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POLICIES AND PROCEDURES

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GENERAL INFORMATION

BENEFICIARY REQUIREMENTS

The South Carolina Department of Health and Human Services (SCDHHS) provides Medicaid reimbursement for medically necessary services provided to Medicaid-eligible individuals. This includes, but is not limited to, children under the age of 21 who have or are at risk of developing sensory, emotional, behavioral, or social impairments, physical disabilities, medical conditions, mental retardation, and developmental disabilities or delays, as well as individuals of any age who are covered under the Head and Spinal Cord Injury Waivers (HASCI).

In order to be eligible for Private Rehabilitative Therapy and Audiological Services, an individual must meet one of the following:

- Be a Medicaid beneficiary under the age of 21 whose need for services is identified through an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination
- Be a Medicaid beneficiary between 0 and 65 years of age and covered under the HASCI Waiver Program
- Be a Medicaid beneficiary under the age of 21 who has a current and valid ITP that identifies the need for rehabilitative therapy or audiology services, when appropriate
- Be a Qualified Medicare Beneficiary (QMB) eligible for payment of the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by SC Medicaid.

Note: Reimbursement for these services will be consistent with the SC State Medicaid Plan. Refer to Section 3 of this manual for instructions regarding billing procedures for dually eligible beneficiaries.

Please refer to the Medicaid Web-Based Claims Submission Tool (The Web Tool), in Section 1, for instructions on how to access beneficiary information, including QMB status.

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GENERAL INFORMATION

PROVIDER QUALIFICATIONS

Private Rehabilitative Therapists and Audiologists 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 Private Rehabilitative Therapy (*e.g.*, Speech-Language Pathology, Physical Therapy, and Occupational 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 acting within the scope of his or her practice under state law must make the referral.

The following categories of private providers are eligible to enroll with DHHS to provide rehabilitative therapy and audiology services to individuals with special needs.

- Speech-Language Pathologists 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, defined as freestanding facilities that utilize a team of specialized rehabilitation personnel to provide integrated and multidisciplinary programs. These programs are designed to improve the physical functioning of individuals with disabilities. In order to enroll with Medicaid as an Ambulatory Rehabilitation Center, the facility must meet one of the following requirements:
 - o 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 to individuals with disabilities. DHHS recognizes those facilities that have CARF accredited programs in

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

**PROVIDER
QUALIFICATIONS
(CONT'D.)**

Outpatient Medical Rehabilitation and /or Early Childhood Development as Ambulatory Rehabilitation Centers

- o Certified by DHEC as a Certified Outpatient Rehabilitation Facility (CORF). A CORF is a non-residential rehabilitation facility that is 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).
- o Developmental Evaluation Centers, defined as independent freestanding facilities that furnish a comprehensive array of developmental pediatric services. Emphasis within this facility is placed on neurodevelopment assessment and psychological evaluation provided to children under the age of 21, who have developmental delays and have been referred by a physician or other Licensed Practitioner of the Healing Arts (LPHA).

**Supervisor/Under the
Direction of**

In accordance with the Centers for Medicare and Medicaid Services (CMS) directives, CMS has interpreted “under the direction of” to mean that the provider is individually involved with the patient and accepts ultimate legal responsibility for the services rendered by the individuals that he or she agrees to direct. The supervisor is responsible for all of the services provided or omitted by the individual that he or she agrees to directly supervise.

The supervisor must be readily available to offer continuing supervision. “Readily available” means that the supervisor must be physically accessible to the individual being supervised within a certain response time, based upon the medical history and condition of the beneficiary and competency of personnel. Supervision should involve specific instructions to the individual regarding the treatment regimen, responses to signs of adverse reactions from the beneficiary, and communication of any other information or provision necessary to ensure that the appropriate treatment is being rendered. All Clinical Service Notes made by staff who require supervision must be co-signed by the supervisor (unless otherwise indicated for a specific Medicaid-reimbursable service).

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GENERAL INFORMATION

Supervisor/Under the Direction of (Cont'd.)

The individual being supervised may not perform tasks when the supervisor cannot be reached through personal contact, phone, pager, or other immediate means. The supervisor must make provisions in writing for emergency situations including designation of another qualified provider who has agreed to be available on an as-needed basis to provide supervision and consultation to the individual when the supervisor is not available.

All supervisory staff licensed by the Department of Labor, Licensing and Regulation (LLR) must adhere to any provisions as required by LLR.

In addition to the above requirements, SC Medicaid requires a supervising entity (physician, dentist, or any program that has a supervising health professional component) to be physically located in SC or within the 25-mile radius of the SC border.

COVERED SERVICES

Reimbursement is available for services that conform to accepted methods of diagnosis and treatment. Reimbursement is not available for services determined to be unproven, experimental or research-oriented, in excess of those deemed medically necessary to treat the client's condition, or not directly related to the client's diagnosis, symptoms, or medical history. Reimbursement is not available for time spent documenting services or traveling to or from services, or for cancelled visits and missed appointments.

