

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

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Audiological Services	1
1.2	Nutrition Services	2
1.3	Occupational Therapy Services	2
1.4	Physical Therapy Services	2
1.5	Psychological Services	3
1.6	Speech and Language Services.....	3
1.7	Medical Services.....	3
1.8	Clinical Social Work Services	3
1.9	Multidisciplinary Evaluations and Assessments.....	4
1.10	Case Management.....	4
1.11	Community Based Rehabilitative Services.....	5
1.12	Developmental Testing.....	5
2.0	Eligibility Requirements	6
2.1	Provisions.....	6
2.1.1	General.....	6
2.1.2	Specific	6
2.2	Special Provisions.....	6
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age	6
3.0	When the Procedure, Product, or Service Is Covered.....	7
3.1	General Criteria Covered	7
3.1.1	Telehealth and Telephonic Services	7
3.2	Specific Criteria Covered.....	8
3.2.1	Specific criteria covered by Medicaid	8
3.2.2	Medicaid Additional Criteria Covered.....	8
4.0	When the Procedure, Product, or Service Is Not Covered.....	8
4.1	General Criteria Not Covered	8
4.2	Specific Criteria Not Covered.....	8
4.2.1	Specific Criteria Not Covered by Medicaid.....	8
4.2.2	Medicaid Additional Criteria Not Covered.....	8
5.0	Requirements for and Limitations on Coverage	8
5.1	Prior Approval	8
5.2	Prior Approval Requirements	9
5.2.1	General.....	9
5.2.2	Specific	9
5.2.3	Prior Approval Requirements for Outpatient Specialized Therapies.....	9
5.2.4	Prior Approval Requirements for Outpatient Behavioral Health Services Provided by Direct Enrolled Providers	9
5.3	Additional Limitations or Requirements	9

**NC Medicaid
Children’s Developmental
Service Agencies (CDSAs)**

**Medicaid
Clinical Coverage Policy No: 8-J
Amended Date: November 1, 2023**

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service 9
6.1 Provider Qualifications 10

7.0 Additional Requirements 12
7.1 Compliance 12
7.2 Documenting Services 12

8.0 Policy Implementation/Revision Information..... 14

Attachment A: Claims-Related Information 20
A. Claim Type 20
B. International Classification of Diseases and Related Health Problems, Tenth Revisions,
Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) 20
C. Code(s)..... 20
D. Modifiers..... 22
E. Billing Units..... 22
F. Place of Service 23
G. Co-payments 23
H. Reimbursement 23

Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

1-H, *Telehealth, Virtual Communications, and Remote Patient Monitoring*

8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*

10A, *Outpatient Specialized Therapies*

8A-5, *Diagnostic Assessment*

1.0 Description of the Procedure, Product, or Service

The Children's Developmental Service Agencies (CDSAs) (formerly known as Developmental Evaluation Centers [DECs]) are the local lead agencies for the North Carolina Infant-Toddler Program, under Part C of the Individuals with Disabilities Education Act (IDEA). The responsibilities of the local lead agency are to provide oversight of all the North Carolina Infant-Toddler Program services.

Oversight responsibilities include:

- a. receiving all referrals for the North Carolina Infant-Toddler Program;
- b. contacting families of young children with special needs who may be eligible for the program;
- c. determining eligibility status of children referred;
- d. providing initial and continuing services through their staff and public and private contract agencies; and
- e. the provision and appropriate review of the Individualized Family Service Plan (IFSP) for each child and family served under the program.

Medicaid covered services include the following:

1.1 Audiological Services

Audiological services include any services or equipment that may be needed to address a child's needs with relation to his auditory skills. Audiological services include:

- a. the identification of children with audiological (hearing) impairment(s) through the utilization of risk criteria and appropriate audiological screening techniques;
- b. a determination of the range, nature, and degree of hearing loss and communication functions through the use of appropriate audiological screening procedures;
- c. a referral for medical and any other services that may be necessary for the habilitation or rehabilitation of children who have a hearing impairment;
- d. the provision of auditory training, aural rehabilitation, speech reading, and listening device orientation and training, and any other related, necessary services;
- e. the provision of services for the prevention of hearing loss; and
- f. a determination of the child's need for amplification, including the selection, fitting, and dispensing of appropriate listening and vibrotactile devices, followed by an evaluation of the effectiveness of those devices.

