2018	Section 3.2.1	Added: **Note:** Home Health: Physician referral, orders, plan of care, and documentation must adhere to Medicare, Medicaid and NCHC guidelines as outlined in DMA's clinical coverage policy 3A, *Home Health Services.* The service must also be in accordance with all other Home Health program guidelines, including the appropriateness of providing service in the home. The policy can be found at http://dma.ncdhhs.gov.

9/15/2018	Section 3.2.1.3 (I)	Removed: Neurologic disorders likely to affect swallowing Added: Neuromuscular degenerative disease likely to affect swallowing regardless of the presence of a communication difficulty;
9/15/2018	Section 3.2.1.5	Added: An evaluation visit also incorporates any immediate treatment warranted based on the evaluation results. No prior authorization is needed for evaluation visits or for treatment rendered as part of an evaluation visit.
9/15/2018	Section 3.2.1.6	Removed criterion: the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.
9/15/2018	Section 5.2.2	Removed: For occupational therapy (OT) and physical therapy (PT) prior approval, a written report of an evaluation must occur within six (6) months of the requested beginning date of treatment. Added: For prior approval, a written report of an evaluation must occur within three months of the requested beginning date of treatment.
9/15/2018	Section 5.2.2	Removed the statement: The re-evaluation report must document the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program, when applicable.
9/15/2018	Section 5.2.2	Removed the paragraph: For audiology services (AUD) and speech/language services (ST) prior approval, a written report of an evaluation must occur within six (6) months of the requested beginning date of treatment. When continued treatment is requested, an annual re-evaluation of the beneficiary's status and performance must be documented in a written evaluation report. The re-evaluation report must include the frequency at which the beneficiary receives the same type of health-related service provided as part of the public school's special education program or as part of an early intervention program when applicable.
9/15/2018	Section 5.4	Added: The first prior approval request within a calendar year shall be for no more than three therapy treatment visits and one month. The PA review vendor will authorize these three treatment visits to begin as early as the day following the submission of the PA request. Any subsequent PA may be obtained for up to 12 therapy treatment visits and six months. A beneficiary can receive a maximum of 27 therapy treatment visits per calendar year across all therapy disciplines combined (occupational therapy, physical therapy and speech/language therapy). Each reauthorization request must document the efficacy of treatment.
9/15/2018	Section 5.4	Removed the following text: In addition to **Subsection 5.2.1**, for a beneficiary 21 years of age and older, the provider shall use the applicable diagnosis or procedure code, found in **Attachment A** (B)(C) of the policy on the prior authorization request. Beneficiaries 21 years of age and older are restricted to annual and episodic visit limits. Annual therapy evaluation and treatment

		visits are separate and in addition to episodic evaluation and treatment visits. Episodic evaluation and treatment visits must be expended prior to annual evaluation and treatment visits when the episode occurs prior to the use of the annual visits. Limits on visits refer to combined PT, OT, and ST visits from all therapy providers in any outpatient setting. Specific diagnoses and procedures covered by the provisions of each visit limit group are listed in **Attachment A**, Section (B) of this policy. Specific diagnoses and procedures are required for prior authorization review (refer to **Subsection 5.2.1**). If multiple disciplines treat on the same date of service, each counts separately toward the total visit limit. Any beneficiary 21 years of age and older may have one (1) therapy evaluation per calendar year. Annual therapy visits A beneficiary 21 years of age and older may have one (1) evaluation visit and a total of three (3) therapy treatment visits per calendar year, if the beneficiary has a neurological or lymphedema diagnosis listed in **Attachment A** of this policy. Evaluation and treatment visits obtained prior to the beneficiary's 21st birthday will count towards the evaluation and treatment visit for that calendar year. Episodic therapy visits A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within four (4) calendar months following a neurosurgical procedure listed in **Attachment A** of this policy. A beneficiary 21 years of age and older may have a total of one (1) evaluation visit and three (3) therapy treatment visits if within four (4) calendar months following a musculoskeletal surgical procedure listed in **Attachment A** of this policy, **or** within two (2) calendar months of cast removal, hardware removal or both **or** elimination of weight bearing restrictions or immobilization post musculoskeletal surgical procedure listed in **Attachment A** of this policy. A new neurosurgical procedure or musculoskeletal surgical procedure allows for a new episode of one (1) evaluation and three (3) therapy treatment visits. A beneficiary 21 years of age and older may have up to two (2) therapy evaluations and a total of eight (8) therapy treatment visits, when: the beneficiary is within six (6) calendar months of discharge from inpatient services for a joint replacement or hip fracture surgical procedure listed in **Attachment A** of this policy, **or** within two (2) calendar months of cast removal, hardware removal or both **or** elimination of weight bearing restriction or immobilization post musculoskeletal surgical procedure listed in Attachment A of this policy. the beneficiary is within six (6) calendar months of receipt of upper extremity or lower extremity prosthesis, or