Medicaid reimbursement is available for the following Private Rehabilitative Therapy and Audiological Services:

- Speech-Language Pathology
- Audiology
- Physical Therapy
- Occupational Therapy

Service Limits

Services are subject to frequency limitations as indicated in this manual. Payment for services that exceed frequency limitations must **only** be justified as a result of an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination, and pre-approved by SCDHHS

Private Rehabilitative Therapy Services (speech-language pathology therapy, occupational therapy, or physical

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Service Limits (Cont'd.)

therapy) will be limited to a combined total of 75 hours (300 units) per state fiscal year **effective April 1, 2011**. The state fiscal year begins July 1st and ends June 30th of each year. The combined therapy limit will be based on total hours as of April 1, 2011. The limits set on August 1, 2009 will apply to services billed before April 1, 2011. Providers may verify the therapy unit count by utilizing the South Carolina Medicaid Web-based Claims Submission Tool's eligibility screen.

Payment for services that exceed frequency limitations must only be justified as a result of an Early and Periodic screening, Diagnosis, and Treatment (EPSDT) examination, and pre-approved by South Carolina Department of Health and Human Services (SCDHHS).

Section 1905 (r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act intended to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening series, be provided to an EPSDT recipient. Children with special health care needs may need to be seen more frequently than children who have no identified specialized health care needs. When a physician identifies, through these screenings, a condition that requires referral to another practitioner, it is the responsibility of that physician to ensure appropriate referral be made to address that condition. It is also important that the physician reassess, on a regular basis, the need for ongoing services.

Should a physician determine through an EPSDT visit that a child requires additional private rehabilitative therapy services, that physician must document the medical necessity and request additional visits in writing for review by the SCDHHS Medical Director. These pre-approved requests must include an evaluation overview, proposed treatment plan with expected outcomes, relative progress notes, and anticipated units of services needed to address need(s). The documentation must indicate the diagnosis and/or functional impairment that establishes medical necessity, and must be signed by the child's primary care physician. Documentation should be faxed to SCDHHS staff at 803-255-8222, attention Private Rehabilitative Therapy Services Authorization, prior to provision of the service. Failure to comply with these requirements may

SECTION 2 POLICIES AND PROCEDURES

GENERAL INFORMATION

Service Limits (Cont'd.)

result in denial or recoupment of payment.

These new limits apply to Private Rehabilitative Therapy Services. School-Based Rehabilitative Therapy Services provided under the Individuals with Disabilities Education Act (IDEA) are exempt from yearly frequency limits. Additionally, these limits do not apply to therapy services provided in Outpatient Hospital Clinics. These limits also do not necessarily apply to beneficiaries enrolled in Medicaid Managed Care Organization (MCOs).

Should you have any questions regarding this policy, please contact SCDHHS staff at 803-898-2655.

Medical Necessity

Medicaid will pay for service when the service is covered under the South Carolina State Plan and is medically necessary. "Medically necessary" means that the service is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability. A provider's medical records on each beneficiary must substantiate the need for services, include all findings and information supporting medical necessity, and entail all treatment provided.

Procedural and Diagnostic Coding

Medicaid recognizes the medical terminology as defined in the Current Procedural Terminology (CPT), Fourth Edition, published by the American Medical Association; and the diagnosis codes as defined in the International Classification of Diseases, Ninth Edition (ICD-9), provided by the U.S. National Center for Health Statistics.

In 1996, the Centers for Medicare & Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The S.C. Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in postpayment review of providers' records. For assistance in billing, providers may access the CCI Edit Information online at the CMS Web site, <http://www.cms.hhs.gov/>.

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GENERAL INFORMATION

DOCUMENTATION REQUIREMENTS

Clinical Records

As a condition of participation in the Medicaid program, providers are required to maintain and allow appropriate access to clinical records that fully disclose the extent of services provided to the Medicaid beneficiary. The maintenance of adequate records is regarded as essential for the delivery of appropriate services and quality health care. Providers must be aware that these records are key documents for post-payment review. If clinical records are not completed appropriately, previous payments made by DHHS may be recovered. It is essential that each provider conduct an internal records review to ensure that the services are medically necessary and that service delivery, documentation, and billing comply with Medicaid policy and procedure.

Providers are required to maintain a clinical record on each Medicaid-eligible child that includes documentation of all Medicaid-reimbursable services. This documentation must be sufficient to justify Medicaid payment. Clinical records must be current, meet documentation requirements, and provide a clear descriptive narrative of the services provided and progress toward treatment goals. The information in the Clinical Service Notes must be clearly linked to the goals and objectives listed in the Individualized Treatment Plan (ITP). For example, descriptions should be used to clearly link information from goals and objectives to the interventions performed and progress obtained in the Clinical Service Notes. Clinical records should be arranged logically so that information may be easily reviewed, copied, and audited.

The provider of services is required to maintain clinical records on each Medicaid-eligible child. Each clinical record must include the following:

- A Referral for services
- A Release of Information/Consent to Bill
- Evaluation reports and test results
- A current and valid ITP when applicable
- Clinical Service Notes (CSNs)
- Progress Summary Notes, if applicable

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Referrals

Referral by Other Licensed Practitioners of the Healing Arts for Rehabilitative Therapy Services Only (Speech-Language Pathology, Occupational Therapy, Physical Therapy) and Audiology.

Referral means that the physician or other LPHA has asked another qualified health care provider to recommend, evaluate, or perform therapies, treatment, or other clinical activities to the beneficiary being referred. This includes any necessary supplies and equipment. The referral must be obtained from a Licensed Practitioner of the Healing Arts other than the beneficiary's direct provider of the Rehabilitative Therapy or Audiological Service.

