South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MC-DRC 06-02

MEDICAID BULLETIN

TO: Local Education Agencies

SUBJECT: LEA Manual Updates

Beginning with dates of service **February 15, 2006**, the South Carolina Department of Health and Human Services (SCDHHS) is updating its Local Education Agency (LEA) Manual to clarify and/or revise/correct several policy and procedure guidelines.

This update is to be used for program information and requirements, billing procedures, and provider services guidelines. **Due to several substantial changes in policy, providers are urged to carefully review this revision. All providers are advised to check the DHHS Web site monthly for possible manual updates.**

1. **On Page 2-1, under General Information, insert the following statement at the end of the page.**

   For all dates of service on or after April 1, 2005, Consultations (G9007-GP, G9007-GO, G9007-TJ, G9007-GN, G9007-HA) are no longer a Medicaid reimbursable service.

2. **On page 2-2, insert the following prior to the Evaluation Section:**
   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 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 SC Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing of CPT Codes and Healthcare Common Procedure Coding Systems (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, www.cms.hhs.gov.
3. **On page 2-7, insert this section following "Referrals":**
   Prior Authorization

School districts that refer children to private therapists/audiologists must provide their seven-digit prior authorization number (beginning with "ED") to the private therapist/audiologist (see Medicaid Bulletin date July 20, 1998). The private therapist/audiologist then must enter this number in field 23 on the CMS 1500 claim form.

4. **On page 2-19, replace <u>Program Description</u> narrative with the following 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 to recommend, evaluate, or perform therapies, treatment, or other clinical activities to or on the behalf of the beneficiary being referred. It includes any necessary supplies and equipment. 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. This includes services related to hearing aid use.

5. **On page 2-23, replace Aural Rehabilitation Following Cochlear Implant with or without Speech Processor Programming with the following language, Evaluation of Auditory Rehabilitation Status. Additionally, 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.**

   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.

   ***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 five 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.**

Audiological Re-evaluation **92557-52: Audiometry threshold re-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 five times every 12 months.**

Tympanometry (Impedance Testing) **92567**
Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. **This service may be performed five times every 12 months.**

Electrocochleography **92584**
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.

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 five 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 five times every 12 months.**

Hearing Aid Re-check **92592-52: Hearing aid re-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 five times every 12 months.**

Fitting/Orientation/Checking of Hearing Aid **V5011-HA:**

Includes hearing aid orientation, hearing aid checks, and electroacoustic analysis. **The service may be provided five times every 12 months.**

V5265-RT and V5265-LT have been deleted and replaced with V5275-RT and V275-LT. The payment rate remains unchanged.

Right Ear Impression **V5275-RT: Ear impression, each ear**
Taking of an earmold impression; please specify one or two units for one or two ears. **This service may be performed five times every 12 months.**

Left Ear Impression **V5275-LT: Ear impression, each ear**
Taking of an earmold impression; please specify one or two units for one or two ears. **This service may be performed five times every 12 months.**

Dispensing Fee **V5090: Dispensing fee, unspecified hearing aid**
The dispensing fee is time spent handling hearing aid repairs. **This service may be performed five times every 12 months.**

6. **On page 2-25, replace <u>Individual and Group Physical Therapy</u> with the following: *Individual and Group Physical Therapy* Individual 97110: Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility Group 97150-GP: Therapeutic procedure(s), group (two or more individuals)** Individual or Group 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. Physical Therapy performed on behalf of two or more clients should be documented and billed as Group Physical Therapy. A group may consist of no more than six children.

7. On page 2-28, Individual and Group Occupational Therapy will read:

Individual and Group Occupational Therapy

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

Group 97150-GO: Therapeutic procedure(s), group (two or more individuals)

Individual or Group 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. Occupational Therapy performed for two or more individuals should be documented and billed as Group Occupational Therapy. A group may consist of no more than six children.

8. On page 2-28, the procedure code descriptions of "Fabrication of Orthotic" will read as follows:

Lower extremity orthosis L2999
Upper limb orthosis, not otherwise specified L3999

9. On page 2-28, instead of "Fabrication of Thumb Splint", the procedure code descriptions will read as follows:

Upper Limb – Wrist, Hand Finger (Long Opponens) L3805
Long opponens; no attachments, custom fabricated
Upper Limb – Wrist, Hand Finger (Short Opponens) L3800
Wrist, Hand Finger (WHFO) orthoses; short opponens; no attachments, custom fabricated

10. On page 2-32, the Service Description section will read as follows:

***Speech Evaluation* 92506-HA: Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status**

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/Therapist and the child for the purpose of evaluating the child'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.**

Note: Reimbursement is available for a subsequent evaluation if, and only if, it is conducted as the result of a separate and distinct speech disorder.

