Clinical Policy: Outpatient Specialized Therapies

Reference Number: WNC.CP.291
Last Review Date: 05/24

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1] - Outpatient Specialized Therapies consist of evaluations, re-evaluations, and multidisciplinary evaluations as well as therapeutic physical, occupational, speech, respiratory, and audiology services provided in all settings except hospital and rehabilitation inpatient settings.

Telehealth Services As outlined in Criteria IV.E., select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance set forth in Clinical Coverage Policy, *WNC.CP.193 Telehealth, Virtual Communications, and Remote Patient Monitoring*, at WellCare NC Clinical Coverage Guidelines.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover medically necessary Outpatient Specialized Therapies when the service is ordered by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Doctor of Podiatric Medicine (DPM), Certified Nurse Midwife (CNM), Physician Assistant (PA), or Nurse Practitioner (NP)'s **AND** when prior authorization is received. Home Health services may only be ordered by the practitioners specified in Clinical Coverage Policy WNC.CP.207 Home Health Services.

Note: Home Health: **ALL** documentation and services must adhere to Medicare and Medicaid requirements as outlined in Clinical Coverage Policy *WNC.CP.207 Home Health Services*. The policy can be found at WellCare NC Clinical Coverage Guidelines

II. Physical Therapy (PT) WellCare of North Carolina® shall cover medically necessary outpatient physical therapy treatment when prior authorization is received.

III. Occupational Therapy (OT) WellCare of North Carolina® shall cover medically necessary occupational therapy treatment when prior authorization is received.

IV. Speech Language Therapy (ST) WellCare of North Carolina® shall cover medically necessary outpatient speech-language therapy treatment when prior authorization is received.

A. Medically necessary treatment for oral phase, pharyngeal phase, or oropharyngeal phase dysphagia must contain documented findings.

1. These findings must address **ONE** of the following deficits consistent with a dysphagia diagnosis:

a. Coughing and choking while eating or drinking;
b. Coughing, choking or drooling with swallowing;
c. Wet-sounding voice;
d. Changes in breathing when eating or drinking;
e. Frequent respiratory infections;
f. Known or suspected aspiration pneumonia;
g. Masses on the tongue, pharynx or larynx;
h. Muscle weakness, or myopathy, involving the pharynx;
i. Neuromuscular degenerative disease likely to affect swallowing regardless of the presence of a communication difficulty;
j. Medical issues that affect feeding, swallowing, and nutrition; **OR**
k. Oral function impairment or deficit that interferes with feeding.

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

B. For a **Member who is a minority language speaker**, there is a continuum of proficiency in English.

1. Determination of the minority language speaker's proficiency on the continuum must be documented as one of the following:
   a. **Bilingual English proficient**: a Member who is bilingual and who is fluent in English or has greater control of English than the minority language;
   b. **Limited English proficient**: a bilingual or monolingual Member who is proficient in his or her native language, but not English; **OR**
   c. **Limited in both English and the minority language**: a Member who is limited in both English and the minority language exhibits limited communication competence in both languages.
2. Evaluation must contain both objective and subjective measures to determine if the Member is more proficient in either the English language or the minority language.
3. For speech and language therapy services to be medically necessary for a Member who is a minority language speaker, **ALL** the following criteria must be met:
   a. All speech deficits must be present in the language in which the Member has the highest proficiency;
   b. All language deficits must be present in the language in which the Member has the highest proficiency;
   c. The delivery of services must be in the language in which the Member has the highest receptive language proficiency; **AND**
   d. If the use of interpreters or translators is the only alternative, the speech-language pathologist or audiologist must:
      i. Provide sufficient instruction to the interpreter or translator regarding the purposes, procedures and goals of the tests and therapy methods;
      ii. For each date of service, the provider must ensure the interpreter or translator understands his or her role as it relates to the clinical procedures to be used and responses expected to address the goal;

iii. Use the same interpreter or translator with a given Member as consistently as possible; **AND**
iv. Use observation or other nonlinguistic measures as supplements to the translated measures, such as (1) Member's interaction with parents, (2) Member's interaction with peers, (3) pragmatic analysis.