The referral documentation must occur before the provision of the Medicaid Rehabilitative Therapy or Audiological Service. The referral must meet the following requirements:

- Be updated annually (every 12 months) before the annual renewal of the evaluation
- Be obtained from a physician or other LPHA, not the direct provider of services. 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)
- Be clearly documented in the clinical record with the name, date, and title of the referring provider
- Explain the reason for the referral

The following list indicates the professional designations of those considered Licensed Practitioners of the Healing Arts for the purpose of Medicaid reimbursement of Private Rehabilitative Therapy and Audiological Services:

- Licensed Physician Assistant
- Licensed Psychologist
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Advanced Practice Registered Nurse
- Licensed Speech-Language Pathologist
- Licensed Audiologist

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GENERAL INFORMATION

Referrals (Cont'd.)

- Licensed Physical Therapist
- Licensed Occupational Therapist
- Licensed Independent Social Worker
- Licensed Master Social Worker
- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

Prior Authorizations

Exception for School Districts

Private Therapists/Audiologists who wish to treat children referred by a school district still must obtain the seven-digit prior authorization number (beginning with “ED”) from the referring school district, and still must enter this number in field 23 on the CMS-1500 claim form.

Release of Information/Consent to Bill

A Release of Information/Consent to Bill authorizes release of any medical information or other information necessary to process claims. It must be signed by the patient or authorized representative for the patient. The authorization must be signed and dated on or before the date of service. (This may be incorporated into a Consent for Treatment form.)

Evaluations

The Evaluation must occur prior to the provision of the Rehabilitative Therapy Service. It must be completed by the enrolled Medicaid provider of services after receiving the referral from another Licensed Practitioner of the Healing Arts (LPHA): the evaluation must be signed and dated by the provider of service.

Evaluations must result in the development of an Individualized Treatment Plan (ITP) in order to be reimbursed by Medicaid. The Medicaid-covered treatment services (if determined necessary) should be indicated on the ITP. If the evaluation findings do not indicate the need for provision of Medicaid treatment services, then the results of the evaluation must be indicated on the ITP or the evaluation instrument in order to be reimbursed by Medicaid.

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Re-evaluations

A re-evaluation is performed subsequently to an initial evaluation and relates to the disorder. A re-evaluation must be conducted annually (every 12 months) for each beneficiary. A re-evaluation must be completed when enough time has passed to accurately assess the beneficiary's progress. This service may be performed twice a year. Signature and date of signature on the evaluation and re-evaluation are mandated requirements.

Individual Treatment Plans (ITP)

If an evaluation indicates that treatment is warranted, the provider must develop and maintain a treatment plan. The treatment plan must be based on the findings of the evaluation. It must outline short- and long-term goals as well as the recommended scope, frequency, and duration of treatment. The ITP is required before treatment can be provided.

The ITP should serve as a comprehensive plan of care by outlining the service that will address the specific needs of the child. The ITP may be developed as a separate document or may appear as a Clinical Service Note. The plan must be individualized and specify the problems to be addressed, goals and objectives of the treatment, types of interventions to be utilized, planned frequency of service, criteria for achievement, and estimated duration of treatment. Addressing the child's strengths and weaknesses in the ITP is recognized as good clinical practice and is strongly recommended. The ITP must contain the signature and title of the provider and the date it is signed.

Treatment Plan Review.

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

Clinical Service Notes

Services must be documented in the Clinical Service Notes. A Clinical Service Note is a written summary of each treatment session. The purpose of these notes is to record the nature of the child's treatment by capturing the services provided and summarizing the child's

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GENERAL INFORMATION

Clinical Service Notes (Cont'd.)

participation in treatment. In the event that services are discontinued, the provider must indicate the reason for discontinuing treatment in the Clinical Service Notes.

Clinical Service Notes must:

- Provide a relevant clinical description of the activities that took place during the session, including the child's response to treatment as related to stated goals and objectives listed in the ITP
- Reflect delivery of a specific billable service identified in the physician's or other LPHA's referral and the child's ITP
- Document that the services rendered correspond to billing [as to date of service, type of service rendered (*i.e.*, minutes or hours), and length of time of service delivery]
- Document child's level of participation and individual response to intervention in group services

When completing Clinical Service Notes:

- Each entry must be individualized, patient-specific, and may not include arrows, ditto marks, "same as above", or etc. notes.
- All entries must be made by the provider delivering the service and should be accurate, complete, and recorded immediately.
- All entries must be typed or legibly handwritten in dark ink. Copies are acceptable, but must be completely legible. Originals must be available if needed.
- All entries must be dated and legibly signed with the provider's name or initials and professional title.
- All entries must be filed in the child's clinical record in chronological order by discipline.

All Clinical Service Notes used must include a clear, concise narrative summary of service and progress towards treatment goals. This documentation must support the number of units billed.

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Progress Summary Notes

The Progress Summary is a written note outlining the child's progress that must be completed by the provider, at a minimum, every three (3) months from the start date of treatment. The purpose of the Progress Summary is to record the long term treatment of the patient, 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 patient'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."

MEDICAL SERVICE DOCUMENTATION

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

- What was done for the patient
- Why
- By whom
- For what length of time
- What future actions are planned, if applicable

A reviewer should be able to discern from this information that adequate and appropriate observations were used in assessing needs and planning care.

Notations should be concise, but descriptive and pertinent. Although minimum parameters must be addressed, documentation should reflect individualization of care.

Abbreviations and Symbols

Each provider must maintain a list of approved abbreviations and symbols used in patient/client record documentation. Providers must maintain a signature sheet that identifies all staff names, signatures and initials.

