

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections
MEDICAID



REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES PROVIDER MANUAL

FEBRUARY 1, 2024

South Carolina Department of Health and Human Services

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1 PROGRAM OVERVIEW

PROGRAM DESCRIPTION

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of rehabilitative therapies and audiological services delivered to Healthy Connections Medicaid members via the following programs:

- Fee-for-Service (FFS)
- Managed Care Organization (MCO)

The Rehabilitative Therapies and Audiological Services Provider Manual supplements SCDHHS's general policies and procedures detailed in the Provider Administrative and Billing Manual. It provides policies and requirements specific for rehabilitative therapy and audiological services providers for the FFS program. For services delivered to MCO members, providers must follow the member's MCO's policies and requirements.

For the purpose of this manual, rehabilitative therapy and audiological services are speech-language pathology, audiological, physical therapy and occupational therapy services furnished in a practice or clinic setting (**exclusive of services furnished in other settings such as an inpatient hospital, institutional care facilities or local education agencies**) by rehabilitative therapists and audiologists meeting all applicable Medicaid provider qualifications and state licensure regulations specified by the South Carolina Department of Labor, Licensing and Regulation (LLR).

Providers must review, reference, and comply with both the Rehabilitative Therapies and Audiological Services Provider Manual and the Provider Administrative and Billing Manual.

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- [Provider Administrative and Billing Manual](#)
- [Forms](#)

2 COVERED POPULATIONS

ELIGIBILITY/ SPECIAL POPULATIONS

Beneficiary Requirements

The South Carolina Department of Health and Human Services (SCDHHS) provides reimbursement for medically necessary services for full-benefit Medicaid-eligible individuals who have or are at risk of developing:

- Sensory, emotional, behavioral, or social impairments
- Physical disabilities or medical conditions
- Intellectual, developmental disabilities or delays, or other related disabilities
- Individuals of any age covered under the Head and Spinal Cord Injury Waiver (HASCI) or Intellectual Disabilities and Related Disabilities Waiver (ID/RD)

Only beneficiaries eligible for full Medicaid benefits, in the following subgroups, may receive medically necessary rehabilitative therapy and audiological services:

- Children: beneficiaries ages 0 through 20 years (through the last day of the month of the 21st birthday)
- Adults: beneficiaries ages 21 years and older
- Waiver members:
 - o Members of the HASCI waiver
 - o Members of the ID/RD waiver

Verifying Beneficiary's Eligibility

Participating Healthy Connections providers must access beneficiary eligibility information through the SCDHHS' Web Portal or Customer Service Center. Beneficiaries must be eligible on the date of service for payment to be made.

3 ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

An eligible provider is an individual speech pathologist, audiologist, occupational therapist, or physical therapist; firm; corporation; association or an institution practicing as one business entity with a written participation agreement in effect with SCDHHS to provide therapy or audiology services to beneficiaries enrolled in the Healthy Connections program pursuant to the South Carolina State Plan for Medical Assistance and in accordance with Title XIX of the Social Security Act, as amended. As it relates to delivery of speech, audiology, occupational or physical therapy services, a Medicaid-enrolled provider will be referred to as “rehabilitative therapy/audiology services provider”.

For general information regarding provider qualifications and enrollment in the South Carolina Healthy Connections Medicaid program please refer to the Provider Administrative and Billing Manual. Specific provider qualifications for rehabilitative therapy/audiology services are listed below.

Rehabilitative therapy/audiology services providers must meet all applicable Medicaid provider qualifications and state licensure regulations specified by the South Carolina Department of Labor, Licensing and Regulation (LLR). **Medicaid reimbursement is available for rehabilitative therapy and audiological services when provided by or under the direction of the qualified rehabilitative therapy/audiology services provider to whom the beneficiary has been referred.** A physician or other Licensed Practitioner of the Healing Arts (LPHA) acting within the scope of his or her practice under state law must make the referral.

Services rendered under the direction of the rehabilitative therapy/audiology provider must conform to the federal and state laws, rules and regulations.

The following providers are eligible to enroll with SCDHHS to bill for rehabilitative therapy and audiology services to eligible members:

- Speech-language pathologists (SLP), an independent or group practice
- Audiologists, an independent or group practice
- Speech and hearing clinics
- Physical therapists, an independent or group practice
- Occupational therapists, an independent or group practice
- Multi-therapy groups

- Ambulatory rehabilitation centers

For specific requirements on Provider enrollment refer to SCDHHS's website at:

<https://www.scdhhs.gov/providers/become-provider>

Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled, terminated or excluded provider.

4 COVERED SERVICES AND DEFINITIONS

DEFINITIONS

1. **Covered Services** means a medical service, including those services coverable through the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program meeting the following criteria:
 - a. Is medically necessary.
 - b. Is provided to an eligible beneficiary by a participating provider.
 - c. Is the most appropriate supply or level of care consistent with professionally recognized standards of medical practice within the service area and applicable policies and procedures.
 - d. Is not rendered for convenience, cosmetic or experimental purposes.

2. **Provider** means an individual, firm, corporation, association or institution providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act, as amended.

3. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** is a program for persons under age 21 made pursuant to 42 U.S.C. Sections 1396a(a)(43), 1396d(a)(4)(B) and 1396d(r), and 42 C.F.R. Part 441, Subpart B to ascertain children's individual physical and mental illness and conditions discovered by screening services, whether such services are covered.

4. **Medically Reasonable and Necessary** means procedures, treatments, medications or supplies, (the provision of which may be limited by specific provisions, bulletins and other directives [42 CFR 440.230 (d) and SC Code of Regulations 126-300 (D)]), ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury which per [S.C. Code of Regulations 126-425(9)]:
 - a. Must be provided at appropriate facilities, at the appropriate levels of care and in the least costly setting required by the beneficiary's condition.
 - b. Must be administered in accordance with recognized and acceptable standards of medical and/or surgical discipline at the time the beneficiary receives the service.
 - c. Must comply with standards of care and not for the beneficiary's convenience, experimental or cosmetic purposes.
 - d. Medical necessity or any referral information must be documented in the beneficiary's health record and must include a detailed description of services rendered. The fact that a provider prescribed a service or supply does not deem it medically necessary.

5. **Ambulatory Rehabilitation Centers** are free-standing facilities that utilize a team of specialized rehabilitation personnel to provide integrated and multidisciplinary services designed to improve the physical functioning of individuals. To enroll with Medicaid as an ambulatory rehabilitation center, the facility must meet one of the following requirements:
- a. Certified by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF is a private, not-for-profit organization that accredits rehabilitation facilities that meet established standards of quality for services. SCDHHS recognizes facilities with CARF-accredited programs in outpatient medical rehabilitation and/or early childhood development as ambulatory rehabilitation centers.
 - b. Certified by the South Carolina Department of Health and Environmental Control (DHEC) as a Comprehensive Outpatient Rehabilitation Facility (CORF). A CORF is a non-residential rehabilitation facility operated exclusively for the purpose of providing diagnostic, therapeutic and restorative services for the rehabilitation of injured, disabled or sick persons at a single fixed location by or under the supervision of a physician (42 CFR 485.51).