1.2 Nutrition Services

Nutritional services include:

- a. the completion of individual assessments in:
 1. nutritional history and dietary intake;
 2. anthropometric, biochemical, and clinical variables;
 3. feeding skills and feeding problems; and
 4. food habits and food preferences;
- b. the development and monitoring of appropriate plans established to address the nutritional needs of the child, based on the individual assessment; and
- c. the referral of the child to appropriate community resources in order to carry out nutritional goals.

1.3 Occupational Therapy Services

Occupational therapy includes the services necessary to address the functional needs of children related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. The intent of these services is to assist in the improvement of a child's functional ability to perform tasks in home, school, and community settings. These services include:

- a. identification, assessment, and intervention;
- b. adaptation of the environment, and the selection and design of assistive and orthotic devices whose purpose is to facilitate development and promote the acquisition of functional skills; and
- c. the prevention or minimization of the impact of initial or future impairment, delay in development, or the loss of any functional ability.

1.4 Physical Therapy Services

Physical therapy includes those services necessary to address the promotion of:

- a. sensorimotor function through the enhancement of musculoskeletal status;
- b. neurobehavioral organization;
- c. perceptual and motor development;
- d. cardiopulmonary status; and
- e. effective environmental adaptation.

These services include:

- a. the screening, evaluation, and assessment of infants and toddlers for the purpose of identifying movement dysfunction;
- b. the attainment, interpretation, and integration of information appropriate for the alleviation, prevention, or compensation for movement dysfunction and related functional problems; and
- c. the provision of individual services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems.

1.5 Psychological Services

Psychological services include:

- a. the administration of psychological and developmental assessments and other evaluation procedures;
- b. the interpretation of assessment results;
- c. obtaining, integrating, and interpreting information about child behavior, and child and family conditions that are related to learning, mental health, and development; and
- d. the planning and management of a program of psychological services, including psychological counseling for children and parent, family counseling, consultation on child development, parent training, and educational programs.

1.6 Speech and Language Services

Speech and language therapy includes:

- a. the identification of children with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
- b. the referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in the development of communication skills; and
- c. the provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in the development of communication skills.

1.7 Medical Services

Medical services in the Infant-Toddler Program refer to services only for evaluation or diagnostic purposes for the determination of a child's:

- a. eligibility;
- b. developmental status; and
- c. need for early intervention services.

1.8 Clinical Social Work Services

Clinical social work services include assessment and may also include treatment. Clinical social work assessment includes interviewing and observation and may include testing to assess the following:

- a. Family social history, which may include:
 1. identifying information;
 2. family composition;
 3. child's home environment;
 4. child-care arrangements;
 5. daily routine;
 6. transportation;
 7. financial or legal issues; and
 8. involvement in community support programs.

- b. Social and emotional development and adaptive behavior of the child, including:
 - 1. the child's emotional development within the family;
 - 2. ability to interact with peers and in community settings;
 - 3. ability to respond to verbal and non-verbal cues; self-help skills; and
 - 4. behavior.
- c. Child and family functioning, which may include:
 - 1. parent's understanding of previous testing (diagnosis);
 - 2. parent's perspective of child's strengths and needs;
 - 3. parent's expectations for the CDSA evaluation;
 - 4. parenting skills and need for supportive services;
 - 5. family dynamics including parent-child relationship; and
 - 6. family's response to and ability to use assistive technology.

Clinical social work treatment includes:

- a. individual or family therapies to ameliorate identified emotional and behavioral dysfunction;
- b. promote healthy child and family relationships and functioning;
- c. and assist the family in coping with and managing an identified disability.