Legibility

All entries must be in ink or typed, legible, and in chronological order. All entries must be dated (month, day, and year) and legibly signed by the appropriate signatory authority

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GENERAL INFORMATION

Error Correction Procedures

The patient's clinical record is a legal document. Therefore, extreme caution should be used when altering any part of the record. Appropriate procedures for correcting errors in legal documents must be followed when correcting an error in a clinical record. Errors in documentation should never be totally marked out and correction fluid should never be used. Draw one line through the error, enter the correction, and add signature or initials and the date next to the correction. If warranted, an explanation of the correction may be appropriate.

Records Maintenance

It is essential that internal audits be conducted by the provider to ensure that the services provided are medically necessary and appropriate both in quality and quantity, and those services are being billed appropriately. Missing or incomplete documentation could result in recoupment of funds.

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PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

SPEECH-LANGUAGE PATHOLOGY SERVICES

Program Description

In accordance with 42 CFR 440.110(c)(1), Speech-Language Pathology Services include diagnostic, screening, preventive, or corrective services provided by or under the direction of a Speech-Language Pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment. Speech-Language Pathology Services means evaluative tests and measures utilized in the process of providing Speech-Language Pathology Services and must represent standard practice procedures. Only standard assessments (*i.e.*, Curriculum-Based Assessments, Portfolio Assessments, Criterion Referenced Assessments, Developmental Scales, and Language Sampling Procedures) may be used. Tests or measures described as “teacher-made” or “informal” are not acceptable for purposes of Medicaid reimbursement. Specific services rendered: Speech Evaluation, Individual Speech Therapy, and Group Speech Therapy (and group may consist of no more than six children).

Speech-Language Pathology Services involve the evaluation and treatment of speech and language disorders for which medication or surgical treatments are not indicated.

Services include preventing, evaluating, and treating disorders of verbal and written language, articulation, voice, fluency, 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) when appropriate

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Program Staff

Speech Language Pathology Services are provided by or under the direction of a licensed Speech-Language Pathologist. These individuals are licensed through LLR as Speech-Language Pathologists, Speech-Language Pathology Assistants, or Speech-Language Pathology Interns. These licensed individuals will need to adhere to any provisions as required by LLR. The licensed Speech-Language Pathologist can supervise the licensed Speech-Language Pathology Intern and Speech-Language Pathology Assistant.

A **Speech-Language Pathologist** in accordance with 42 CFR 440.110(c)(2)(i)(ii)(iii) is an individual who meets one of the following conditions: (i) Has a certificate of Clinical Competence from the American Speech and Hearing Association. (ii) Has completed the necessary equivalent educational requirements and work experience to qualify for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

A **Speech-Language Pathology Assistant** is an individual currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology. A licensed Speech-Language Pathology Assistant works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

A **Speech-Language Pathology Intern** is an individual who is currently licensed by the South Carolina Board of Examiners in Speech-Language Pathology and is seeking the academic and work experience requirements established by the American Speech and Hearing Association (ASHA) for the Certification of Clinical Competence in Speech-Language Pathology. A Speech-Language Pathology Intern works under the direction of a qualified Speech-Language Pathologist pursuant to 42 CFR 440.110(c)(2)(i) and (ii).

Supervision Requirements

See Supervision/Under the Direction of under Provider Qualifications.

Service Description

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. Only standard

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PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Service Description (Cont'd.)	<p>assessments (<i>e.g.</i>, curriculum-based assessments, portfolio assessments, criterion referenced assessments, developmental scales, and language sampling procedures) may be used. Tests or measures described as “teacher-made” or “informal” are not acceptable for purposes of Medicaid reimbursement. The following services are components of Speech-Language Pathology Services.</p>
Speech Evaluation	<p>92506-HA: Evaluation of speech, language, voice, communication, and/or auditory processing</p> <p>Upon receipt of the physician or other LPHA referral, a Speech Evaluation is conducted. A Speech Evaluation is a face-to-face interaction between the Speech-Language Pathologist and the child for the purpose of evaluating the patient’s dysfunction and determining the existence of a speech disorder. The evaluation should include review of available medical history records and must include diagnostic testing and assessment, and a written report with recommendations. This service may be performed once per lifetime.</p> <p>Note: Reimbursement is available for a subsequent evaluation when it is conducted as the result of a <u>separate and distinct speech disorder</u>. Presentation of medical justification is required. Contact your Medicaid program manager for more information.</p> <p>S9152: Speech Therapy Re-evaluation</p> <p>Speech Re-evaluation includes a face-to-face interaction between the Speech-Language Pathologist and the child for the purpose of evaluating the patient’s progress and determining if there is a need to continue therapy. Re-evaluation must include a written report with recommendations.</p> <p>Any evaluation performed subsequently to the initial evaluation and related speech disorder is considered a re-evaluation and should be billed under this code.</p>
Individual Speech Therapy	<p>92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual</p> <p>Individual Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps to a child whose speech and/or language patterns deviate from</p>

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Individual Speech Therapy (Cont'd.)

standard, based on evaluation and testing, to include training of teacher or parent with child present.

Effective April 1, 2011, the South Carolina Department of Health and Human Services (SCDHHS) will apply limits to this procedure code. A maximum combined total of 75 hours will be permitted for speech-language pathology, occupational, and physical therapies per state fiscal year for each beneficiary. Providers must start counting the beneficiary's hours of service at the beginning of the state fiscal year. This requirement is for the fee-for-service Medicaid population. The state fiscal year begins July 1st and ends June 30th of each year.