		the beneficiary is within six (6) calendar months of discharge from inpatient services for a laryngectomy surgical procedure listed in Attachment A of this policy. A new joint replacement, hip fracture surgical procedure or receipt of new prosthesis allows for a new episode of two (2) therapy evaluations and eight (8) therapy treatment visits. A beneficiary 21 year of age and older may have up to three (3) therapy evaluations, and a total of 24 therapy treatment visits when the beneficiary is within nine (9) calendar months of discharge from inpatient services for a cerebrovascular accident (CVA), traumatic brain injury (TBI) or spinal cord injury (SCI) diagnosis listed in Attachment A of this policy. A documented occurrence of a new CVA, TBI or SCI with a corresponding inpatient stay allows for a new episode of up to three (3) therapy evaluations and a total of 24 therapy treatment visits. Refer to **Attachment A**, Sections B and C for qualifying diagnoses and CPT codes. Note: Home Health: Physician referral, orders, plan of care, and documentation must adhere to Medicare, Medicaid and NCHC guidelines as outlined in DMA's clinical coverage policy 3A, Home Health Services. The service must also be in accordance with all other Home Health program guidelines, including the appropriateness of providing service in the home. The policy can be found on DMA's website at http://dma.ncdhhs.gov.
9/15/2018	Section 6.0	Removed from the last sentence of paragraph three: ...and area mental health centers.
9/15/2018	Section 7.2 (b)	Removed: (IEP accepted for LEAs only);
9/15/2018	Section 7.5	Removed the statement: the combined frequency of services must be medically necessary to address the beneficiary's deficits. The provider must document on the PA request as well as on the Treatment Plan the frequency at which the beneficiary receives the same type of health-related treatment services provided as part of the public school's special education program or as part of an early intervention program.
9/15/2018	Attachment A, Section B	Removed the statement: In order for a Medicaid beneficiary 21 years and older to have treatments or evaluations as outlined in Subsection 5.4, the following diagnosis codes must apply to the beneficiary and must be documented on the request for prior authorization and the billed therapy claim. There is a time element involved in qualifying for services.

9/15/2018	Attachment A, Section B	Removed all charts containing ICD-10-CM diagnosis codes.
9/15/2018	Attachment A, Section C	Removed the statement: In order for a Medicaid beneficiary 21 years and older to have treatments or evaluations as outlined in Subsection 5.4, the following surgical procedure codes must apply to the beneficiary and must be documented on the request for prior authorization. There is a time element involved in qualifying for services.
9/15/2018	Attachment A, Section C	Removed all charts containing surgical CPT codes.
9/15/2018	Attachment A Section E	Added: Billing for co-treatment services, therapy treatment services provided by OT and PT for a single Medicaid or NCHC beneficiary as a single visit, shall not exceed the total amount of time spent with the beneficiary. OT and PT must split the time and bill only timed CPT codes. Co-treatment visits including speech therapy must be at least 38 minutes in session length to bill both one event of speech therapy and one unit of a timed CPT code for occupational or physical therapy. Additional timed CPT codes for occupational or physical therapy may be billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment.
10/15/2018	Subsection 3.2.1.7 (e)	Removed language expanding the universe of documentation that an LEA can use as a basis for providing school-based therapy services that was posted prior to the related State Plan Amendment being approved. No change to Amended Date.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
04/15/2019	Subsection 3.2.1.7 (e)	Added: For a Local Education Agency (LEA), the prior approval process is deemed met by the Individualized Education Program (IEP) Individual Family Service Plan (IFSP), Individual Health Plan (IHP), Behavior Intervention Plan (BIP), or 504 Plan processes. An LEA provider shall review, renew and revise the IEP, IFSP, IHP, BIP or 504 Plan annually along with obtaining a dated physician order with signature. Policy posted 04/15/2019, but Revision is effective 10/01/2018.
04/15/2019	Subsection 5.3	Updated second sentence: For an LEA, the prior approval process is deemed met by the IEP, IFSP, IHP, BIP or 504 Plan processes. Policy posted 04/15/2019, but Revision is effective 10/01/2018.
01/12/2020	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”