C. The following criteria applies to a Medicaid Member under 21 years of age:

Language Impairment Classifications Infant/Toddler – A Medicaid Member Birth to 3 Years	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **OR** • Scores in the 7th – 15th percentile, **OR** • A language quotient or standard score of 78 – 84, **OR** • A 20% - 24% delay on instruments that determine scores in months, **OR** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Moderate	• Standard scores 1.5 to 2 standard deviations below the mean, **OR** • Scores in the 2nd – 6th percentile, **OR** • A language quotient or standard score of 70 – 77, **OR** • A 25% - 29% delay on instruments which determine scores in months, **OR** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **OR** • Scores below the 2nd percentile, **OR** • A language quotient or standard score of 69 or lower, **OR** • A 30% or more delay on instruments that determine scores in months, **OR** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

Language Impairment Classifications A Medicaid Member 3 to 5 Years of Age	
Mild	• Standard scores 1 to 1.5 standard deviations below the mean, **OR** • Scores in the 7th – 15th percentile, **OR** • A language quotient or standard score of 78 – 84, **OR** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 6 to 12-month delay, **OR**

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

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

Language Impairment Classifications – A Medicaid Member 5 through 20 Years of Age	
	• Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.
Severe	• Standard scores more than 2 standard deviations below the mean, **OR** • Scores below the 2nd percentile, **OR** • A language quotient or standard score of 69 or lower, **OR** • If standard scores are not obtainable or are deemed unreliable, information gathered from checklists, observations, etc. that demonstrates a 2 year or more delay, **OR** • Additional documentation indicating that the child exhibits functional impairment in one or more of the following language components: syntax, morphology, semantics or pragmatics.

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

Articulation/Phonology Impairment Classifications A Medicaid Member Birth through 20 Years of Age	
Severe	• Three or more phonological processes that are not developmentally appropriate, with a 20% occurrence, **OR** • At least one phonological process that is not developmentally appropriate, with more than 40% occurrence, **OR** • Additional documentation indicating a delay, such as percent consonant correct measures, measures of intelligibility, tests of stimulability, etc. Member typically has more than five sounds in error with a combination of error types. Inconsistent errors and lack of stimulability are evident. Conversational speech is generally unintelligible.

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

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

Phonology Treatment Goals Based on Age of Acquisition of Phonological Rules	
After Age 4 years, 0 months	Deaffrication, vowelization and vocalization, cluster reduction
After Age 5 years, 0 months	Gliding

Eligibility Guidelines for Stuttering	
Borderline/Mild	3 – 10 sw/m or 3% - 10% stuttered words of words spoken, provided that prolongations are less than 2 seconds and no struggle behaviors and that the number of prolongations does not exceed total wholeword and part-word repetitions.
Moderate	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies up to 2 seconds; secondary characteristics may be present.
Severe	More than 10 sw/m or 10% stuttered words of words spoken, duration of dysfluencies lasting 3 or more seconds, secondary characteristics are conspicuous.
Note: The service delivery may be raised to the higher level when: the percentage of stuttered words and the duration fall in a lower severity rating, and the presence of physical characteristics falls in a higher severity rating.	

Differential Diagnosis for Stuttering

Characteristics of normally dysfluent members:

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

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

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

Crossover Behaviors
- Monosyllabic word repetitions or syllable repetitions with relatively even stress and rhythm but four or more repetitions per instance, monosyllabic word repetitions or syllable

Differential Diagnosis for Stuttering
repetitions with relatively uneven rhythm and stress with two or more repetitions per instance. **More Unusual (Atypical Dysfluencies)** • Syllable repetitions ending in prolongations; sound, syllable or word prolongations; or prolongations ending in fixed postures of speech mechanism, increased tension noted in the act.

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

1. Selection of the device must meet **ALL** the criteria specified in Clinical Coverage Policy WNC.CP.108 Physical Rehabilitation Equipment and Supplies
   a. Employ the use of a dedicated speech generating device that produces digitized speech output, using pre-recorded messages (these are typically classified by how much recording time they offer); **OR**
   b. Employ the use of a dedicated speech-generating device that produces synthesized speech output, with messages formulated either by direct selection techniques or by any of multiple methods.
2. AAC therapy treatment programs consist of the following treatment services:
   a. Counseling;
   b. Product Dispensing;
   c. Product Repair and Modification;
   d. AAC Device Treatment and Orientation;
   e. Prosthetic and Adaptive Device Treatment and Orientation; **AND**
   f. Speech and Language Instruction.
3. AAC treatment must be used for the following:
   a. Therapeutic intervention for device programming and development;
   b. Intervention with parent(s), legal guardian(s), family members, support workers, and the Member for functional use of the device; **AND**
   c. Therapeutic intervention with the Member in discourse with communication partner using his or her device.
4. The above areas of treatment must be performed by a licensed speech-language pathologist with education and experience in augmentative communication to provide therapeutic intervention to help a Member communicate effectively using his or her device in all areas pertinent to the Member. Treatment may be authorized when the results of an authorized AAC evaluation recommend either a low-tech or a high-tech system. Possible reasons for additional treatment include:
   a. update of device;
   b. replacement of current device;
   c. significant revisions to the device and/or vocabulary; **AND**
   d. medical changes.

E. Telehealth

1. A select set of speech and language evaluation and treatment interventions may be provided to a Member using a telehealth delivery method as described in Clinical Coverage Policy WNC.CP.193Telehealth, Virtual Communications and Remote

Patient Monitoring. Telehealth delivery may be medically necessary when a Member's medical condition is such that exposure to others should be avoided, or if their location is remote or underserved such that access to appropriately qualified providers is limited.