Requests for services in excess of these guidelines must be submitted to SCDHHS for review and approval **before** services are provided. Requests must document the medical necessity for the additional hours, expected outcome for beneficiary, and must indicate the number of additional hours requested to meet the beneficiary's needs. Requests should be mailed or faxed to:

SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29201-8206
Attn: Division of Medical Support Services
Private Therapy Coordinator
Fax: (803) 255-8222

Group Speech Therapy

92508: Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals

Group Speech Therapy is the delivery of remedial services for identified speech and/or language handicaps in a group setting to children whose speech and/or language patterns deviate from standard, based on evaluation and testing, to include training of teacher or parent with child present. A group must consist of at least two patients but no more than six children.

Effective April 1, 2011, the South Carolina Department of Health and Human Services (SCDHHS) will apply limits to this procedure code. A maximum combined total of 75 hours will be permitted for speech-language pathology, occupational, and physical therapies per state fiscal year for each beneficiary. Providers must start counting the beneficiary's hours of service at the beginning of the state

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PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Group Speech Therapy (Cont'd.)

fiscal year. This requirement is for the fee-for-service Medicaid population. The state fiscal year begins July 1st and ends June 30th of each year.

Requests for services in excess of these guidelines must be submitted to SCDHHS for review and approval **before** services are provided. Requests must document the medical necessity for the additional hours, expected outcome for beneficiary, and must indicate the number of additional hours requested to meet the beneficiary's needs. Requests should be mailed or faxed to:

SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29201-8206
Attn: Division of Medical Support Services
Private Therapy Coordinator
Fax: (803) 255-8222

Speech-Language Disorders

Reimbursement may be available for assessment and treatment of the following categories of speech-language disorders.

1. A **developmental language disorder** is the impairment or deviant development of comprehension and/or use of a spoken, written, and/or other symbol system (*e.g.*, sign/gesture). A developmental language disorder ranges from mild delays to severe impairment. The disorder may evidence itself in the form of language (phonologic, morphologic, and syntactic systems), content of language (semantic system), and/or function of language in communication (pragmatic system) in any combination.
2. An **acquired language disorder** (non-developmental) occurs after gestation and birth with no common set of symptoms. Acquired language disorders may differ in the areas of language affected and in severity, and may occur at any age. Causes may include focal and diffuse lesions such as those associated with traumatic brain injury and other kinds of brain injury or encephalopathy.
3. An **articulation disorder** is incorrect production of speech sounds due to faulty placement, timing, direction, pressure, speech, or integration of the movement of the lips, tongue, velum, or pharynx.

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PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Speech-Language Disorders (Cont'd.)

4. A **phonological disorder** is a disorder relating to the component of grammar that determines the meaningful combination of sounds.
5. A **fluency disorder** is an interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. This may be accompanied by excessive tension, struggle behavior, and secondary mannerisms.
6. A **voice disorder** is any deviation in pitch, intensity, quality, or other basic vocal attribute which consistently interferes with communication, or adversely affects the speaker or listener, or is inappropriate to the age, sex, or culture of the individual.
7. A resonance disorder is an acoustical effect of the voice, usually the result of a dysfunctioning in the coupling or uncoupling of the nasopharyngeal cavities.
8. Dysphagia is difficulty in swallowing due to inflammation, compression, paralysis, weakness, or hypertonicity in the oral, pharyngeal, or esophageal phases.

Note: Medical necessity criteria must be met for all services billed to Medicaid

Documentation

See Documentation Requirements under General Information.

AUDIOLOGICAL SERVICES

Program Description

In accordance with 42 CFR 440.110(c)(1), Audiological Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of an audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. It includes any necessary supplies, equipment, and services related to hearing aid use. Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment.

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Program Description (Cont'd.)

Audiological Services include diagnostic, screening, preventive, and/or corrective services provided to individuals with hearing disorders or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts, within the scope of his or her practice under state law, must refer individuals to receive these services. A referral occurs when the physician or other LPHA has asked another qualified health care provider (Licensed Audiologist) to recommend, evaluate, or perform therapies, treatment, or other clinical activities for the beneficiary.

Program Staff

The following requirements are cited from Section 440.110(c)(3) of the Code of Federal Regulations:

- (c) [**Audiological Services** are] services for individuals with speech, hearing, and language disorders.
- (1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

A “qualified audiologist” means an individual with a master’s or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets **one** of the following conditions:

- (i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or paragraph (c)(3)(ii)(B) of this section, **and** the individual is licensed by the State as an audiologist to furnish audiology services.
- (ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet **one** of the following conditions:

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Program Staff (Cont'd)

- (A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.
- (B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

Supervision

See Supervision under Provider Qualifications.

Hearing Aids

Hearing aids may be provided for individuals under the age of 21 when the medical need 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 should be sent to the South Carolina Department of Health and Environmental Control's (DHEC) local Children's Rehabilitative Services (CRS) office. DHEC will arrange for the requested hearing aids. Children from birth to 21 years of age should be enrolled in the CRS program. Requests for hearing aids for children birth to 21 years of age should be sent to:

CRS Central Office
Robert Mills Complex
PO Box 101106
Columbia, SC 29211

For more information, call CRS at (803) 898-0784.