Presentation of medical justification is required. Contact your Medicaid program manager for more information.

***Speech Re-evaluation* 92506: Re-evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status**
Speech Re-evaluation includes a face-to-face interaction between the Speech-Language Pathologist/Therapist and the child for the purpose of evaluating the child's progress and determining if there is a need to continue therapy. Reevaluation may consist of a review of available medical records and diagnostic testing and/or assessment, but must include a written report with recommendations. **Any evaluation performed subsequently to the initial evaluation and related speech disorder is considered a re-evaluation and should be billed under this code.**

***Individual Speech Therapy* 92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual**
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 standard, based on evaluation and testing, to include training of teacher or parent with child present. Individual Speech Therapy Services may be provided in a regular education classroom.

***Group Speech Therapy* 92508: 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 may consist of no more than six children. Group Speech Therapy services may be provided in a regular education classroom

11. On pages 2-32 through 2-33, the section <u>Speech-Language Disorders</u> will read as follows:
Reimbursement is 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 **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.

4. 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.

5. A **phonological disorder** is a disorder relating to the component of grammar that determines the meaningful combination of sounds.

6. 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.

7. A **voice disorder** is any deviation in pitch, intensity, quality, or other basicvocal attribute that consistently interferes with communication or adversely affects the speaker or listener, or is inappropriate to the age, sex, or culture of the individual.

8. 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.

9. **Dysphagia** is difficulty in swallowing due to inflammation, compression, paralysis, weakness, or hypertonicity in the oral pharyngeal, or esophageal phases.

12 Page 2-35, under Service Description, delete 96100, and insert the following updated CPT Code information:

Psychological Testing/ Evaluation 96101:
Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS, per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report

13. Pages 2-85 thru 2-89 have been replaced with the new/revised Medicaid Adolescent Pregnancy Prevention Services (MAPPS) Information as follows:

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)
Purpose Medicaid Adolescent Pregnancy Prevention Services (MAPPS) are educational and counseling services delivered to adolescents at risk of engaging in sexual behavior at an early age. The goal of these services is to delay or prevent unintended and unwanted pregnancies. MAPPS enhance the ability of adolescents to make responsible decisions about sexual activity, including the importance of effective use of contraception. The result is a lowered incidence of pregnancy and sexually transmitted diseases, and improved overall physical and mental health.

Medical Necessity Criteria
MAPPS include education about the health risks associated with unprotected sexual activity and counseling services related to birth control alternatives.

Eligibility Criteria
- Participant is a Medicaid beneficiary.
- Participant is between the ages of 10 and 19.
- Participant has one or more of the following risk factors:
  - Parent(s) were teen parents.
  - Sibling is pregnant and/or is a teen parent.
  - Participant is a teen parent.
  - Peer pressure to engage in sexual activity is identified as a problem by the adolescent.
  - Participant is sexually active and/or has a history of sexual abuse.

Service Descriptions *Needs Assessment and Intervention Case Plan* Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol (T1023-FP)

A basic screening assessment must be completed and filed in each participant's record that includes all information contained in the Basic Needs Assessment Form (see Section 5), along with a description of services to be provided. Relevant information should be documented on social, psychological, environmental, and health risk factors that justify the delivery of MAPPS to the participant. The assessment must also identify the capacities and resources of the participant and his or her family that may help address the identified risks. The assessment findings will be used to develop the initial service or case plan. Individual and family member interviews may be used in the completion of the assessment process. All contact for the purpose of gathering information for the assessment must be face-to-face. The assessment must be completed by a licensed or certified health care professional. A written intervention/case plan must be completed based on the results of the Needs Assessment for that individual adolescent and placed in the record. The Needs Assessment and the Intervention Case Plan must be completed prior to providing Family Planning Counseling and Family Planning Instruction/Education services for new participants. The plan must include family planning goals and objectives based on the assessment, expected time frames for completion of the goals and objectives, the worker's signature, the signature of the participant, the signature of the parent/caregiver, and the date of agreement. The intervention/case plan must be completed by a licensed or certified health care professional and must be updated at least annually (every 12 months) or whenever additional risk factors are identified.

- **Procedure Code:** T1023-FP
- **Unit of Service:** 15 minutes
- **Frequency:** Up to a maximum of eight units per contract year for assessment/case plan of a new participant.

Statewide MAPPS rates will be incorporated in contracts on an annual basis.

Services in excess of these guidelines must be submitted in written format for prior approval by a DHHS review committee. The documentation must contain information on the specific individual's risk factors that necessitate additional units of service.