Note: Within this therapeutic context, it may also include the provision of instruction to the child or family.

1.9 Multidisciplinary Evaluations and Assessments

Multidisciplinary evaluation and assessment services are:

- a. Screening;
- b. Evaluation; and
- c. assessment procedures used to determine:
 - 1. a child's initial and continuing eligibility for early intervention services;
 - 2. the child's level of functioning in the developmental domains;
 - 3. and a medical perspective on the child's development.

This service is used to determine:

- a. a child's strengths and needs and services appropriate to meet those needs;
- b. resources and concerns of the family; and
- c. supports and services necessary to enhance the family's capacity to meet their child's developmental needs.

1.10 Case Management

Case Management services include:

- a. assessment and periodic reassessment to determine types and amounts of services needed;
- b. development and implementation of an individualized case management service plan with the client;

- c. consistent with SSA 1902(a)(23), coordination and assignment of responsibilities among staff and service agencies; and
- d. monitoring and follow-up to ensure that services are received and are adequate for the client's needs.

1.11 Community Based Rehabilitative Services

This service is provided to meet the cognitive, communication, social, emotional, and adaptive development needs of the child. The ITFS, in consultation with the IFSP team, will work with caregivers on planning and developing individualized intervention strategies for the child to extend opportunities to practice the following skills, described below, into everyday activities in the home, daycare or other community setting:

- a. **Cognitive** – This refers to the acquisition, organization, and ability to process and use information.
- b. **Communication** – This includes expressive and receptive communication skills, both verbal and non-verbal.
- c. **Social and Emotional Skills** – This refers to interpersonal relationship abilities. This includes interactions and relationships with parent(s) and caregivers, other family members, adults and peers, as well as behavioral characteristics, e.g., passive, active, curious, calm, anxious, and irritable.
- d. **Adaptive Development** – This refers to the ability to function independently within the environment and the child's competency with daily living activities such as sucking, eating, dressing, playing, etc., as appropriate for the child's age.
- e. **Physical** [gross and fine motor] – This service refers to abilities with tasks requiring large and small muscle coordination, strength, stamina, flexibility, and motor development appropriate for the developmental age.

1.12 Developmental Testing

Developmental testing is generally used as a screening tool to identify children who should receive a more intensive diagnostic evaluation and assessment.

This service is provided by:

- a. an educational diagnostician;
- b. psychologist;
- c. certified Infant toddler family specialist;
- d. other clinical staff who meet the qualifications of an educational diagnostician; or
- e. other clinical staff who holds typically a master's degree and has demonstrated competence in developmental testing to the satisfaction of the CDSA.

This service is not for education purposes but to determine if there is risk for or determined intellectual/developmental delay for referral to health-related services such as occupational therapy, physical therapy, speech therapy, etc.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

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

2.1.2 Specific

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

- a. **Medicaid**
Eligibility ends on the child's third birthday.

2.2 Special Provisions

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

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

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

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

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

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

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

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

b. EPSDT and Prior Approval Requirements

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

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

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

3.1.1 Telehealth and Telephonic Services

As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth or telephonically. Services delivered via telehealth or telephonically must follow the requirements and guidance in clinical coverage Policy 1-H, Telehealth, *Virtual Communications, and Remote Patient Monitoring*, at <https://medicaid.ncdhhs.gov/>,

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover services as listed in **Section 1.0** of this policy when medically necessary and provided as outlined in an IFSP.

Refer to **Section 3.0** of clinical coverage policy 10A, *Outpatient Specialized Therapies*, at <https://medicaid.ncdhhs.gov/>, for medical necessity criteria for physical therapy, occupational therapy, and speech/language-audiology therapy.

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

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

4.1 General Criteria Not Covered

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

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

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, Medicaid shall not cover services under this policy when the services provided are not outlined in the IFSP and the guidelines in this policy are not met.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall not require prior approval for Children's Developmental Service Agencies (CDSAs).