SERVICE DESCRIPTION

Note: CPT Code 92510 has been deleted. Replace 92510 with the updated 2006 CPT Code 92626 for evaluation of auditory rehabilitation status following a cochlear implant.

SECTION 2 POLICIES AND PROCEDURES**PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES****Pure Tone Audiometry****92552: Pure tone audiometry (threshold); air only**

In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies in each ear. **This service may be performed six times every 12 months.**

Audiological Evaluation**92557: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)**

In comprehensive audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold is recorded for a number of frequencies on each ear. Bone thresholds are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sounds. The patient is also asked to repeat bisyllabic (spondee) words. The threshold is recorded for each ear. The word discrimination score is the percentage of spondee words that a patient can repeat correctly at a given intensity level above speech reception threshold in each ear. **This service may be performed once every 12 months.**

92557-52: Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

An audiological re-evaluation is when appropriate components of the initial evaluation are re-evaluated and provided as a separate procedure. The necessity of an audiological re-evaluation must be appropriately documented. This service may be performed six times every 12 months.

**Tympanometry
(Impedance Testing)****92567: Tympanometry Impedance Testing**

Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. **This service may be performed six times every 12 months.**

**Acoustic Reflex Testing;
Threshold**

92568: Acoustic reflex testing; threshold
Acoustic reflex test results give the clinician valuable information regarding the severity of a hearing loss and the possible cause of a hearing loss. It is also a valuable

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Acoustic Reflex Testing; Threshold (Cont'd.)	test in detecting problems in the auditory pathway. This service may be performed two times every 12 month.
Electrocochleography	<p>92584: Electrocochleography</p> <p>An electrocochleography tests the internal components of the implanted receiver and connected electrode array. This procedure verifies the integrity of the implanted electrode array and is completed immediately after the operation. This procedure is to be completed only by a licensed Audiologist on a cochlear implant team and may be performed once per implantation.</p>
Auditory Evoked Potentials; Comprehensive	<p>92585: Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</p> <p>Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. There is no frequency limitation on this procedure.</p> <p>92585–52: Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive</p> <p>Recheck:</p> <p>Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. There is no frequency limitation on this procedure.</p>
Evoked Otoacoustic Emissions; Limited	<p>92587: Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)</p> <p>A probe tip is placed in the ear canal. The probe tip emits a repeated clicking sound that passes through the tympanic membrane, middle ear space, and then to the outer hair cells of the inner ear. Computerized equipment is then able to record an echo off of the hair cell in the inner ear. There is no frequency limitation on this procedure.</p>
Evoked Otoacoustic Emissions; Comprehensive or Diagnostic Evaluation	<p>92588: Comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)</p> <p>A probe tip is placed in the ear canal. The probe tip emits a repeated clicking sound that passes through the tympanic</p>

SECTION 2 POLICIES AND PROCEDURES**PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES**

Evoked Otoacoustic Emissions; Comprehensive or Diagnostic Evaluation (Cont'd.)

membrane, middle ear space, and then to the outer hair cells of the inner ear. Computerized equipment is then able to record an echo off of the hair cell in the inner ear. **There is no frequency limitation on this procedure.**

Hearing Aid Examination and Selection

92590: Hearing aid examination and selection; monaural

History of hearing loss and ears are examined, medical or surgical treatment is considered if possible, and the appropriate type of hearing aid is selected to fit the pattern of hearing loss. **This service may be performed six times every 12 months.**

Hearing Aid Check

92592: Hearing aid check; monaural

The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. **This service may be performed six times every 12 months.**

92592-52: Hearing aid check; monaural

Recheck:

The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. **This service may be performed six times every 12 months.**

Cochlear Implant

Audiologists can provide services for diagnostic evaluation of cochlear implants without the supervision of a Physician. All referrals from a Physician must be documented and maintained in the beneficiary's medical records.

92601: Diagnostic analysis of cochlear implant, patient younger than 7 years; with programming

92602: Subsequent reprogramming (Do not report 92602 in addition to 92601) (For aural rehabilitation services following cochlear implant, including evaluation of rehabilitation status, see 92626-92627, 92630-92633)

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Cochlear Implant (Cont'd.)	<p>92603: Diagnostic analysis of cochlear implant, age 7 years or older; with programming)</p> <p>92604: Subsequent reprogramming (Do not report 92603 in addition to 92604)</p>
Evaluation of Auditory Rehabilitation Status	<p>92626: Evaluation of auditory rehabilitation status; first hour</p> <p>This service involves the measurement of patient responses to electrical stimulation used to program the speech processor and functional gain measurements to assess a patient's responses to his or her cochlear implant. Instructions should be provided to the parent/guardian, teacher, and/or patient 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 and may be performed 10 times a year.</p>
Fitting/Orientation/Checking of Hearing Aid	<p>V5011: Fitting/orientation/checking of hearing aid</p> <p>Includes hearing aid orientation, hearing aid checks, and electroacoustic analysis. The service may be provided six times every 12 months.</p>
Dispensing Fee	<p>V5090: Dispensing fee, unspecified hearing aid</p> <p>The dispensing fee is time spent handling hearing aid repairs. This service may be performed six times every 12 months.</p>
Ear Impression	<p>V5275: Ear impression, each</p> <p>Taking of an ear impression; please specify one or two units for one or two ears. This service may be performed six times every 12 months.</p> <p>Modifiers LT and RT have been removed from V5275. If you are billing this procedure code, instead of using the modifiers to identify the right and left ear impression, SCDHHS asks that you put one unit with no modifier if you are billing only one ear impression. If you are billing both ear impressions, SCDHHS asks that you put two units with no modifier.</p>
Documentation	See Documentation Requirements under General Information.