2. To ensure a Member receives high quality care aligned with best practices, the following criteria must be considered when making decisions about providing care using a telehealth delivery method:
   a. Unless in-person care is contraindicated or unavailable, telehealth must be used as an adjunct to in-person care and not as a replacement.
   b. Telehealth must be used in the best interest of the Member and not as a convenience for the therapist.
   c. Telehealth must never be used solely to increase therapist productivity.

Note: CPT codes that may be billed when service is furnished via telehealth are indicated in Clinical Coverage Policy 10B, Independent Practitioners Attachment A, Section C: Codes at Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).

V. Audiology Therapy (Aural Rehabilitation)

A. WellCare of North Carolina® shall cover medically necessary audiology services when the Member demonstrates the following:
1. The presence of any degree or type of hearing loss on the basis of the results of an audiologic (aural) rehabilitation evaluation; **OR**
2. The presence of impaired or compromised auditory processing abilities based on the results of a central auditory test battery.

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

C. Aural rehabilitation consists of:
1. Facilitating receptive and expressive communication of a Member with hearing loss;
2. Achieving improved, augmented or compensated communication processes;
3. Improving auditory processing, listening, spoken language processing, auditory memory, overall communication process; **AND**
4. Benefiting learning and daily activities.

D. Evaluation for aural rehabilitation
1. Service delivery requires **ALL** the following elements:
   a. The provider shall check the functioning of hearing aids, assistive listening systems and devices, and sensory aids prior to the evaluation.
   b. Through interview, observation, and clinical testing, the provider shall evaluate the Member's skills, in both clinical and natural environments, for the following:
      i. Medical and audiological history;

ii. Reception, comprehension, and production of language in oral, or manual language modalities;
iii. Speech and voice production;
iv. Perception of speech and non-speech stimuli in multiple modalities;
v. Listening skills;
vi. Speechreading; **AND**
vii. Communication strategies.

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

E. Evaluation for Central Auditory Processing Disorders (CAPD)

1. CAPD evaluation is to be completed by an audiologist and consists of tests to evaluate the Member's overall auditory function. Through interview, observation, and clinical testing, the provider shall evaluate the Member for **ALL** the following:
   a. Communication, medical, and educational history;
   b. Medicaid shall cover the following Central auditory tests for the identification of CAPD:
      i. Auditory discrimination test;
      ii. Auditory temporal processing and patterning test;
      iii. Dichotic speech test;
      iv. Monaural low-redundancy speech test;
      v. Binaural interaction test;
      vi. vi. electroacoustic measures; **AND**
      vii. Electrophysiologic measures.
   c. Interpretation of evaluations are derived from the Member's performance on multiple tests. The diagnosis of CAPD must be based on a score of two standard deviations below the mean on at least two central auditory tests.
   d. The provider shall determine the specific functional limitation(s), which must be measurable, for the Member.
   e. Functional deficits consist of a Member's inability to:
      i. Hear normal conversational speech;
      ii. Hear conversation via the telephone;
      iii. Identify, by hearing, environmental sounds necessary for safety (such as siren, car horn, doorbell, baby crying);
      iv. Understand conversational speech (in person or via telephone);
      v. Hear and understand teacher in classroom setting;
      vi. Hear and understand classmates during class discussion;
      vii. Hear and understand co-workers or supervisors during meetings at work;
      viii. Hear and process the super-segmental aspects of speech or the phonemes of speech; **OR**
      ix. localize sound.

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

VI. Evaluation Services

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

VII. Treatment Plan (Plan of Care)

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

A. Each Treatment Plan in combination with the evaluation or reevaluation written report must contain **ALL** the following:

1. Duration of the therapy treatment plan consisting of the start and end date (no more than six months);
2. Discipline specific treatment diagnosis and any related medical diagnoses;
3. Rehabilitative or habilitative potential;
4. Defined goals (specific and measurable goals that have reasonable expectation to be achieved within the duration of the therapy plan) for each therapeutic discipline;
5. Skilled interventions, methodology, procedures and specific programs to be utilized;
6. Frequency of services;
7. Length of each treatment visit in minutes; **AND**
8. Name, credentials and signature of professional completing the Treatment Plan dated on or prior to the start date of the treatment plan.

VIII. Treatment Services

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

A. Treatment Services must adhere to the following requirements:

1. A verbal or a written order must be obtained for services prior to the start of services. All verbal orders must report the date and signature of the person receiving the order, must be recorded in the Member's health record and shall be countersigned by the physician within 60 calendar days. All verbal orders are

valid up to six months from the documented date of **receipt**. All written orders are valid up to six months from the date of the physician's signature. Backdating is not allowed.