COVERED SERVICES

All rehabilitative therapy and audiological services are subject to a medical necessity determination by SCDHHS through established utilization management policies based on the application of industry standards of medical practice, and through applications of reasonable limitations and criteria, as defined in Section 8 of this manual.

Medically necessary rehabilitative therapy and audiological services are covered as follows:

State Plan Services

Speech-Language Pathology Services

Children, adults and HASCI waiver beneficiaries are eligible to receive speech-language pathology services under the State Plan benefit with limitations as defined in Section 8 of this manual.

In accordance with 42 CFR 440.110(c)(1), services for individuals with speech and language disorders include diagnostic, screening, preventive, or corrective services. These services are provided by or under the direction of a speech-language pathologist. Beneficiaries must be referred by a physician or other LPHA. Services include any necessary supplies and equipment related to speech-language pathology. Services include evaluating and treating disorders of verbal and written language, speech sound disorders (articulations, phonological disorders), voice, fluency, feeding, swallowing, cognition/communication, auditory and/or visual processing and memory, and interactive communication, as well as the use of augmentative and alternative communication systems (e.g., sign language, gesture systems, communication boards, electronic automated devices, and mechanical devices).

Audiological Services

Children, adults, HASCI and ID/RD waiver beneficiaries are eligible to receive audiological services under the State Plan benefit (authority) with limitations as defined in Section 8 of this manual.

In accordance with 42 CFR 440.110(c)(1), audiological services for individuals with hearing disorders include diagnostic, screening, preventive or corrective services provided by or under the direction of an audiologist or speech pathologist. Beneficiaries must be referred by a physician or other LPHA. A referral occurs when the physician or other LPHA has asked another qualified health care provider (licensed audiologist) to recommend, evaluate, perform therapies, treatment, or other clinical activities for the beneficiary. Services include any necessary supplies and equipment related to audiological services. Services include testing and evaluation of hearing-impaired beneficiaries who may or may not improve with medication or surgical treatment.

Physical Therapy Services

Children, adults and HASCI waiver beneficiaries are eligible to receive physical therapy services under the State Plan benefit (authority) with limitations as defined in Section 8 of this manual.

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a physician or other LPHA within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified physical therapist. Services include any necessary supplies and equipment. Physical therapy services involve evaluation and treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Physical therapy services involve the use of physical agents, mechanical means, and other remedial treatment to restore normal physical functioning following illness or injury. Specific services rendered: physical therapy evaluation, individual or group therapy, and individual fabrication of upper and lower extremities orthotics and splints.

Occupational Therapy Services

Children, adults and HASCI waiver beneficiaries are eligible to receive occupational therapy services under the State Plan benefit (authority) with limitations as defined in Section 8 of this manual.

In accordance with 42 CFR 440.110(b)(1), occupational therapy means services prescribed by a physician or other LPHA within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified occupational therapist. Services include any necessary supplies and equipment. Occupational therapy services are channels to improve or restore functional abilities for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level.

Occupational therapy services are related to self-help skills, feeding, adaptive behavior, fine/gross motor, visual, sensory motor, functional cognition, postural and emotional development that have

been limited by a physical injury, illness, cognitive impairment, or other dysfunctional condition. Occupational therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance. Services include evaluation and interventions, individual or group therapy, and individual fabrication of upper and lower extremity orthotics and splints.

Telehealth

Telehealth is defined as the provision of healthcare via electronic communications technology between a provider in one location and a beneficiary in another location without loss of quality of care. Electronic communication means the use of interactive telecommunication equipment that typically includes audio and video equipment permitting two-way, real-time interactive communication between the beneficiary and the physician or practitioner at the referring site. Children and adult beneficiaries are eligible to receive rehabilitative therapy services via telehealth modality under the State Plan benefit with limitations as defined in Section 8 of this manual.

SCDHHS provides coverage for the delivery of certain rehabilitative therapy services via telehealth from a consultant site to a referring site within the limitations described below:

- The consultant site (distant site) is the physical location where a specialty physician or practitioner providing medical care is located at the time the service is provided via telehealth. The provider performing the medical care must have a valid, active license in South Carolina.
- The referring site (patient site) is the location of a Medicaid beneficiary at the time the service is being furnished.

The following conditions apply to all rehabilitative therapy services rendered via telehealth:

- The beneficiary must be present and participating in the telehealth visit.
- Interactive audio and video telecommunication must allow encrypted communication between the distant site practitioner and the Medicaid beneficiary. The telecommunication system must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted.
- The telehealth equipment and transmission speed and image resolution must be technically sufficient to support the service billed. Any staff involved in the telehealth visit must be trained in the use of the telehealth equipment and competent in its operation.
- A trained healthcare professional at the referring site (patient site presenter) is required to present the beneficiary to the practitioner at the consulting site and remain available as clinically appropriate (this condition is waived when the referring site is the beneficiary's home).
- If the beneficiary is a minor (under 18 years), a parent and/or guardian must present the minor for telehealth service unless otherwise exempted by State or Federal law. The parent

and/or guardian need not attend the telehealth session unless attendance is therapeutically appropriate.

- The beneficiary retains the right to withdraw from the telehealth visit at any time.
- All telehealth activities must comply with the requirements of HIPAA: Standards for Privacy of individually identifiable health information and all other applicable State and Federal Laws and regulations.
- The beneficiary has access to all transmitted medical information, except for live interactive video, as there is often no stored data in such encounters.
- The provider at the distant site must obtain prior approval for service when services require prior approval, based on service type or diagnosis.

Rehabilitative therapy services delivered via telehealth are a continuation of the therapy services provided in an office or outpatient setting. Quality of health care must be maintained regardless of the mode of delivery.

EPSDT Benefit

Children under the age of twenty-one (21) are eligible for medically necessary rehabilitative therapy and audiological services as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal law at 42 U.S.C. §1396d(r), §1905(r) of the Social Security Act (SSA)] requires state Medicaid programs to provide EPSDT for recipients under 21 years of age. The scope of EPSDT benefits under the federal law covers services that are medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether the service is covered under the State Plan. EPSDT rehabilitative therapy and audiological benefit includes services provided at intervals that meet reasonable standards of medical practice and at intervals necessary to determine the existence of a suspected illness or condition. EPSDT benefit is detailed on the SCDHHS EPSDT website at [EPSDT | SCDHHS](#). SCDHHS has adopted the [periodicity schedule.pdf \(aap.org\)](#) for medical, hearing and vision screenings as well as age-appropriate assessment, procedures and immunization.

NON-COVERED SERVICES

- Services determined to be unproven, experimental, research-oriented, or those deemed not medically necessary to treat the beneficiary’s condition or not directly related to the beneficiary’s diagnosis, symptoms or medical history are not reimbursable.
- Time spent documenting services, traveling to or from services, canceled visits, and missed appointments are considered part of doing business and are not reimbursable. Provider is prohibited from charging the beneficiary, beneficiary’s parent/guardian, or the beneficiary’s legal representative for these services.
- Services provided in an inpatient hospital or other institutional care facility are not reimbursable under the Rehabilitative Therapy and Audiological Services benefit.
- Biofeedback therapy may be utilized as a modality of treatment, but it is not reimbursable separately.