01/12/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
10/15/2022	Subsection 3.1.1	Added the following language: "As outlined in Attachment A and in Subsection 3.2.1.3.e, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy 1-H: Telehealth, Virtual Communications, and Remote Patient Monitoring."
10/15/2022	Subsection 3.2.1.3	Added guidance for the delivery of select speech and language evaluation and treatment interventions using telehealth.
10/15/2022	Attachment A, Section C	Added, "NOTE: CPT codes for providers who bill professional claims can be found in Clinical Coverage Policy 10B, Independent Practitioners, Attachment A, Section C."
04/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.
06/15/2024	Subsection 3.2.1	Amended ordering practitioners for home health services to align with Clinical Coverage Policy 3A, Home Health Services per 42 CFR 440.70.
06/15/2024	Subsections 5.3 and 5.4	Amended the vendor name to "DHHS utilization review contractor".
06/15/2024	Subsection 5.4	Removed the requirement for the first PA request to be three visits and one month. Amended "Any subsequent" to "Prior authorization (PA)" and amended "may" to "can" in the sentence, "Any subsequent PA may be obtained for up to 12 therapy treatment visits and six months" and added "in a single PA request". Updated the visit limit from "a maximum of 27 therapy treatment visits per calendar year across all therapy disciplines combined (occupational therapy, physical therapy and speech/language therapy)" to "Annual treatment visits must be medically necessary and are available to beneficiaries 21 years and older as follows: • A total maximum of 30 treatment visits per calendar year combined across occupational and physical therapy habilitative services. • A total maximum of 30 treatment visits per calendar year combined across occupational and physical therapy rehabilitative services. • A total maximum of 30 treatment visits per calendar year for speech therapy habilitative services. • A total maximum of 30 treatment visits per calendar year for speech therapy rehabilitative services." Added reference for definitions of habilitative and rehabilitative services, "Habilitative and Rehabilitative Services are defined by U.S. Centers for Medicare & Medicaid Services: Glossary of Health Coverage and Medical Terms https://www.healthcare.gov/sbc-glossary/ and 45 CFR § 156.115."