Note: Prior approval is required for clinical coverage policy 10A. Refer to policy 10A, *Outpatient Specialized Therapies* for prior approval requirements. Prior approval is not

required for Clinical Coverage Policy 8A-5, Diagnostic Assessment and 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.

- a. ~~Prior approval from The Carolinas Center for Medical Excellence (CCME) (<http://www.thecarolinascenter.org>) is required for Clinical Coverage Policy 10A, Outpatient Specialized Therapies. The provider shall obtain prior approval before rendering Outpatient Specialized Therapies treatments.~~
- b. ~~Prior approval for Outpatient Behavioral Health Services Provided by Direct Enrolled Providers for reimbursement by Medicaid is required from NC Medicaid's contracted utilization review vendor or the Prepaid Inpatient Health Plan (PIHP) for the beneficiary's county of residence.~~

5.2 Prior Approval Requirements

5.2.1 General

None Apply.

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

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

5.2.2 Specific

None Apply.

~~5.2.3 Prior Approval Requirements for Outpatient Specialized Therapies~~

~~Refer to Section 5.0 of clinical coverage policy 10A, *Outpatient Specialized Therapies*, at <https://medicaid.ncdhhs.gov/>, for details on prior approval requirements for these services~~

~~5.2.4 Prior Approval Requirements for Outpatient Behavioral Health Services Provided by Direct Enrolled Providers~~

~~Refer to Section 5.0 of clinical coverage policy 8C, *Outpatient Behavioral Health Services Provided by Direct Enrolled Providers*, at <https://medicaid.ncdhhs.gov/>, for details on prior approval requirements for these services.~~

5.3 Additional Limitations or Requirements

None Apply.

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

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

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

6.1 Provider Qualifications

In the service delivery process, the role of the CDSA is to share with families the listing of qualified providers for each of the IFSP services. Any willing provider who meets provider criteria for enrollment can enroll with the CDSA and NC Medicaid as a Medicaid provider. The family makes the choice of providers utilized for their needs, and the providers bill Medicaid directly for the services they provide.

Staff of the CDSA, private or public providers providing services to Medicaid beneficiaries through a contract with the CDSA, shall meet the following requirements, as appropriate to the discipline:

- a. As defined in 10A NCAC 27G .0104 & in accordance with HB478, a qualified professional in early intervention is an individual in any of the following categories:
 1. Individual holds a master's degree in a human service field, has one year of full time pre or post graduate experience with young children and their families in the provision of child health, early childhood, special education, family development, and early intervention or related services, with infant/toddler/family specialist [ITFS] certification, or is working toward this certification at the required rate. If the individual does not have the required number of years' experience in the aforementioned areas described, the individual must be supervised by a certified ITFS or an individual approved by the CDSA, in accordance with an individual supervision plan in order to function as a qualified professional.
 2. Individual holds a bachelor's degree in a human service field, has two years of full time pre or post graduate experience with young children and their families in the provision of child health, early childhood, special education, family development, and early intervention or related services, with infant/toddler/family specialist [ITFS] certification, or is working toward this certification at the required rate. If the individual does not have the required number of years' experience in the aforementioned areas described, the individual must be supervised by a certified ITFS or an individual approved by the CDSA, in accordance with an individualized supervision plan in order to function as a qualified professional.
 3. Individual is a registered nurse, licensed in the state of North Carolina, with two years of full time pre or post graduate experience with young children and their families in the provision of child health, early childhood, special education, family development, and early intervention or related services, with infant/toddler/family specialist [ITFS] certification, or is working toward this certification at the required rate. If the individual does not have the required number of years' experience in the aforementioned areas described, the individual must be supervised by a certified ITFS or an individual approved by the CDSA, in accordance with an individualized supervision plan, in order to function as a qualified professional.
- b. As defined in 42 CFR 440.110, a **speech pathologist** who has a valid license issued by the N.C. Board of Examiners for Speech and Language Pathologists and Audiologists and has a certificate of clinical competence from the American Speech and Hearing Association; has completed the equivalent educational requirements and

work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate. Only therapy assistants and speech language pathologists in their clinical fellowship year may work under the direction of the licensed therapist. The Supervising Therapist is the biller of the service.