REIMBURSEMENT AND CHARGE LIMITS

For general policies regarding charge limits and reimbursements, providers must refer to the Provider Administrative and Billing Manual. Reimbursement and Charge limits specific to rehabilitative therapy and audiology providers are addressed in this section of the manual.

Reimbursement fees for covered rehabilitative therapy and audiological services are documented in the SCDHHS fee schedule accessible at: <https://www.scdhhs.gov/providers/fee-schedules>

Payment for all approved services must be accepted as payment in full.

The reimbursement fee for a speech-language pathology, audiological, physical or occupational therapy service is inclusive of any items or related activities/services that are considered necessary to accomplish the procedure, which may include, but are not limited to: materials, supplies or equipment. None of these items or related activities/services are separately billable to SCDHHS, the beneficiary or to the beneficiary's representative.

Providers must check the beneficiary's eligibility and service history.

Once a provider has accepted a beneficiary as a Medicaid patient, the provider must accept the amount paid by the Medicaid program (or paid by a third party, if equal or greater) as payment in full. Neither the beneficiary, beneficiary's family, guardian, or legal representative may be billed for any difference between the Medicaid allowable amount for a covered service and the provider's actual charge, or for any coinsurance or deductible not paid by a third party. In addition, providers may not charge the beneficiary for the primary insurance carrier's co-payment.

Billing covered procedures prior to the date of service is prohibited.

Providers are prohibited from billing the beneficiary for any service that the beneficiary is eligible to receive under the Healthy Connections Medicaid program, except co-payments when applicable. Medicaid payments may be made only to a provider, a provider's employer or an authorized billing entity. Payments will not be reimbursed to a beneficiary. Therefore, seeking payment from a beneficiary is prohibited except where a co-payment is applicable. For services and beneficiaries that are exempt from co-pay, refer to the Copayment Schedule.

Providers are prohibited from billing a beneficiary for coverable services denied due to the following:

- untimely filing (refer to the Administrative and Billing Provider Manual)
- insufficient/lack of medical necessity documentation
- claims filed with clinical and/or administrative errors
- failure to obtain prior authorization (when applicable)

Providers are prohibited from billing a beneficiary while the prior authorization process is ongoing.

Providers are prohibited from billing a beneficiary during an appeals process. Beneficiaries have the right to appeal any decision that delays, denies, or reduces a covered benefit.

Provider must inform the beneficiary if services requested through prior authorization were deemed by SCDHHS as not medically necessary, therefore:

- no claim will be filed with Medicaid and no reimbursement is expected from Medicaid for the service(s), and
- provider and beneficiary may agree to forego with the service delivery, or
- provider and beneficiary agree to proceed with the service delivery without Medicaid reimbursement.

5 UTILIZATION MANAGEMENT

For general policies regarding Program Integrity, Utilization Management, Fraud, Waste and Abuse providers must refer to the Provider Administrative and Billing Manual.

PRIOR AUTHORIZATION

Authorizations are a utilization tool that require participating providers to submit “documentation” associated with certain services for a beneficiary. Participating providers will not be paid if this “documentation” is not furnished to SCDHHS. Participating providers must hold the beneficiary and SCDHHS harmless as set forth in the Provider Participation Agreement if coverage is denied for failure to obtain authorization.

SCDHHS requires prior authorization for rehabilitative therapy treatment services delivered to beneficiaries aged 21 years and older. Additionally, prior authorization is required when combined speech-language pathology, physical therapy and occupational therapy treatment services, delivered to beneficiaries under the age of 21 years or to waiver members, exceed the 420 of combined units (unit =15 minutes) per patient **allowed per State Fiscal Year (SFY)**, as indicated in Section 8 of this manual. Providers may verify the therapy unit count by utilizing the South Carolina Medicaid Web-based Claims Submission Tool’s eligibility screen. Requests must be submitted to SCDHHS’s Quality Improvement Organization (QIO) for authorization. SCDHHS’s QIO will use InterQual’s Outpatient Rehabilitation criteria for medical necessity determinations. Prior Authorization requests for therapy services may be submitted by the primary care physician, nurse practitioner, physician assistant, physical therapist, occupational therapist, or speech-language pathologist, and must follow the guidelines outlined in the Rehabilitative Therapy and Audiological Services provider manual.

Services are subject to frequency limitations as indicated in this manual. Payment for services that exceed frequency limitations must be justified through an EPSDT examination and pre-approved by SCDHHS. School-based rehabilitative therapy services provided under the Individuals with Disabilities Education Act are exempt from frequency limits and excluded from the combined 420 units of speech-language pathology, physical therapy and occupational therapy services per patient per SFY. The presence or absence of school-based services must not reduce beneficiaries’ access to rehabilitative therapy and audiological services delivered in private practice or clinical settings.

Beneficiaries with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier denied the service or the service is considered not covered. This is applicable only for services that require prior authorization by Medicaid.

All applicable forms for requests for prior authorizations are posted to QIO website

<https://scdhhs.kepro.com>.

QIO Customer Service Phone: +1 855 326 5219

QIO Fax #: +1 855 300 0082

Provider Issues Email: atrezzoissues@Kepro.com

For beneficiaries enrolled in a managed care organization (MCO), refer to the individual MCO plan regarding its services and authorization policies. Failure to comply with these requirements may result in denial or recoupment of payment.

6 REPORTING/DOCUMENTATION

General policies for Medicaid beneficiaries' health records requirements and documentation are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, rehabilitative therapy and audiology providers must comply with specific policies for health records requirements and documentation detailed below.

HEALTH RECORDS

In addition to providers' compliance with state and federal laws and regulations regarding health record retention requirements [e.g., Social Security Act 1902(a)(27), 42 CFR 431.107]. SCDHHS requires rehabilitative therapy and audiology providers to retain on site, all health and fiscal records pertaining to Medicaid beneficiaries for a minimum period of four (4) years after the last payment was made for services rendered, to facilitate audits and reviews of the beneficiary's health record. No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes prior authorization forms, ledger cards, claim forms, and computer records.

Health Record Compliance requirements

Providers must:

- Document the rationale and justification of medical necessity for services, including all findings, diagnosis and supporting information.
- Detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the Current Procedural Terminology (CPT) or the Healthcare Common Procedure Coding System (HCPCS) nomenclatures and descriptors, or as indicated in the SCDHHS policy.
- Ensure that health records are signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media; and information, including rendering provider, date, and time of the service, must be verifiable.

Medicaid services that are not properly documented in clinical notes are subject to denial or recoupment. All required documentation must be present in the health record before the provider files claims for reimbursement. All services performed must be recorded in the beneficiary's health record, which must be available as required by the Participating Provider Agreement.

Referrals

Referral means a physician or other qualified LPHA, within the scope of his or her practice under state law, has asked another qualified health care provider to recommend, evaluate or perform therapies, treatment, or other clinical activities for the beneficiary. This includes any necessary

supplies and equipment. The referral must be obtained from a physician or an LPHA other than the beneficiary's direct provider of the rehabilitative therapy or audiological service.