2. All services must be provided according to a treatment plan that meets the requirements in Criteria VII, above.
3. Service providers shall review and renew or revise treatment plans and goals at least every six calendar months.
4. Prior approval is required prior to the start of treatment services.
5. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or order sheet. Electronic signatures and printed dates are acceptable. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper or unauthorized use, and reconstruction of records in the event of a system breakdown. Stamped signatures are not permitted.

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

IX. Re-evaluation Services

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

X. Discharge and Follow-up

A. Discharge

1. The therapy must be discontinued when the Member meets **ONE** of the following criteria:
   a. Achieved functional goals and outcomes;
   b. Performance is within normal limits for chronological age on standardized measures ; **OR**
   c. Overt and consistent non-compliance with treatment plan on the part of the Member; **OR**
   d. Overt and consistent non-compliance with treatment plan on the part of parent(s) or legal guardian(s).
2. At discharge, the therapist shall identify indicators for potential follow-up care.

B. Follow-Up

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

1. Functional status (abilities and deficits);

2. Living situation;
3. School or childcare; or
4. Personal interests.

XI. WellCare of North Carolina® **shall not** cover Outpatient Specialized Therapies when:
A. The Member does not meet the Policy Criteria in Sections I. through XI.; **AND**
B. Therapy services are solely for maintenance.

Background[1]

A. Requirements for and Limitations on Coverage

A. Prior Approval

WellCare of North Carolina® shall require prior approval for all Outpatient Specialized Therapies treatments. The provider shall obtain prior approval before rendering Outpatient Specialized Therapies treatments. In order to obtain prior approval, the request must clearly indicate that the service of a licensed therapist is required. Retroactive prior approval is considered when a Member, who does not have Medicaid coverage at the time of the procedure, is later approved for Medicaid with a retroactive eligibility date. Exceptions may apply.

1. The provider(s) **shall submit** to WellCare of North Carolina® the following:
   a. The prior approval request; **and**
   b. All health records and any other records that support the Member has met the specific Criteria in sections I through X above.
2. **For prior approval**,
   a. A written report of an evaluation must occur within **three months** of the requested beginning date of treatment.
   b. When continued treatment is requested, an annual re-evaluation of the Member's status and performance must be documented in a written evaluation report.
   c. Each reauthorization request must document the efficacy of treatment.

B. Members under the Age of 21 Years

Prior approval is required prior to the start of all treatment services.

C. Visit Limitations Members 21 Years of Age and Older

1. Prior approval is required at the start of all treatment services.
2. Each reauthorization request must document the efficacy of treatment.
3. Annual treatment visits must be medically necessary and are available to members 21 years and older as follows:
   a. A total maximum of 30 treatment visits per calendar year combined across occupational and physical therapy habilitative services.
   b. A total maximum of 30 treatment visits per calendar year combined across occupational and physical therapy rehabilitative services.
   c. A total maximum of 30 treatment visits per calendar year for speech therapy habilitative services.
   d. A total maximum of 30 treatment visits per calendar year for speech therapy rehabilitative services.

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

D. Physical and Occupational Therapy Medical Necessity Visit Guidelines for Members Under 21 Years of Age

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

E. Speech-Language-Audiology Therapy

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

II. Provider Qualifications and Occupational Licensing Entity Regulations

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

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

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

A. For Laws & Regulations for each Therapy Discipline; Please refer to North Carolina Medicaid State Policy Site for Clinical Coverage Policy No: 10A Outpatient Specialized Therapies Section 6.1 at https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

III. Additional Requirements

A. For **Compliance and Documenting Services**, Please refer to North Carolina Medicaid State Policy Site for Clinical Coverage Policy No: 10A Outpatient Specialized Therapies Section 7.0 at **https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.**

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

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

IV. BILLING UNITS

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

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

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

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

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

billed only when the session length is extended by an additional 15 minutes for either the occupational therapy or physical therapy treatment.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612	Flexible endoscopic evaluation of swallowing by cine or video recording;
92613	Flexible endoscopic evaluation of swallowing by cine or video recording; interpretation and report only
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording;

CPT®* Codes	Description
92615	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording; interpretation and report only
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording;
92617	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording; interpretation and report only
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
S9128	Speech therapy, in the home, per diem
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	05/24	05/24

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No:10A Outpatient Specialized Therapies. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published April 1, 2023. Accessed February 14, 2024.

North Carolina Guidance

Eligibility Requirements

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

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

- 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:

I. that is unsafe, ineffective, or experimental or investigational.
II. 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.

EPSDT and Prior Approval Requirements

- 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.

- **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/

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:

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

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

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

Claims-Related Information
Provider(s) shall comply with the NC Tracks 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:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- 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.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue

codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

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

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.