Individual Session **Patient Education, (S9445-FP), Not Otherwise Classified, Non-Physician Provider, Individual, Per Session**

An individual session is defined as a face-to-face **educational/counseling session** to assist reproductive-age individuals in making informed decisions about family planning and appropriate usage of birth control methods. This procedure code will be measured in 15-minute units and must address a minimum of three documentation points plus the client's response from the Documentation Points list (see Section 5). All documentation must contain the content in the Individual or Group Session Form (see Section 5) along with a narrative description. Documentation of the session must support time billed and points discussed. DHHS will provide reimbursement for a maximum of 16 hours

or 64 units of individual sessions per contract year for each participant. Individual sessions maybe provided to the participant or the participant and parent. This procedure code should also be used at least every six months to review the assessment/case plan. Providers must take reasonable steps to ensure that communication with the participant is confidential.

Individual sessions may be provided by licensed/certified staff or by staff directly supervised by licensed/certified staff. Licensed/certified staff must cosign all documentation provided by unlicensed/non-certified staff. Unlicensed/non-certified staff providing individual sessions must also attend an approved individualized counseling training before providing individual educational/counseling sessions.

- **Procedure Code:** S9445-FP
- **Unit of Service:** 15 minutes
- **Frequency:** Up to a maximum of 64 units per contract year. Services in excess of these guidelines must be submitted to a DHHS review committee for approval prior to delivery of the service. Requests must be in written format specifying individualized risk factors that necessitate additional units of service.

Group Session **Patient Education, (S9446-FP), Not Otherwise Classified, Non-Physician Provider, Group, Per Session**

A group session is face-to-face consultation designed to assist reproductive age individuals in making informed decisions regarding family planning and voluntary utilization of appropriate birth control methods, there by preventing unwanted or unintended pregnancies. Groups size will be defined as at least two participants, but no more than 15 participants. Groups larger than 15 are not billable as Medicaid services. A group session will be measured in 15-minute units; a group session must last a minimum of 45 continuous minutes and must address at least five documentation points plus the client's response from the Documentation Points list (see Section 5). All provider forms for documentation must contain the content included in the Individual or Group Session Form (see Section 5) along with a narrative description of the services. Evidence-based curricula must be used. Curricula must be age/reading level appropriate. Students may only attend each curriculum series once. Group sessions may be provided by licensed/certified staff or by staff directly supervised by licensed/certified staff. Licensed/certified staff must cosign all documentation provided by unlicensed/non-certified staff.

- **Procedure Code:** S9446-FP
- **Unit of Service:** 15 minutes
- **Frequency: A minimum of 3 units per session;** up to a maximum of 64 units per contract year

Statewide MAPPS rates will be incorporated in contracts on an annual basis.

Services in excess of these guidelines must be submitted to a DHHS review committee prior to delivery of the service. Requests must be in written format specifying the individualized risk factors that necessitate additional units of service.

Appropriate Staff

Individuals providing MAPPS assessments and intervention case plans must be licensed or certified by appropriate state authorities as health care professionals. DHHS recognizes the following as eligible: Licensed

Professional Counselor (LPC), Licensed Marriage and Family Counselor (LMFC), Licensed Psycho-Educational Specialist (LPES), Certified Health Educator, Licensed Practical Nurse (LPN), Registered Nurse (RN), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Certified Nurse Midwife (CNM), Licensed Baccalaureate Social Worker (LBSW), Licensed Master Social Worker (LMSW), Licensed Independent Social Worker-Clinical Practice (LISW-CP), Licensed Independent Social Worker-Advanced Practice (LISW-AP), Licensed Psychologist, or Licensed Physician Assistant. Unlicensed or non-certified staff must be **directly** supervised by a licensed or certified health care professional in order to provide individual and/or group educational counseling. For Medicaid billing purposes, direct supervision means that the supervising licensed or certified health care professional is accessible when the services are being provided; and, the supervising licensed or certified health care professional is responsible for all services rendered, fees charged, and reimbursement received. The supervising licensed or certified health care professional must cosign all documentation provided by unlicensed/non-certified staff, indicating that he or she accepts responsibility for the service rendered. All staff providing direct services (both professional and paraprofessional) must attend a minimum of 20 hours of family planning training per contract year. New staff providing direct services must receive at least 12 of the 20 hours of family planning training during the first quarter of employment as a MAPPS provider. All non-licensed/non-certified staff providing individual counseling/education must receive training that is approved by DHHS in individual counseling prior to providing individual sessions. This training may be included in the 20 hours of family planning training required each year.