The referral documentation must occur before the provision of services. The referral must meet the following requirements:

- An initial referral which must be updated annually (every 12 months) thereafter for speech-language therapy, occupational therapy and physical therapy services. For audiological services only the initial referral is required, however, medical clearance is required at the time of upgrade for all new devices. obtained from a physician or LPHA. Provider self-referrals are prohibited. Providers who bill using the same provider number cannot refer within their group (see South Carolina Code of Laws Title 44, Chapter 113, Provider Self-Referral).
- The referral form must contain:
 - o Name, title, and NPI of the referring provider
 - o date referral was made
 - o documentation supporting medical necessity
- The referral documentation must be maintained and properly documented in the beneficiary's record.

The following providers are qualified to issue a referral for rehabilitative therapy and audiological services:

- Licensed physician
- Licensed physician assistant
- Licensed psychologist
- Licensed advanced practice registered nurse

Individual Treatment Plans (Excludes Audiology Services)

Individual treatment plans are applicable to speech-language therapy, occupational therapy and physical therapy services only. If an evaluation indicates treatment is warranted, the rehabilitative therapy services provider must develop and maintain an individual treatment plan (ITP). The ITP must be based on the findings of the evaluation and outline short and long-term goals as well as the recommended scope, frequency, and duration of treatment. The ITP is required before treatment is provided.

The ITP serves as a comprehensive plan of care outlining the service(s) addressing the specific needs of the beneficiary. The ITP may be developed as a separate document or may appear as a clinical service note. The ITP must be individualized and specify the problems to be addressed, goals and objectives of the treatment, types of interventions, planned frequency of service, criteria for achievement and estimated duration of treatment. Addressing the beneficiary's strengths and weaknesses in the ITP is recognized as good clinical practice and is strongly recommended. Providers performing the evaluation and/or re-evaluation must sign and date the ITP, indicating their title and specialty.

Individual Treatment Plan Review

The ITP must be reviewed and updated based on the level of progress. If a determination is made that additional services are required, services must be added to ITP. When long-term treatment is required, each year a new referral must be obtained, an evaluation must be performed, and a new ITP developed. If services are discontinued, the qualified health care provider must indicate the reason for discontinuing treatment on the ITP.

Progress Summary Notes (Excludes Audiology Services)

Progress summary notes are applicable to speech-language therapy, occupational therapy and physical therapy services only. The progress summary is a written note outlining the beneficiary's progress and must be completed by the provider, at a minimum, no later than 90 days from the start date of treatment and every three (3) months thereafter. The purpose of the progress summary is to record the long-term treatment of the beneficiary, describe the attendance at therapy sessions, document progress toward treatment goals and objectives and establish the need for continued participation in treatment.

The progress summary must be written by the provider, contain the provider's signature and title as well as the date written and must be filed in the beneficiary's clinical record. The progress summary may be developed as a separate document or may appear as a clinical service note. If a progress summary is written as a clinical service note, the entry must be clearly labeled "Progress Summary".

Clinical Service Notes

Clinical service notes are applicable to rehabilitative therapy and audiological services. Services must be documented in the clinical service notes. All clinical service notes made by staff who require supervision must be co-signed by the supervising provider (unless otherwise indicated for a specific Medicaid-reimbursable service).

All clinical service notes used must include a clear, concise narrative summary of service and progress toward treatment goals. This documentation must support the number of units billed.

MEDICAL SERVICE DOCUMENTATION

Documentation of services must comply with guidelines set forth under each service in this section. Adequate documentation reflects:

- Services performed
- Medical necessity
- Performing provider and supervising provider (when required)
- Time period the services were performed
- Treatment plan if applicable

If multiple therapies are performed on the same day by the same provider, provider location or billing entity, the patient record must contain documentation justifying the additional service. Each service must be distinct or independent from each other when performed on the same day.

Signature Policy

The signature of the provider rendering or authorizing the services may be handwritten, electronic or digital. Stamped signatures are unacceptable. For acceptable electronic signatures, refer to the SCDHHS Provider Administrative and Billing Manual, section "Electronic Signatures".

- Services delivered under direct care
 - For therapy and audiological services rendered by the treating provider, the signature or initials of the treating provider must be documented in the beneficiary's clinical notes.
- Services delivered under direct or indirect supervision
 - For therapy and audiological services delivered under direct or indirect supervision of the qualified provider, the signature or initials of the supervising provider must be documented in the beneficiary's clinical notes along with the signature or initials of the qualified healthcare professional performing the services under direct or indirect supervision. This includes services performed by interns or students under the direct supervision of a licensed provider.
- Services delivered under general supervision
 - For therapy and audiological services authorized to be delivered under general supervision (when applicable), the signature or initials of the qualified healthcare professional performing the services under general supervision must be documented in the beneficiary's clinical notes.
 - Additionally, a supervision agreement form approved by the Licensing Board for the period when services are rendered under general supervision must be included and maintained in the beneficiary's health record.

Procedure Codes

Providers are required to submit the applicable Current Procedural Terminology (CPT) codes as defined in the CPT reference guide or Healthcare Common Procedure Coding System (HCPCS) for rehabilitative therapy/audiology services or as otherwise specified by SCDHHS in this manual.

7 Billing Guidance

General Billing Guidance, such as Usual and Customary Rates; Timely Filing; Beneficiary Co-Payments; Third Party Liability and Coordination of Benefits (COB); Adjustments and Refunds; Remittance Advices; and Electronic Fund Transfer, is detailed in the Provider Administrative and Billing Manual. Additional Billing Guidance specific to rehabilitative therapy/audiological services is detailed in this manual.

Providers must follow the National Correct Coding Initiative (NCCI) edits and its related coding policy, unless otherwise indicated in this manual. For detailed information about the NCCI refer to the Administrative and Billing Provider manual.

Providers must bill for rehabilitative therapy and audiological services utilizing the procedure codes from the current editions of the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT). Procedure codes that deviate in description from the HCPCS/CPT assigned description, will be indicated in section 8 of this manual. For additional information on procedural coding, refer to the Administrative and Billing Provider Manual.

SCDHHS requires rehabilitative therapy and audiology providers to submit all claims on a professional CMS 1500 claim form.

Modifiers:

The most common modifiers used by rehabilitative therapy and audiology providers in an outpatient clinic or private practice setting are listed below:

- GT – Telehealth services delivered via interactive audio and video telecommunication systems.
 - When providers file a claim for a service performed via telehealth, they must use the GT modifier as the initial modifier and then include the secondary modifier on the claim.
- GO – Occupational therapy services delivered under an outpatient occupational therapy plan of care.
 - Licensed Occupational Therapists must bill approved codes using the GO modifier. Physical therapy (PT) providers shall not bill the GO modifier.
- GP – Physical Therapy services delivered under an outpatient physical therapy plan of care.
 - Licensed Physical Therapists must bill approved codes using the GP modifier. Occupational therapy (OT) providers shall not bill the GP modifier.
- For bilateral procedures, SCDHHS will allow billing of the procedure code by units. Bilateral modifiers LT and RT are not required.
- 52-- Reduced service, when a bilateral service is performed unilaterally, provider must bill the procedure with modifier 52.

- 59 – Used to identify distinct or independent procedures or services that are not typically reported together but are appropriate under certain circumstances. Documentation must support the use of separate sessions or services.