- c. As defined in 42 CFR 440.110, an **audiologist** who has a valid license issued by the N.C. Board of Examiners for Speech and Language Pathologists and Audiologists. Only therapy assistants may work under the direction of the licensed therapist. The supervising therapist is the biller of the service.
- d. As defined in 42 CFR 440.110, an **occupational therapist** who is registered by the American Occupational Association; or a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association and, where applicable, licensed by the state. Only therapy assistants may work under the direction of the licensed therapist. The supervising therapist is the biller of the service.
- e. As defined in 42 CFR 440.110, a qualified **physical therapist** is an individual who is a graduate of a program of physical therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Physical Therapy Association or its equivalent; and where applicable, licensed by the State. Only therapy assistants may work under the direction of the licensed therapist. The supervising therapist is the biller of the service.
- f. A **nutritionist** or **registered dietitian** registered with the American Dietetic Association's Commission on Dietetic Registration or licensed by the N.C. Board of Dietetics and Nutrition.
- g. A **pediatrician** or **physician's assistant**, in accordance with the scope of the North Carolina Medical Practice Act, or a nurse practitioner within the scope of the Nurse Practice Act.
- h. A **licensed clinical social worker (LCSW)** in accordance with the Ethical Guidelines of the Social Worker Act and (General Statutes of North Carolina, Chapter 90B, Social Worker Certification and Licensure Act) and the NASW Code of Ethics.
- i. An **educational diagnostician**, with a master's degree in special education or related field, with at least six hours of coursework and two years' experience in educational and developmental testing, or a bachelor's degree in special education or related field, with at least six hours of coursework and three years' experience in educational and developmental testing.
- j. A licensed **psychologist** licensed by the N.C. Psychology Board, in accordance with the North Carolina Psychology Act.
- k. Any qualified provider who meets the following criteria can enroll with the CDSA and NC Medicaid as a Medicaid **provider of Community Based Rehabilitative Services (CBRS)**:
 1. An eligible provider of CBRS must receive endorsement from the CDSA and enroll with NC Medicaid as a:
 - i. Medicaid individual licensed provider; or
 - ii. A group provider who employs or contracts with individuals who hold a

valid and active license in the healing arts in full force and effect to practice in the state of North Carolina, or a professional who meets the certification requirements for the infant/toddler/family specialist (ITFS) as delineated in the *North Carolina Infant Toddler Program Procedures for Personnel Certification*.

2. The Division of Public Health (DPH), through CDSA, documents and verifies the qualifications, training, and certification of the ITFS, verifies the valid licensure status, and endorses the provider for Medicaid participation.
3. Community Based Rehabilitative Service providers must be a:
 - i. licensed psychologist as defined in 10A NCAC 27G.0104(17);
 - ii. licensed clinical social worker as defined in 10A NCAC 27G.0104(9);
 - iii. a qualified mental health professional (QMHP), including a licensed marriage and family therapist as defined in 10A NCAC 27G.0104(12);
 - iv. a certified ITFS or an individual working toward certification at the required rate or a paraprofessional, as defined in 10A NCAC 27G.0104(15), may also be a provider if he or she meets the certification requirements for ITFS as delineated in the *North Carolina Infant Toddler Program Procedures for Personnel Certification* and is under the direct supervision of a professional certified according to these procedures. All providers of this service must possess the ITFS certification or be working toward certification at the required rate.

7.0 Additional Requirements

Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

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

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

7.2 Documenting Services

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

- a. The beneficiary's name and Medicaid identification number.
- b. A copy of the treatment plan with clearly defined goals and measurable baselines.
- c. A copy of the physician's order for treatment services. The date that the order was signed must precede the treatment dates.
- d. Progress notes with achievements or measurable progress; description of services performed, and dates of service.
- e. The duration of service (i.e., length of assessment or treatment session in minutes).