Documentation

Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project or Treatment Protocol (T1023-FP); Patient Education, Individual, Not Otherwise Classified, Non-Physician Provider, Per Session, (S9445- FP); and Patient Education, Group, Not Otherwise Classified, Non-Physician Provider, Per Session (S9446- FP) must be documented in the beneficiary's record. All documentation must specify group or individual service time spent providing the service, number of units billed, date of service, and signature of the provider. All documentation of services provided by unlicensed/non-certified staff must be cosigned and dated by the supervisory professional staff. Documentation of Patient Education, Not Otherwise Classified, Non-Physician Provider, Individual, Per Session (S9445-FP); and Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per Session (S9446-FP) must reflect services specific to the client. This includes individualization of all documented services, including purpose, objective of the session, and the client's response and participation level related to family planning. Documentation must reflect that the service provided meets an objective in the plan of care. All provider forms must include the information in the samples provided in the **Adolescent Pregnancy Prevention Provider Training Manual** or the Basic Needs Assessment Form and Individual or Group Session Form (see Section 5) along with a narrative description of the services. All documentation must support time billed for services. Providers must continue to use evidence-based curricula when conducting group sessions. Curricula must be age/reading level appropriate. Participants may only attend each curriculum series once.

14. On page 4-2, the following will change to the following.

MEDICAID ADOLESCENT PREGNANCY PREVENTION SERVICES (MAPPS)

Services provided to a female client known to be pregnant are not considered family planning; therefore, they are not billable.

Procedure Code	*Level of Service*	*Unit of Service*	*Unit Frequency*	*Place of Service*
T1023*	Screening to Determine the Appropriateness of Consideration of an Individual for Participation in a Specified Program, Project, or Treatment Protocol	15 minutes	Up to a maximum of eight units per contract year for assessment/case plan of a new participant	11, 12, 99
S9445* Individual	Patient Education, Not Otherwise Specified, Non-Physician Provider, Individual, Per Session	15 minutes	Up to a maximum of 64 units per contract year	11, 12, 99
S9446* (Group)	Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per Session	15 minutes	A minimum of three units per session; up to a maximum of 64 units per contract year	11, 12, 99

*** Must use FP modifier.**

15. On page 4-4, the following service descriptions have been changed/added:

Hearing Evaluation is **Audiological Evaluation**
Hearing Re-evaluation is **Audiological Re-evaluation**
Hearing Aid Evaluation - Amplification Selection is **Hearing Aid Examination and Selection: Monaural**
Hearing Aid Re-check - Amplification Follow-up is **Hearing Aid Re-check: Monaural**
Hearing Aid Orientation is **Fitting/Orientation/Checking of Hearing Aid**
Right Ear Mold V5265-RT is **Right Ear Impression V5275-RT**

16. On page 4-5, the following service descriptions have changed:

Left Ear Mold V5265-LT is **Left Ear Impression V5275-LT**
Hearing Aid Analysis – Amplification Analysis is
Hearing Aid Check: Monaural
Pure Tone Air Conduction Testing is **Pure Tone Audiometry**
Impedance Testing is **Tympanometry (Impedance Testing)**
Handling Fee is now **Dispensing Fee**

17. On page 4-5, under Aural Rehabilitation Following Cochlear Implant with or without Speech Processor Programming, replace 92510 under procedure code with 92626, and under procedure code description, replace description with, Evaluation of auditory rehabilitation status, first hour.

18. On page 4-7, make the following change:

Individual Physical Therapy should be billed **97110** instead of **97110-GP.**

19. On page 4-8, the following service descriptions have changed:

Fabrication of Orthotic for Lower Extremities and
Fabrication of Orthotic for Upper Extremities are both listed under the service description **Fabrication of Orthotic.**

Fabrication of Thumb Splint and **Fabrication of Finger Splint** are both listed under the service description **Upper Limb – Wrist, Hand, Finger.**

20. On page 4-8, the following procedure code descriptions have changed:

L3800 is **Short opponens**
L3805 is **Long opponens**

21. Page 4-9, should be changed to reflect the following language:
Psychological Testing/Evaluation 96101
Psychological Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathlogy, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.

22. The following forms have been added to Section 5:

- **Medicaid Adolescent Pregnancy Prevention Services Documentation Points**

- **Medicaid Adolescent Pregnancy Prevention Services Basic Needs Assessment Form**
- **Medicaid Adolescent Pregnancy Prevention Services Individual or Group Session Form**

Questions regarding this Medicaid Bulletin billing or policy update changes should be addressed to your Program Coordinator in School-Based Services at (803) 898-2655.

Thank you for your continued support and participation in the South Carolina Medicaid Program.

/s/

Robert Kerr
Director

RMK/bmhw

NOTE: To receive Medicaid bulletins by mail or to sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.dhhs.state.sc.us/dhhsnew/QLEbulletins.asp