Billing by units

When billing for services with units of fifteen (15) minutes, at least eight (8) minutes of direct contact with the patient must be provided for a single unit of service to be appropriately reported and billed.

8 BENEFITS CRITERIA AND LIMITATIONS

The criteria outlined in SCDHHS' Rehabilitative Therapy and Audiological Services Provider Manual are based around procedure codes as defined in the Code of Procedural Terminology (CPT) Code (unless otherwise in this manual).

Healthy Connections providers are required to maintain comprehensive treatment records that meet professional standards for risk management. Please refer to the "Patient Record" and "Documentation Required" sections for additional detail.

The **Healthy Connections** Covered Rehabilitative Therapy and Audiological services are defined as follows:

1. State Plan Covered Services
2. EPSDT Services (Non-State Plan Covered Services)

This manual will provide the criteria, documentation required, and benefit limitations for each covered service.

STATE PLAN COVERED SERVICES

Speech-Language Pathology Services

Criteria

Reimbursable speech-language pathology services are evaluative tests and measures utilized in the process of providing speech-language pathology services and must represent standard practice procedures. Providers must utilize standardized assessment tools, tests, techniques and data sources developed and/or recommended by the American Speech Language Hearing Association (ASHA) when conducting comprehensive speech-language assessments.

Providers must select the most appropriate method(s) and measure(s) to use for a particular patient, based on his or her age, cultural background, and values; language profile; severity of suspected communication disorder; and factors related to language functioning (e.g., hearing loss and cognitive functioning). The Provider uses a variety of assessments or tests to determine the presence and severity of a disorder. Reporting of a standardized test score is not required to indicate the presence of a disorder.

Tests or measures described as "teacher-made" or "informal" are not acceptable for purposes of Medicaid reimbursement.

Speech-language pathology services are allowed when delivered for the assessment and treatment of the following categories of speech-language disorders:

- *A developmental language disorder*
- *An acquired language disorder*
- *An articulation disorder*
- *A phonological disorder*
- *A fluency disorder*
- *A voice disorder*
- *A resonance disorder*
- *Dysphagia*
- *Pediatric feeding disorder*

All speech-language pathology services require a referral from the physician or the LPHA prior to service being rendered. Reimbursement for speech-language pathology service is inclusive of any necessary supplies and equipment.

Services include preventing, evaluating, and treating disorders of verbal and written language, speech sound disorders (articulation, phonological disorders), voice, fluency, feeding, swallowing, mastication, deglutition, cognition/communication, auditory and/or visual processing and memory, and interactive communication, as well as the use of augmentative and alternative communication systems (e.g., sign language, gesture systems, communication boards, electronic automated devices, and mechanical devices).

Individual Speech Therapy

Speech-language or feeding/swallowing therapy, performed directly with one beneficiary must be documented and billed as individual speech-language or feeding/swallowing therapy. This may include training of a teacher or parent with the beneficiary present.

Group Speech Therapy

A group may consist of no less than two (2) and no more than six (6) patients. Speech-language therapy performed for two or more patients must be documented and billed as group speech-language therapy. Feeding/swallowing therapy shall not be delivered in group therapy.

Documentation Required

Proper documentation must be maintained in the beneficiary's records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record requirements.

Benefit Limitations

<i>Speech-Language Pathology Services</i>				
Code	Description	Beneficiary subgroup	Coverage Limitations	
			Prior Authorization Requirement	Frequency/Timespan/ Criteria
92507*	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	Children & HASCI Waiver	No	*SCDHHS policy reimburses this procedure by units of 15 minutes; up to four (4) units per day per patient. Not allowed on the same days as 92508. Units count towards the combined total of 420 allowed units. Allowed to be performed via telehealth.
		Adults	Yes	
92508*	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group	Children & HASCI Waiver	No	*SCDHHS policy reimburses this procedure by units of 15 minutes; up to four (4) units per day per patient. Not allowed on the same day as 92507. Units count towards the combined total of 420 allowed units. Group therapy not allowed via telehealth encounter.
		Adults	Yes	
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 92522, 92523, or 92524, on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Children & HASCI Waiver	No	Allowed one (1) for new plan of care, per provider, provider location or billing entity. Not allowed with 92521, 92523, or 92524 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
92523	Evaluation of speech sound production with evaluation of language comprehension and expression (e.g., receptive and expressive language)	Children & HASCI Waiver	No	Allowed one (1) for new plan of care, per provider, provider location or billing entity. Not allowed with 92521, 92522, or 92524, on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
92524	Behavioral and qualitative analysis of voice and resonance	Children & HASCI Waiver	No	Allowed one (1) per plan of care, per provider, provider location or billing entity. Not allowed with 92521, 92522, or 92523, on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
92526	Treatment of swallowing dysfunction and/or oral function for feeding	Children & HASCI Waiver	No	Allowed one (1) per day per patient. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	

92606	Therapeutic service(s) for the use of non-speech generating device	Children & HASCI Waiver	No	Allowed one (1) per day per patient. Units count towards the combined total of 420 allowed units. Not allowed via telehealth
		Adults	Yes	
92607	Eval for speech generating augmentative & alternative communication device, face to face; first hour	Children & HASCI Waiver	No	Allowed one (1) per plan of care, per provider, provider location or billing entity. Not allowed with 92606, 92609 or S9152 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth
		Adults	No	
92608	Eval for speech generating augmentative & alternative communication device, face to face; additional 30 min	Children & HASCI Waiver	No	Allowed up to two (2) per day in conjunction with 92607 per plan of care, per provider, provider location or billing entity. Not allowed with 92606, 92609 or S9152 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
92609	Therapeutic services for the use of speech-generating device, including programming and modification	Children & HASCI Waiver	No	Allowed one (1) per day per patient. Units count towards the combined total of 420 allowed units. Not allowed via telehealth
		Adults	Yes	
92610	Evaluation of oral and pharyngeal swallowing function	Children & HASCI Waiver	No	Allowed one (1) per plan of care, per provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
S9152	Speech therapy, re-evaluation	Children & HASCI Waiver	No	Allowed one (1) per day, with maximum of two (2) per 12 months per provider, provider location or billing entity. Not allowed on the same day or for the same plan of care with 92521, 92522, 92523, or 92524 by the same provider, provider location or billing entity. Re-evaluation of the plan of care is allowed when substantial modifications are necessary to an established plan of care. Not allowed via telehealth.
		Adults	No	

Audiological Services

Audiological services involve testing and evaluation of hearing-impaired beneficiaries who may or may not improve with medication or surgical treatment. This includes services related to hearing aids, cochlear implants and other related audiological services. Providers must utilize standardized assessment tools, procedures and data sources developed and or recommended by the American Speech Language Hearing Association (ASHA) when conducting comprehensive audiological assessments.