- f. The signature of the person providing each service.
- g. A copy of each test performed or a summary listing all test results and the written evaluation report.
- h. A copy of the completed prior approval form with the prior approval authorization number.

CDSAs are responsible for ensuring that salaried and contracted personnel adhere to these requirements

8.0 Policy Implementation/Revision Information

Original Effective Date: September 1, 2003

Revision Information:

Date	Section Revised	Change
10/14/2003	1.3, Child Service Coordination	Medicaid: The first sentence was corrected to read “...provided by a Child Service Coordinator to a child referred to or eligible under the Infant-Toddler Program...”
10/14/2003	Section 6.0, item 1.	Medicaid: Item 1 was corrected to read “Infant, Toddler, and Family certification . . .”
11/14/2003	Section 7.1, 3 rd bullet	Medicaid: Deleted text pertaining to verbal orders; effective with date of policy publication 09/01/03.
12/01/2003	Section 5.0	Medicaid: The section was renamed from Policy Guidelines to Requirements for and Limitations on Coverage.
12/01/2003	Section 8.0	Medicaid: This section was reformatted into three subsections; there was no change to the content.
03/01/2005	Section 1.0	Medicaid: Deleted the following services from policy: 1.1 Assistive Technology Services and Devices, 1.3 Child Service Coordination, 1.4 Early Identification and Screening, and 1.5 Family Counseling and Therapy Services; effective with date of State Plan Amendment 7/1/03.
03/01/2005	Section 1.0	Medicaid: Added the following services to policy: 1.9 Multidisciplinary Evaluations and Assessments, 1.10 Case Management, 1.11 Community Based Rehabilitative Service and 1.12 Developmental Testing; effective with date of State Plan Amendment 7/1/03.
03/01/2005	Section 2.0 Eligible Recipients	Medicaid: Added text pertaining to the two services the CDSA may provide to 3 and 4 year olds who are transitioning from the N.C. Infant-Toddler Program to Preschool services; effective with date of State Plan Amendment 7/1/03.
03/01/2005	Section 6.0 Eligible Providers	Medicaid: Revised text in item 1 to broaden definition, revised text in items 2,3 and 4 to include requirements set forth in 42 CFR 440.110; effective with date of State Plan Amendment 7/1/03.
03/01/2005	Section 6.0 Eligible Providers	Medicaid: Added requirement #12 for providers who are eligible to enroll to provide Community Based Rehabilitative Services; effective with date of State Plan Amendment 7/1/03.

Date	Section Revised	Change
03/01/2005	Section 8.3	Medicaid: The procedure codes listed in Attachment A were incorporated into section 8.3. Y codes were converted to national codes to comply with HIPPA. Procedure code T1016 was replaced with T1017.
03/01/2005	Section 8.4	Medicaid: A statement was added to instruct providers to contact DMA Financial Operations for a reimbursement rate schedule.
09/01/2005	Section 2.0	Medicaid: A special provision related to EPSDT was added.
12/01/2005	Section 2.3	Medicaid: The Web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Section 5.2	Medicaid: This section was updated to reflect MRNC's name change to The Carolinas Center for Medical Excellence (CCME).
01/01/2006	Section 8.3	Medicaid: CPT procedure code 95210 was end-dated and replaced with 92626, 92627, 92630 and 92633; 97520 was end-dated and replaced with 97761; 97703 was end-dated and replaced with 97762; 96100 was end-dated and replaced with 96101; 96115 was end-dated and replaced with 96116; and 96117 was end-dated and replaced with 96118.
12/01/2006	Section 2.3	Medicaid: The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0, 4.0, and 5.0	Medicaid: A note regarding EPSDT was added to these sections.
02/01/2007	Section 2.2	Medicaid: The statement that CDSAs may only perform evaluation services and community based rehabilitative services at the request of the Local Education Agency for 3- and 4-year olds who are transitioning from the N.C. Infant-Toddler Program to preschool services was deleted from the policy.
02/01/2007	Section 6.0	Medicaid: The requirements for an occupation therapist were amended to indicate that, where applicable, the therapist must be licensed by the State.
05/01/2007	Sections 2 through 5	Medicaid: EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
08/01/2012	Throughout	Technical changes made to place policy on the combined template.
08/01/2012	Section 5.1	Prior authorization information was revised to bring into compliance with Medicaid Clinical Policy 10A and 8C, as promulgated 1/1/12.