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

PHYSICAL THERAPY SERVICES

Program Description

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts (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. It includes 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. Specific services rendered: Physical Therapy Evaluation and Individual Therapy.

Physical Therapy Services involve the use of physical agents, mechanical means, and other remedial treatment to restore normal physical functioning following illness or injury.

Program Staff

Physical Therapy Services are provided by or under the direction of a Physical Therapist.

Physical Therapists

A Physical Therapy is a person licensed to practice physical therapy by the South Carolina Board of Physical Therapy Examiners. In accordance with 42 CFR 440.110(a)(2)(i)(ii), a qualified physical therapist is an individual who is (i) A graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and (ii) where applicable, licensed by the State.

Physical Therapy Assistants

A Physical Therapist Assistant (PTA) is a person who is licensed by the board to assist a physical therapist in the practice of physical therapy and whose activities are supervised and directed by a licensed physical therapist.

Supervision of Physical Therapy Assistants

Physical Therapist Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Supervision of Physical Therapy Assistants (Cont'd.)

licensed Physical Therapist. Additionally, the supervising therapist must review and initial each Summary of Progress completed by the assistant. These licensed individuals must adhere to any provisions as required by the South Carolina Department of Labor, Licensing and Regulation (LLR).

Supervision Requirements

See Supervision/Under the Direction of under Provider Qualifications.

Service Description

Physical Therapy Evaluation

97001–GP: Physical Therapy Evaluation

A Physical Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Physical Therapy Association and South Carolina Board of Physical Therapy Examiners guidelines, the physician or other LPHA, the Physical Therapist's professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records, an observation of the patient, and an interview, when possible. The evaluation must include diagnostic testing and assessment, and a written report with recommendations.

Individual Physical Therapy

Individual 97110–GP: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility

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 child should be documented and billed as Individual Physical Therapy.

Effective April 1, 2011, the South Carolina Department of Health and Human Services (SCDHHS) will apply limits to this procedure code. A maximum combined total of 75 hours will be permitted for speech-language pathology,

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Individual Physical Therapy (Cont'd.)

occupational, and physical therapies per state fiscal year for each beneficiary. Providers must start counting the beneficiary's hours of service at the beginning of the state fiscal year. This requirement is for the fee-for-service Medicaid population. The state fiscal year begins July 1st and ends June 30th of each year.

Requests for services in excess of these guidelines must be submitted to SCDHHS for review and approval **before** services are provided. Requests must document the medical necessity for the additional hours, expected outcome for beneficiary, and must indicate the number of additional hours requested to meet the beneficiary's needs. Requests should be mailed or faxed to:

SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29201-8206
Attn: Division of Medical Support Services
Private Therapy Coordinator
Fax: (803) 255-8222

Aquatic Therapy

Individual 97113–GP: Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

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 patient's condition and must require the unique skills of a therapist. Aquatic therapy is a timed code that requires direct, one-on-one patient contact by the therapist/assistant.

Consider the following points when providing aquatic therapy services:

- Does your patient require your unique skills as a therapist, or could the patient achieve functional improvement through a community-based aquatic exercise/activity program?
- Documentation should support why aquatic therapy is necessary.
-

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Aquatic Therapy (Cont'd.)

- There are a limited number of exercises generally performed in the water. These exercises become repetitive quickly. Once a patient can demonstrate an exercise safely, you may no longer bill Medicaid for the time it takes the patient to perform this now independent exercise. If the same exercise or activity is performed over a number of sessions, the documentation must describe the skilled nature of the exercise or activity to demonstrate medical necessity.
- Patients who will not be continuing their water-based program as a maintenance program should be transitioned to land-based exercises as soon as reasonably possible for the patient's condition.
- The treatment minutes documented for aquatic therapy should only include actual exercise/activity time that required direct one-on-one patient contact by the therapist/assistant. Do not include minutes for the patient to dress/undress, get into and out of the pool, etc.
- Do not bill for the water modality used to provide the aquatic environment such as whirlpool (97022) in addition to 97113.

Effective April 1, 2011, the South Carolina Department of Health and Human Services (SCDHHS) will apply limits to this procedure code. A maximum combined total of 75 hours will be permitted for speech-language pathology, occupational, and physical therapies per state fiscal year for each beneficiary. Providers must start counting the beneficiary's hours of service at the beginning of the state fiscal year. This requirement is for the fee-for-service Medicaid population. The state fiscal year begins July 1st and ends June 30th of each year.

Documentation

See Documentation Requirements under General Information.

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

OCCUPATIONAL THERAPY SERVICES

Program Description

In accordance with 42 CFR 440.110(b)(1), Occupational Therapy means services prescribed by a Physician or other Licensed Practitioner of the Healing Arts 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. It includes 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, Adaptive Behavior, Fine/Gross Motor, Visual, Sensory Motor, Postural, and Emotional Development that have been limited by a physical injury, illness, or other dysfunctional condition. Occupational Therapy involves the use of purposeful activity interventions and adaptations to enhance functional performance. Specific services rendered: Occupational Therapy Evaluation, Individual Fabrication of Orthotic, Fabrication of Thumb and Finger Splints.