Criteria

Hearing Aids

Hearing aids may be provided for individuals under the age of 21 years when medical necessity is established through an audiological evaluation. The attending audiologist may send a request for a hearing aid or aids, along with a physician’s statement completed within the last six months indicating that there is no medical contraindication to the use of a hearing aid. This information must be sent to the (DHEC) Children’s Rehabilitative Services (CRS), Hearing Program. Providers must follow DHEC’s Hearing Program Guidance when submitting requests for hearing aids available at <https://scdhec.gov/health/child-teen-health/services-children-special-health-care-needs/hearing-program>

Cochlear Implants

Cochlear implants and related services, which includes initial implantation, implant replacement and maintenance services are covered services for children, HASCI and ID/RD waiver members. Additionally, cochlear implants and related services which includes initial implantation, implant replacement and maintenance, are covered for adults with unilateral or bilateral severe to profound sensorineural hearing loss. For adult beneficiaries, hearing aid trial is not required to qualify for the cochlear implantation.

All referrals from a physician must be documented and maintained in the beneficiary’s medical records.

Instructions must be provided to the parent/guardian, teacher and/or beneficiary on the use of a cochlear implant device to include care, safety, and warranty procedures. This procedure is to be completed only by a licensed audiologist on a cochlear implant team.

Documentation Required

Proper documentation must be maintained in the beneficiary’s records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record requirements.

Benefit Limitation

Audiology Services				
Code	Description	Beneficiary subgroup	Coverage Limitations	
			Prior Authorization Requirement	Frequency/Timespan/ Criteria
92517	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report, cervical (cVEMP).	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92517 per 12 months per patient. Not allowed on the same day as 92519 for same patient.
		Adults	Not a covered service	
92518	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report, ocular (oVEMP).	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92518 per 12 months per patient. Not allowed on the same day as 92519 for same patient.
		Adults	Not a covered service	

92519	Vestibular evoked myogenic potential (VEMP) testing, with interpretation and report, cervical (cVEMP) and ocular (oVEMP).	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92519 per 12 months per patient. Not allowed on the same day as 92517 or 92518 for same patient.
		Adults	Not a covered service	
92550	Tympanometry & reflex threshold measurements	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92550 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92567, 92568 or 92570 for same patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92551	Screening test, pure tone, air only	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92551 per day and up to two (2) per 12 months per patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92552	Pure tone audiometry (threshold); air only	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92552 per day and up to two (2) per 12 months per patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92553	Pure tone audiometry (threshold); air & bone	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92553 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92557 per same patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92555	Speech audiometry threshold	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92555 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92557 per same patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92556	Speech audiometry threshold; w/speech recognition	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92556 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92557 per patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92557	Comprehensive audiometry threshold evaluation and speech recognition	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92557 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92553 or 92556 per same patient. This service reflects bilateral testing.
		Adults	No	Allowed one (1) 92557 per lifetime for the purpose of evaluation for cochlear implant only. Additional evaluations for cochlear implants may be allowed with prior authorization if medically necessary.
92563	Tone decay hearing test	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92563 per 12 months per patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92567	Tympanometry (impedance testing)	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92567 per day and up to four (4) per 12 months per patient. Not allowed on the same day as 92550, 92568 or 92570 per same patient. This service includes bilateral testing.
		Adults	No	Allowed one (1) 92567 per lifetime for the purpose of evaluation for cochlear implant only. Additional evaluations for cochlear implants may be allowed with prior authorization if medically necessary

92568	Acoustic reflex testing; threshold	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92568 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92550, 92567 or 92570 per same patient This service reflects bilateral testing.
		Adults	Not a covered service	
92570	Acoustic immittance testing, tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92570 per day and up to two (2) per 12 months per patient. Not allowed on the same day as 92567 or 92568 per same patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92579	Visual reinforcement audiometry (VRA)	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92579 per day and up to four (4) per 12 months per patient.
		Adults	Not a covered service	
92582	Conditioning play audiometry	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92582 per day and up to two (2) per 12 months per patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92583	Select picture audiometry	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92583 per day and up to two (2) per 12 months per patient. This service reflects bilateral testing.
		Adults	Not a covered service	
92584	Electrocochleography	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92584 per 12 months per patient. This service reflects bilateral testing.
		Adults	No	Allowed one (1) 92584 per 12 months for patients with cochlear implants only
92587	Evoked otoacoustic emissions; limited (single stimulus level to confirm the presence or absence of hearing disorder, 3-6 frequencies), either transient or distortion products), with interpretation and report.	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92587 per day per patient. Allowed up to four (4) 92587 per 12 months for children under the age of 3 years or for non-compliant and difficult to test patients, malingerers, and for ototoxic monitoring patient. Patient records must document the criteria above. Allowed up to two (2) 92587 per 12 months per patient for all other patients. This service reflects bilateral testing.
		Adults	Not a covered service	
92588	Comprehensive or diagnostic evaluation (quantitative analysis of outer hair cell function) comparison of transient and/or distortion product otoacoustic emissions at multiple levels and minimum 12 frequencies) with interpretation and report.	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92588 per day per patient. Allowed up to four (4) 92588 per 12 months for children under the age of 3 years or for non-compliant and difficult to test patients, malingerers, and for ototoxic monitoring patient. Patient records must document the criteria above. Allowed up to two (2) 92588 per 12 months per patient for all other patients This service reflects bilateral testing.
		Adults	Not a covered service	
92590	Hearing aid examination and selection; monaural	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92590 per 12 months per patient when one ear is fitted with a hearing aid. Not allowed on the same day as 92591, 92594 or 92595 per same patient.
		Adults	Not a covered service	

92591	Hearing aid examination and selection; binaural	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92591 per 12 months per patient when both ears are fitted with hearing aids. Not allowed on the same day as 92590, 92594 or 92595 per same patient.
		Adults	Not a covered service	
92592	Hearing aid check; monaural	Children, HASCI & ID/RD Waiver	No	Allowed one (1) per day and up to four (4) 92592 per 12 months per patient when one hearing aid is checked. Not allowed on the same day as 92593 or V5011 per same patient.
		Adults	Not a covered service	
92593	Hearing aid check; binaural	Children, HASCI & ID/RD Waiver	No	Allowed one (1) per day and up to four (4) per 12 months per patient when both hearing aids are checked. Not allowed on the same day as 92592 or V5011 per same patient.
		Adults	Not a covered service	
92594	Electroacoustic evaluation for hearing aid, monaural	Children, HASCI & ID/RD Waiver		Allowed one (1) 92594 per 12 months per patient when one ear is fitted with a hearing aid. Not allowed on the same day as 92595, 92590 or 92591 per same patient.
		Adults	Not a covered service	
92595	Electroacoustic evaluation for hearing aid, binaural	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92595 per months per patient when both ears are fitted with hearing aids. Not allowed on the same day as 92594, 92590 or 92591 per same patient.
		Adults	Not a covered service	
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years; with programming	Children, HASCI & ID/RD Waiver	No	Allowed one (1) per patient. Not allowed on the same day as 92602
		Adults	Not a covered service	
92602	Subsequent reprogramming of cochlear implant, patient younger than 7 years	Children, HASCI & ID/RD Waiver	No	Allowed up to six (6) per patient within 12 months of implantation and up to two (2) per 12 months per patient thereafter. Not allowed on the same day as 92601
		Adults	Not a covered service	
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) per patient. Not allowed on the same day as 92604
92604	Subsequent reprogramming of cochlear implant, age 7 years or older	Children, HASCI & ID/RD Waiver Adults	No	Allowed up to six (6) per patient within 12 months of implantation and up to two (2) per 12 months per patient thereafter. Not allowed on the same day as 92603
92620	Evaluation of central auditory function, initial 60 min	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92620 per 12 months per patient
		Adults	Not a covered service	
92621	Evaluation of central Auditory function, each additional 15 minutes	Children, HASCI & ID/RD Waiver	No	Allowed up to two (2) 92621 per 12 months per patient.
		Adults	Not a covered service	
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	Children, HASCI & ID/RD Waiver	No	Allowed one (1) 92625 per 12 months per patient.
		Adults	Not a covered service	