		The amended visit limitations for beneficiaries aged 21 and older are effective December 1, 2023.
02/01/2025	Subsection 1.0	Added abbreviation for Outpatient Specialized Therapy (OST) services and amended sentence structure.
02/01/2025	Subsection 1.1	Added: Independent Practitioner Provider (IPP): An individual or group of individuals in private practice who are licensed in their field to provide OST services. The IPP does not provide services through an institutional provider and is not employed by a physician's office.
02/01/2025	Subsection 3.2.1, 3.2.1.1, 3.2.1.2, and 3.2.1.3	Amended language requires the criteria to pertain to the beneficiary.
02/01/2025	Subsection 3.2.1 and 3.1.2	Moved list of ordering practitioners from Subsection 3.2.1 to new Subsection 3.1.2 and added "NC Medicaid enrolled" for ordering practitioners (per 42 CFR § 455.410). Removed: "Prior authorization is received" due to redundancy with Subsection 5.1. Moved the following sentence from Subsection 3.2.1 to 3.1.2 "Note: Home Health services may be ordered by the practitioners specified in Clinical Coverage Policy 3A, Home Health Services."
02/01/2025	Subsection 3.2.1.1	Added reference to CCP 1A-27 for physical therapists who perform electrodiagnostic evaluations.
02/01/2025	Subsection 3.2.1.3 c.	Amended title of chart to remove "A Medicaid Beneficiary" to "Beneficiaries". Condensed three charts for language impairment classifications by age to one comprehensive chart that includes age criteria for the 4th bullet and titled "A delay measured by other methods for beneficiary age ranges:"
02/01/2025	Subsection 3.2.1.3 e.	Removed the reference to CCP 10B
02/01/2025	Subsection 3.2.1.4	Added reference to CCP 1A-4 for audiologists who perform post-operative diagnostic cochlear implant programming services
02/01/2025	Subsection 3.2.1.6	Treatment Plan (Plan of Care): amended to be more appropriate for the adult population by adding Authorized Representative (if applicable) to the development of the treatment plan.
02/01/2025	Subsection 3.2.1.9 a.	Added discharge criteria: D. the treatment plan does not require the service of a licensed therapist to address the targeted improvement(s).
02/01/2025	Subsection 5.1	Removed: "Exceptions may apply". Replaced with: "Medicaid does not guarantee approval of retroactive requests".
02/01/2025	Subsections 5.1.1 and 5.1.2	Renumbered Subsection 5.2, "General" as 5.1.1, and 5.2.2 "Specific" as 5.1.2. Removed "Please note that approval, if granted" and replaced with "When granted, the approval is for medical approval only"
02/01/2025	Subsection 5.2	Renumbered Subsection 5.3 as 5.2, "Beneficiaries under the Age of 21". Added language from CCP 10B: "The provider shall submit information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available."
02/01/2025	Subsections 5.3, 5.4, 5.4.1, 5.4.2, and 5.4.3	Renumbered the following Subsections: 5.4 as 5.3, "Visit Limitations Beneficiaries 21 Years of Age and Older"; 5.5 as 5.4, "Medical Necessity Visit Guidelines for

		Beneficiaries Under 21 Years of Age; 5.5.1 as 5.4.1, "Physical and Occupational Therapy"; 5.5.2 as 5.4.2, Speech Language-Audiology Therapy"; 5.5 as 5.4.3, "Respiratory Therapy".
02/01/2025	Subsection 6.0	Amended to include coverage provided by an independent practitioner provider for beneficiaries aged 21 and older.
02/01/2025	Subsection 6.1	Removed reference to 42 CFR §484.4. Removed "clinical fellowship year" and replaced with "supervised experience year".
02/01/2025	Subsections 7.1, 7.1.1, 7.1.2, 7.3, 7.4 and 7.5	Created subsections 7.1.1 and 7.1.2 under 7.1 "Compliance" to move subsections titled, "Post-payment Reviews" and "Prepayment Claims Review", that were previously located under Subsections 7.3 and 7.4. Re-numbered subsection 7.5 to 7.3 and deleted 7.4 and 7.5.
02/01/2025	Subsection 7.2 c.	Added: "OST services as specified in Subsection 3.2.1." Removed list of practitioners due to redundancy with Subsection 3.2.1.
02/01/2025	Attachment A, Section A.	Removed Independent Practitioner Provider definition from Claims section: "An Independent Practitioner Provider is an individual or group of individuals who are licensed in the field of occupational therapy, physical therapy, audiology, respiratory therapy, or speech/language pathology and who are not providing services through an institutional provider (CDSA, Home Health Agency, Hospital or LEA) or are not employed by a physician's office." Removed: "Independent practitioner providers may only bill for services rendered to a Medicaid beneficiary under 21 years of age." Added the following language from CCP 10B: "Prior approval must be obtained under the same NPI for which the service(s) will be billed." Clarified the sentence to read, "Prior approval must be obtained under the billing NPI under which the service(s) will be billed." "Procedures must be billed using the most comprehensive CPT code to describe the service performed. The Correct Coding Initiative (CCI) was developed by the Centers for Medicare and Medicaid Services (CMS). It bundles the component procedures of the service into the comprehensive code. Only the comprehensive code is paid. If providers submit a claim using component codes in addition to comprehensive codes, the claim will deny. Providers receive an Explanation of Benefits (EOB) code indicating that the component code cannot be billed in addition to the comprehensive code. Additional information about CCI can be found online at https://www.cms.gov/medicare/coding-billing/ncci-medicaid." "Refer to NC Tracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html."
02/01/2025	Attachment A, Section C.	Removed reference to 10B for professional billers to reference CPT codes. Added all covered CPT codes that were previously listed in CCP 10B.