Program Staff

Only Occupational Therapists or Occupational Therapy Assistants provide Occupational Therapy Services.

Occupational Therapists

An **Occupational Therapist (OT)** is a person licensed to practice occupational therapy by the South Carolina Board of Occupational Therapy. In accordance with 42 CFR 440.110(b)(2)(i)(ii) a qualified occupational therapist is an individual who is (i) certified by the National Board of Certification for Occupational Therapy; or (ii) a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before certification by the National Board of Certification for Occupational Therapy.

Occupational Therapist Assistants

An Occupational Therapy Assistant (OTA) is a person licensed to assist in the practice of occupational therapy under the supervision of a licensed occupational therapist.

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Supervision of Occupational Therapy Assistants

Occupational Therapy Assistants shall perform their duties in accordance with applicable licensure requirements only after examination and evaluation of the child and development of a treatment plan have been completed by a licensed Occupational Therapist. Additionally, the supervising therapist must review and initial each Progress Summary completed by the assistant. These licensed individuals must adhere to any provisions as required by the South Carolina Department of Labor, Licensing and Regulation (LLR).

Supervision Requirements

See “Supervision” under “Provider Qualifications” earlier in this section.

Service Description

Occupational Therapy Evaluation

97003–GO: Occupational Therapy Evaluation

An Occupational Therapy Evaluation is a comprehensive evaluation that should be conducted in accordance with the American Occupational Therapy Association and South Carolina Board of Occupational Therapy guidelines, the physician or other LPHA referral, the Occupational Therapist’s professional judgment, and the specific needs of the child. The evaluation should include a review of available medical history records and an observation of the patient and interview, when possible. The evaluation must include diagnostic testing and assessment and a written report with recommendations.

Individual Occupational Therapy

Individual 97530–GO: Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

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 child should be documented and billed as Individual Occupational Therapy.

Effective April 1, 2011, the South Carolina Department of

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Individual Occupational Therapy (Cont'd.)

Health and Human Services (SCDHHS) will apply limits to this procedure code. A maximum combined total of 75 hours will be permitted for speech-language pathology, occupational, and physical therapies per state fiscal year for each beneficiary. Providers must start counting the beneficiary's hours of service at the beginning of the state fiscal year. This requirement is for the fee-for-service Medicaid population. The state fiscal year begins July 1st and ends June 30th of each year.

Requests for services in excess of these guidelines must be submitted to SCDHHS for review and approval **before** services are provided. Requests must document the medical necessity for the additional hours, expected outcome for beneficiary, and must indicate the number of additional hours requested to meet the beneficiary's needs.

Requests should be mailed or faxed to:

SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29201-8206
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Private Therapy Coordinator
Fax: (803) 255-8222

Aquatic Therapy

Individual 97113–GO: Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises

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 patient's condition and must require the unique skills of a therapist. Aquatic therapy is a timed code that requires direct, one-on-one patient contact by the therapist/assistant.

Consider the following points when providing aquatic therapy services:

- Does your patient require your unique skills as a therapist, or could the patient achieve functional improvement through a community-based aquatic exercise/activity program?

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

Aquatic Therapy (Cont'd.)

- Documentation should support why aquatic therapy is necessary.
- There are a limited number of exercises generally performed in the water. These exercises become repetitive quickly. Once a patient can demonstrate an exercise safely, you may no longer bill Medicaid for the time it takes the patient to perform this now independent exercise. If the same exercise or activity is performed over a number of sessions, the documentation must describe the skilled nature of the exercise or activity to demonstrate medical necessity.
- Patients who will not be continuing their water-based program as a maintenance program should be transitioned to land-based exercises as soon as reasonably possible for the patient's condition.
- The treatment minutes documented for aquatic therapy should only include actual exercise/activity time that required direct one-on-one patient contact by the therapist/assistant. Do not include minutes for the patient to dress/undress, get into and out of the pool, etc.
- Do not bill for the water modality used to provide the aquatic environment such as whirlpool (97022) in addition to 97113.

Effective April 1, 2011, the South Carolina Department of Health and Human Services (SCDHHS) will apply limits to this procedure code. A maximum combined total of 75 hours will be permitted for speech-language pathology, occupational, and physical therapies per state fiscal year for each beneficiary. Providers must start counting the beneficiary's hours of service at the beginning of the state fiscal year. This requirement is for the fee-for-service Medicaid population. The state fiscal year begins July 1st and ends June 30th of each year.

Fabrication of Orthotic

Fabrication of Orthotics for Upper and Lower Extremities and Thumb and Finger Splints: Fabrication of Orthotic is the fabrication of orthotics for lower and upper extremities, and the Fabrication of Thumb Splint and Finger Splint is the fabrication of orthotic for the thumb and likewise, the fabrication of Finger Splint is the fabrication of orthotic for the finger.

SECTION 2 POLICIES AND PROCEDURES**PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES**

*Fabrication of Orthotic
(Cont'd.)*

L2999

Lower extremity orthoses, not otherwise specified (NOS)

L3999

Upper limb orthosis, not otherwise specified (NOS)

*Wrist Hand Finger Orthosis
(WHFO)*

L3808

Wrist hand finger orthosis (WHFO), rigid without joints, may include soft interface material; straps, custom fabricate, includes fitting and adjustment

Documentation

See Documentation Requirements under General Information.

SECTION 2 POLICIES AND PROCEDURES

PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES

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