92626	Evaluation of auditory function for surgically implanted device candidacy or post- op status of a surgically implanted device, first hour	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) 92526 per day and up to four (4) within 12 months post cochlear implantation per patient. Allowed up to two (2) 92626 per 12 months thereafter, per patient.
92627	Evaluation of auditory function for surgically implanted device candidacy or post operative status of a surgically implanted device, each additional 15 minutes	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) 92527 per day and up to four (4) within 12 months post cochlear implantation per patient. Allowed up to two (2) 92627 per 12 months thereafter, per patient
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) 92650 per day and up to two (2) per 12 months per patient. This service reflects bilateral testing. Not a covered service
92651	Auditory evoked potentials for hearing status determination, broadband stimuli, with interpretation and report	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) 92651 per day and up to two (2) per 12 months per patient. This service reflects bilateral testing. Not a covered service
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) 92652 per day and up to three (3) per 12 months per patient. This service reflects bilateral testing. Not a covered service
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) 92653 per 12 months per patient. This service includes bilateral testing. Not a covered service
V5011	Fitting/orientation/ checking of hearing aid	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) V5011 per day and up to two (2) per 12 months per patient for unilateral hearing aid; Allowed two (2) V5011 per day and up to four (4) per 12 months per patient for bilateral hearing aids Not a covered service
V5020	Conformity evaluation	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) V5020 per day and up to two (2) per 12 months per patient Not a covered service
V5090	Dispensing fee, unspecified hearing aid	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) V5090 per day per initial fitting or per replacement fitting, per patient. Allowed up to two (2) V5090 per 12 months, for unilateral hearing aid per patient. Allowed two (2) V5090 per day per initial fitting or per replacement fitting, per patient. Allowed up to four (4) V5090 per 12 months, for bilateral hearing aids, per patient. *Dispensing fee is allowed for initial fit or replacement hearing aid fittings only. Not a covered service
V5275	Ear impression, each	Children, HASCI & ID/RD Waiver Adults	No	Allowed one (1) V5275 per day and up to two (2) per 12 months per patient for unilateral ear impression; Allowed two (2) V5275 per day and up to four (4) per 12 months per patient for bilateral ear impressions. For patients under the age of four (4) years allowed up to four (4) per 12 months per patient for unilateral ear impression, or up to eight (8) per 12 months per patient for bilateral ear impressions. Not a covered service

Physical Therapy Services

Physical therapy services involve evaluation and treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Physical therapy services involve the use of physical agents, mechanical means, and other remedial treatment to restore normal physical functioning following illness or injury.

Providers must utilize standardized assessment tools, tests, techniques and data sources developed and/or recommended by the American Physical Therapy Association (APTA) when conducting physical therapy evaluations and interventions.

Physical Therapy Evaluation

The evaluation must include a review of available medical history records, an observation of the beneficiary and an interview, when possible. The evaluation must include diagnostic testing and assessment, and a written report with recommendations.

Individual Physical Therapy

Individual physical therapy is the development and implementation of specialized physical therapy programs that incorporate the use of appropriate modalities; performance of written and/or oral training of teachers and/or family regarding appropriate physical therapy activities/therapeutic positioning in the school or home environment; recommendations on equipment needs and safety inspections and adjustments of adaptive and positional equipment. Physical therapy performed on behalf of one beneficiary must be documented and billed as individual physical therapy.

Group Physical Therapy

A group may consist of no less than two (2) and no more than six (6) patients. Physical therapy performed for two or more patients must be documented and billed as group physical therapy.

Aquatic Therapy

Aquatic therapy refers to any exercise/activity that is performed in a water environment, including whirlpools, Hubbard tanks, underwater treadmills and pools. Aquatic therapy is covered following the general medical necessity guidelines for all therapy services. The exercises/activities in the water must be medically necessary for the beneficiary's condition and must require the unique skills of a therapist. Aquatic therapy is a timed code that requires direct, one-on-one contact with the beneficiary.

- Documentation must support the medical necessity for aquatic therapy.
- Aquatic therapy is no longer reimbursable once a patient can perform the exercise independently. If the same exercise or activity is performed over several sessions, the documentation must describe the skilled nature of the exercise or activity to demonstrate medical necessity.

- Patients who will not continue their water-based program as a maintenance program must be transitioned to land-based exercises as soon as reasonably possible for the patient's condition.
- The treatment minutes documented for aquatic therapy must **only** include actual exercise/activity time that required direct one-on-one contact with the patient. Time spent for the patient to dress/undress, get into and out of the pool, shall not be considered part of treatment.

Documentation Required

Proper documentation must be maintained in the beneficiary's records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record requirements.

Benefit Limitation

Physical Therapy Services				
Code	Short Description	Beneficiary subgroup	Coverage Limitations	
			Prior Authorization Requirement	Frequency/Timespan/ Criteria
97022	Application of a modality to 1 or more areas; whirlpool	Children & HASCI Waiver	No	Allowed one (1) per day per provider, provider location or billing entity. Not allowed on the same day as 97110, 97112, 97113, 97140, 97150, 97530 per same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	Yes	
97110	Therapeutic procedure, one or more areas, each 15 minutes; to develop strength and endurance, range of motion and flexibility.	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Allowed via telehealth.
		Adults	Yes	
97112	Therapeutic procedure, 1 or more areas, each 15 minutes;	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 or 97150 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 or 97150 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	

97140	manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), each 15 minutes	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 or 97150 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	
97150	Therapeutic procedure(s), group (2 or more individuals)	Children & HASCI Waiver	No	Allowed one (1) per day per provider, provider location or billing entity. Not allowed on the same day as 97112, 97113, 97140 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Group therapy not allowed via telehealth.
		Adults	Yes	
97161	Physical therapy evaluation: low complexity. Typically, 20 minutes are spent face-to-face with the patient and/or family	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 97162, 97163 or 97164 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
97162	Physical therapy evaluation: moderate complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 97161, 97163 or 97164 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
97163	Physical therapy evaluation: high complexity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 97161, 97162 or 97164 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
97164	Re-evaluation of physical therapy established plan of care. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Children & HASCI Waiver	No	Allowed one (1) per day, with maximum of two (2) per 12 months per provider, provider location or billing entity. Not allowed on the same day or for the same plan of care with 97161, 97162, or 97163 by the same provider, provider location or billing entity. Re-evaluation of the plan of care is allowed when substantial modifications are necessary to an established plan of care. Not allowed via telehealth.
		Adults	No	