02/01/2025	Attachment A, Section D.	Added telehealth modifier information previously listed in CCP 10B: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.
02/01/2025	Attachment A, Section F.	Added the following place of service language from 10B: "For independent practitioner providers: office, private residence, school, Head Start program, and childcare (regular and developmental day care) settings." and "Telehealth claims should be filed with the provider's usual place of service code(s)".

Attachment A: Claims-Related Information

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

A. Claim Type

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

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

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

Prior approval must be obtained under the billing National Provider Identifier (NPI) under which the service(s) will be billed.

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

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

Refer to specific clinical coverage policies for each area. Policies are posted at https://medicaid.ncdhhs.gov/.

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

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

C. Code(s)

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

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

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.

Audiology Evaluation

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

92620	(1 unit = 60 min)
92621	(1 unit = each additional 15 min) must be billed with 92620
92626	(1 unit = 60 min)
92627	(1 unit = each additional 15 min) must be billed with 92626
92652	(1 unit = 1 event)
92653	(1 unit = 1 event)

Audiology Treatment

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

Speech/Language Evaluation

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

Speech/Language Treatment

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

92630	(1 unit = 1 visit)	No
92633	(1 unit = 1 visit)	No

Note: Telehealth eligible services may be provided to beneficiaries by the eligible providers listed within this policy.

Occupational Therapy Evaluation

Code	Unit of Service
92610	(1 unit = 1 event)
96125	(1 unit = 1 hour)
97165	(1 unit = 1 event)
97166	(1 unit = 1 event)
97167	(1 unit = 1 event)
97168	(1 unit = 1 event)
97750	(1 unit = 15 minutes)

Occupational Therapy Treatment

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

97761	(1 unit = 15 minutes)
97763	(1 unit = 15 minutes)

Physical Therapy Evaluation

Code	Unit of Service
92610	(1 unit = 1 event)
97161	(1 unit = 1 event)
97162	(1 unit = 1 event)
97163	(1 unit = 1 event)
97164	(1 unit = 1 event)
97750	(1 unit = 15 minutes)

Physical Therapy Treatment

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

Code	Unit of Service
97018	(1 unit = 1 event)
97022	(1 unit = 1 event)
97024	(1 unit = 1 event)
97026	(1 unit = 1 event)
97028	(1 unit = 1 event)
97032	(1 unit = 15 minutes)
97033	(1 unit = 15 minutes)
97034	(1 unit = 15 minutes)
97035	(1 unit = 15 minutes)
97036	(1 unit = 15 minutes)
97110	(1 unit = 15 minutes)
97112	(1 unit = 15 minutes)
97116	(1 unit = 15 minutes)
97124	(1 unit = 15 minutes)
97140	(1 unit = 15 minutes)
97530	(1 unit = 15 minutes)
97533	(1 unit = 15 minutes)
97535	(1 unit = 15 minutes)
97542	(1 unit = 15 minutes)
97602	(1 unit = 1 event)
97760	(1 unit = 15 minutes)
97761	(1 unit = 15 minutes)
97763	(1 unit = 15 minutes)

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual communications or remote patient monitoring.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Timed units billed must meet CMS regulations:

1 unit: ≥8 minutes through 22 minutes
2 units: ≥23 minutes through 37 minutes
3 units: ≥38 minutes through 52 minutes
4 units: ≥53 minutes through 67 minutes
5 units: ≥68 minutes through 82 minutes

6 units: ≥83 minutes through 97 minutes
7 units: ≥98 minutes through 112 minutes
8 units: ≥113 minutes through 127 minutes

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

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

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

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

F. Place of Service

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

For independent practitioner providers: office, private residence, school, Head Start program, and childcare (regular and developmental day care) settings.

Telehealth claims should be filed with the provider's usual place of service code(s).

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

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