Date	Section Revised	Change
08/01/2012	Section 6.1.b through d	Updated provisions related to who can work under the direction of specialized therapists to bring into compliance with Medicaid Clinical Policy 10A, Specialized Therapies, as promulgated 1/1/12.
8/01/2014	All Sections and Attachments	Updated: 2013 CPT codes, language pertaining to intellectual/ developmental disabilities, as well as other technical, nonsubstantive, and clarifying changes including grammar, readability, typographical accuracy, and format without affecting coverage.
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.
12/01/2018	Subsection 6.1	Technical changes made to policy that adhere to HB478. Deleted word baccalaureate.
12/15/2018	All Sections and Attachments	Policy posted 12/15/2018 with an Amended Date of December 1, 2018.
02/01/2019	Attachment A	Medicaid: CPT procedure code 96101 was end-dated and replaced with 96130, 96136, and 96137; 96111 was end-dated and replaced with 96112 and 96113; 96121 was added to 96116; 96118 was end-dated and replaced with 96132, 96133, 96136 and 96137; 92588 was end-dated and replaced with 92587.
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.
12/15/19	Attachment A	Removed: Note: For behavioral health diagnosing, it is recommended that providers diagnose to the highest level of specificity using DC 0-5, however, claims are submitted using ICD-10 diagnosis codes. Providers shall utilize the appropriate ICD-10 diagnosis that corresponds to the chosen DC 0-5 diagnosis. A DC 0-5 to ICD-10 crosswalk is found in the DC 0-5 manual.
12/15/19	Attachment A	Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.
12/15/19	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.”

Date	Section Revised	Change
12/15/19	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.
12/01/2020	Related Coverage Policies	Added 1-H, <i>Telehealth, Virtual Communications, and Remote Patient Monitoring</i>
12/01/2020	Subsection 3.1.1,	Added new subsection 3.1.1 Telehealth Services.
12/01/2020	Section 6.1.f	Added the word “registered” in front of dietician.
12/01/2020	Attachment A, Letter C	Added new billing guidance and table to reflect new telehealth-eligible services. Added the following note: Note: The “+” symbol identifies add-on codes that are always performed in addition to the primary service or procedure and must never be reported as stand-alone codes.
12/01/2020	Attachment A, Letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for virtual patient communications or remote patient monitoring
12/01/2020	Attachment A, Letter F	Added language indicating telehealth codes should be filed with the provider’s usual place of service code(s). Removed incorrect acronym “ISFP”. Added correct acronym “IFSP.”
12/01/2020	Added beginning of Policy	Added the language “This clinical coverage policy has an effective date of November 15, 2020; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of COVID-19 Special Medicaid Bulletins will remain in effect.”
02/01/2022	Attachment A, Letter C	Deleted CPT code 99201.
02/01/2022	Attachment A, Letter D	Added: "All claims: Modifier TL must be appended to CPT or HCPCS code to indicate that an IFSP service is being provided."
02/15/2023	Subsection 3.1.1	Added: “and Telephonic” in front of Services to subsection header
02/15/2023	Subsection 3.1.1	Added: “or telephonically” as a service delivery method
02/15/2023	Attachment A, Letter C	Added new billing guidance and table to reflect new telehealth-eligible and telephonic eligible services.