97530	Therapeutic activities, direct (one-on one) patient contact by the provider, each 15 minutes	Children & HASCI Waiver	No	Allowed up to six (6) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Allowed via telehealth.
		Adults	Yes	
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reporting), upper extremity, lower extremity and/or trunk, initial orthotic(s) encounter, each 15 minutes	Children & HASCI Waiver	No	Allowed one (1) unit per day per patient per plan of care. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	No	
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity, lower extremity, and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	Children & HASCI Waiver	No	Allowed up to three (3) units per day per patient per plan of care. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	No	
L3808	Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment	Children & HASCI Waiver	No	Allowed one (1) per day per patient and up to four (4) per 12 months.
		Adults	Yes	
L2999	Lower extremity orthoses, not otherwise specified, (NOS)	Children & HASCI Waiver	No	Allowed one (1) per day per patient and up to four (4) per 12 months.
		Adults	Yes	
L3999	Upper limb orthosis, not otherwise specified, (NOS)	Children & HASCI Waiver	No	Allowed one (1) per day per patient and up to four (4) per 12 months.
		Adults	Yes	

Occupational Therapy Services

Occupational therapy services are channels to improve or restore functional abilities for maximum reduction of physical or mental disability and restoration of a beneficiary to his/her best possible functional level. Occupational therapy services are related to self-help skills, feeding, adaptive behavior, fine/gross motor, visual, sensory-motor, functional cognition, postural, and emotional development that have been limited by a physical injury, illness, cognitive impairment or other dysfunctional condition. Occupational therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance.

Providers must utilize standardized assessment tools, tests, techniques and data sources developed and/or recommended by the American Occupational Therapy Association (AOTA) when conducting occupational therapy evaluations and interventions.

Occupational Therapy Evaluation

The evaluation must include a review of available medical history records and an observation of the beneficiary and interview, when possible, including a summary of the patient's occupational history and experiences, patterns of daily living, interests, values, needs and relevant contexts. The evaluation must include diagnostic testing and assessment and a written report with recommendations.

Individual Occupational Therapy

Individual occupational therapy involves the development and implementation of specialized occupational therapy programs that incorporate the use of appropriate interventions, occupational therapy activities in the school or home environment and recommendations on equipment needs and adaptations of physical environments. Occupational therapy performed directly with one beneficiary must be documented and billed as individual occupational therapy.

Group Occupational Therapy

A group may consist of no less than two (2) and no more than six (6) patients. Occupational therapy performed for two or more patients must be documented and billed as group occupational therapy.

Aquatic Therapy

Aquatic therapy refers to any exercise/activity that is performed in a water environment, including whirlpools, Hubbard tanks, underwater treadmills and pools. Aquatic therapy is covered following the general medical necessity guidelines for all therapy services. The exercises/activities in the water must be medically necessary for the beneficiary's condition and must require the unique skills of a therapist. Aquatic therapy is a timed code that requires direct, one-on-one contact with the beneficiary.

- Documentation must support the medical necessity for aquatic therapy.

- Aquatic therapy is no longer reimbursable once a patient can perform the exercise independently. If the same exercise or activity is performed over several sessions, the documentation must describe the skilled nature of the exercise or activity to demonstrate medical necessity.
- Patients who will not continue their water-based program as a maintenance program must be transitioned to land-based exercises as soon as reasonably possible for the patient's condition.
- The treatment minutes documented for aquatic therapy must **only** include actual exercise/activity time that required direct one-on-one contact with the patient. Time spent for the patient to dress/undress, get into and out of the pool, shall not be considered part of treatment.

Documentation Required

Proper documentation must be maintained in the beneficiary's records. Please refer to Section 6: Reporting/Documentation of this manual for general treatment record requirements.

Benefit Limitation

Occupational Therapy Services				
Code	Short Description	Beneficiary subgroup	Coverage Limitations	
			Prior Authorization Requirement	Frequency/Timespan/ Criteria
97022	Application of a modality to 1 or more areas; whirlpool	Children & HASCI Waiver	No	Allowed one (1) per day per provider, provider location or billing entity. Not allowed on the same day as 97110, 97112, 97113, 97140, 97150, 97530 per same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	Yes	
97110	Therapeutic procedure, one or more areas, each 15 minutes; to develop strength and endurance, range of motion and flexibility.	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Allowed via telehealth.
		Adults	Yes	
97112	Therapeutic procedure, 1 or more areas, each 15 minutes;	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 or 97150 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	

97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises.	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 or 97150 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	
97140	manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), each 15 minutes	Children & HASCI Waiver	No	Allowed up to four (4) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 or 97150 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	Yes	
97150	Therapeutic procedure(s), group (2 or more individuals)	Children & HASCI Waiver	No	Allowed one (1) per day per provider, provider location or billing entity. Not allowed on the same day as 97112, 97113, 97140 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Group therapy not allowed via telehealth.
		Adults	Yes	
97165	Occupational therapy evaluation: low complexity. Typically, 30 minutes are spent face-to-face with the patient and/or family	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 97166, 97167 or 97168 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
97166	Occupational therapy evaluation: moderate complexity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 97165, 97167 or 97168 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
97167	Occupational therapy evaluation: high complexity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	Children & HASCI Waiver	No	Allowed one (1) for new plan of care per provider, provider location or billing entity. Not allowed with 97165, 97166 or 97168 on the same day or for the same plan of care by the same provider, provider location or billing entity. Not allowed via telehealth.
		Adults	No	
97168	Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face-to-face with the patient and/or family.	Children & HASCI Waiver	No	Allowed one (1) per day, with maximum of two (2) per 12 months per provider, provider location or billing entity. Not allowed on the same day or for the same plan of care with 97165, 97166, or 97167 by the same provider, provider location or billing entity. Re-evaluation of the plan of care is allowed when substantial modifications are necessary to an established plan of care. Not allowed via telehealth.
		Adults	No	

97530	Therapeutic activities, direct (one-on one) patient contact by the provider, each 15 minutes	Children & HASCI Waiver	No	Allowed up to six (6) units per day per provider, provider location or billing entity. Not allowed on the same days as 97022 by same provider, provider location or billing entity. Units count towards the combined total of 420 allowed units. Allowed via telehealth.
		Adults	Yes	
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reporting), upper extremity, lower extremity and/or trunk, initial orthotic(s) encounter, each 15 minutes	Children & HASCI Waiver	No	Allowed one (1) unit per day per patient per plan of care. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	No	
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity, lower extremity), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	Children & HASCI Waiver	No	Allowed up to three (3) units per day per patient per plan of care. Units count towards the combined total of 420 allowed units. Not allowed via telehealth.
		Adults	No	
L3808	Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment	Children & HASCI Waiver	No	Allowed one (1) per day per patient and up to four (4) per 12 months.
		Adults	Yes	
L2999	Lower extremity orthoses, not otherwise specified, (NOS)	Children & HASCI Waiver	No	Allowed one (1) per day per patient and up to four (4) per 12 months.
		Adults	Yes	
L3999	Upper limb orthosis, not otherwise specified, (NOS)	Children & HASCI Waiver	No	Allowed one (1) per day per patient and up to four (4) per 12 months.
		Adults	Yes	