Date	Section Revised	Change
2/22/2023	Attachment A, Letter C	Corrected omission in 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
07/06/2023		Corrected Date typo in section 8.0 amended date not changed
11/01/2023	Attachment A, Letter C	Corrected omission of CPT codes 90838, 90849, 90853, 96138, and 96139. Corrected omission of CPT codes 90849, 90838 and 96121 as Telehealth Eligible. Corrected omission of 90849 as telephonic eligible.
11/01/2023		Policy posted 11/06/2023 with an amended date of 11/01/2023
	<u>Section 5.0</u>	<u>To comply with the Mental Health Parity and Addiction Equity Act and the Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900 revised:</u> <u>(b) to indicate: “Prior approval is not required for Clinical Coverage Policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers.”</u> <u>Added “c. Prior approval is not required for Clinical Coverage Policy 8A-5, Diagnostic Assessment.”; and</u> <u>Removed “Prior approval for Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers for reimbursement by Medicaid is required from NC Medicaid’s contracted utilization review vendor or the Prepaid Inpatient Health Plan (PIHP) for the beneficiary’s county of residence.”</u>
	<u>Section 5.1</u>	<u>Added “Note: Prior approval is required for clinical coverage policy 10A. Refer to policy 10A, Outpatient Specialized Therapies for prior approval requirements. Prior approval is not required for Clinical Coverage Policy 8A-5, Diagnostic Assessment and 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers”</u>
	<u>Subsection 5.2.1</u>	<u>Removed prior approval requirements.</u>
	<u>Subsection 5.2.3</u>	<u>Removed “Refer to Section 5.0 of clinical coverage policy 10A, Outpatient Specialized Therapies, at https://medicaid.ncdhhs.gov/, for details on prior approval requirements for these services”</u>

Date	Section Revised	Change
	<u>Subsection 5.2.4</u>	Removed “Refer to Section 5.0 of clinical coverage policy 8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers, at https://medicaid.ncdhhs.gov/ , for details on prior approval requirements for these services.”
	<u>Attachment A, Letter C</u>	Added missing codes 90792, +90833, +90836, 99417, to align with 8C Outpatient Behavioral Health Services.

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

CMS-1500 (through HSIS)

Professional (CMS-1500/837P transaction)

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

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

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

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

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

HCPCS Code(s)
H0031
H0036
H0036 HI
H0036 HM
H0036 HQ
H0036 TL
T1017 HI
T1023

CPT Code(s)			
90785+	92557	96131	97542
90791	92567	96112	97750
90792	92568	96113	97802
90832	92579	96121	97803
+90833	92583	96132	99202
90834	92585	96133	99203
+90836	92587	96136	99204
90837	92590	96137	99205
90838	92591	96138	99211
90839	92592	96139	99212
90840+	92593	96146	99213
90846	92594	97001	99214
90847	92595	97002	99215
90849	92610	97003	99241
90853	92626	97004	99242
92507	92627	97110	99243
92508	92630	97112	99244
92521	92633	97113	99245
92522	96110	97116	99417
92523	96116	97124	
92524	96130	97140	
92526		97530	
92551		97533	
92552		97535	
92553			
92555			
92556			

Telehealth Eligible Services	Telephonic Eligible Services
+90785	+90785
90791	
90792	90832
90832	90834
+90833	90837
90834	90839
+90836	
90837	+90840
90838	90846
90839	90847
+90840	90849
90846	
90847	
90849	
90853	
96110	
96116	

96121	
96130	
96131	
96132	
96133	
96146	
99202	
99203	
99204	
99205	
99211	
99212	
99213	
99214	
99215	
99241	
99242	
99243	
99244	
99245	
T1023	

Note: The “+” symbol identifies add-on codes that are always performed in addition to the primary service or procedure and must never be reported as stand-alone codes.

Unlisted Procedure or Service

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

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

D. Modifiers

All Claims: Modifier TL must be appended to CPT or HCPCS code to indicate that an IFSP service is being provided.

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

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

E. Billing Units

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

F. Place of Service

Location of service is identified on the IFSP.

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

Place of service shall be designated appropriately on the claim.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

In accordance with 42 CFR 447.53 and 457.540, copayment may not be charged for Interactive Complexity (90785) service add-on.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>