

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Healthy Connections
MEDICAID



PRIVATE REHABILITATIVE THERAPY & AUDIOLOGICAL SERVICES PROVIDER MANUAL

JULY 1, 2019

South Carolina Department of Health and Human Services

CONTENTS

1. Program Overview	1
• Program Description.....	1
2. Covered Populations.....	3
• Eligibility/Special Populations	3
3. Eligible Providers	4
• Provider Qualifications	4
4. Covered Services and Definitions	9
5. Utilization Management.....	19
• Prior Authorization.....	19
• Other Service/Product Limitations	20
6. Reporting/Documentation	22
• Clinical Records	22
• Medical Service Documentation	24

1

PROGRAM OVERVIEW

PROGRAM DESCRIPTION

Speech Language Pathology Services

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 mean 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.

Audiological Services

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.

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 (LPHA), 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.

Physical Therapy Services

In accordance with 42 CFR 440.110(a), physical therapy means services prescribed by a physician or other LPHA within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified physical therapist. 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.

Occupational Therapy Services

In accordance with 42 CFR 440.110(b)(1), occupational therapy means services prescribed by a physician or other LPHA within the scope of his or her practice under state law and provided to a beneficiary by or under the direction of a qualified occupational therapist. 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.

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

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

2

COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS

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, child individuals who have or are at risk of developing sensory, emotional, behavioral or social impairments, physical disabilities, medical conditions, intellectual disabilities or related disabilities 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 years whose need for services is identified through an early and periodic screening, diagnostic and treatment (EPSDT) examination
- Be a Medicaid beneficiary between 0 years and 65 years of age and covered under the HASCI Waiver Program
- Be a Medicaid beneficiary under the age of 21 years who has a current and valid individualized treatment plan (ITP) that identifies the need for rehabilitative therapy or audiology services, when appropriate
- Be a qualified Medicare beneficiary eligible for payment of the Medicare cost sharing for services that are covered by Medicare without regard to whether the service is covered by South Carolina Medicaid
- Be a Medicaid beneficiary over the age of 21 years who is eligible to receive physical medicine and therapy — Age 21 years and over services

Note: Reimbursement for these services will be consistent with the South Carolina State Medicaid Plan.

3

ELIGIBLE PROVIDERS

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 LPHA 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 SCDHHS 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:
 - 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. SCDHHS recognizes those facilities that have CARF accredited programs in outpatient medical rehabilitation and /or early childhood development as ambulatory rehabilitation centers.
 - Certified by South Carolina Department of Health and Environmental Control (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).

- 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 years who have developmental delays and have been referred by a physician or other 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).

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 LLR must adhere to any provisions as required by LLR.

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

Program Staff — Speech Language Pathology Services

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 in speech-language pathology by the South Carolina Board of Examiners and is seeking the academic and work experience requirements established by the American Speech and Hearing Association 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).

Program Staff — Audiological Services

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

Audiological services are services for individuals with speech, hearing and language disorders.

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 LPHA 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 masters or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:

- 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.
- 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:

- Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association
- 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 nine months of full-time audiology services under the supervision of a qualified master- or doctoral-level audiologist after obtaining a masters or doctoral degree in audiology or a related field and successfully completed a national examination in audiology approved by the Secretary

Program Staff — Physical Therapy Services

Physical therapy services are provided by or under the direction of a physical therapist.

Physical Therapists

A physical therapist 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 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 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 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 LLR.

Program Staff — Occupational therapy

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 is a person licensed to assist in the practice of occupational therapy under the supervision of a licensed occupational therapist.

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 LLR.

4

COVERED SERVICES AND DEFINITIONS

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

Reimbursement is not available for services provided in an inpatient hospital or other institutional care facility.

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 LPHA: the evaluation must be signed and dated by the provider of service.

Evaluations must result in the development of an 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, the results of the evaluation must be indicated on the ITP or the evaluation instrument in order to be reimbursed by Medicaid.

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

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.

Speech Language Pathology Services

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 assessments (e.g., curriculum-based assessments, portfolio assessments, criterion referenced assessments, development 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.

Speech Evaluation

The appropriate procedure code may be billed for an initial speech evaluation performed on or after January 1, 2014.

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.**

Note: Reimbursement is available for a subsequent initial evaluation when it is conducted as the result of a **separate and distinct speech disorder**. Presentation of medical justification is required. Contact the PSC or submit an online inquiry for additional information.

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.

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

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.

Group Speech Therapy

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.

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.

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, 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 dysfunction 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.

Audiological Services

Hearing Aids

Hearing aids may be provided for individuals under the age of 21 years 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 (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 +1 803 898 0784.

Pure Tone Audiometry

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.

In speech audiometry, earphones are placed and the patient is asked to repeat bi-syllabic (spondee) words. The threshold is recorded for each ear. This service may be performed six times every 12 months.

Audiological Evaluation

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 bi-syllabic (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.

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)

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

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 test in detecting problems in the auditory pathway. This service may be performed two times every 12 months.

Acoustic Immittance Testing, Includes Tympanometry (Impedance Testing), Acoustic Reflex Threshold Testing, and Acoustic Reflect Decay 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.

Electrocochleography

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.

Auditory Evoked Potentials

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.

Evoked Otoacoustic Emissions

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.

Hearing Aid Examination and Selection

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

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.

Evaluation of Auditory Rehabilitation Status

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.

Fitting/Orientation/Checking of Hearing Aid

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

Dispensing Fee

The dispensing fee is time spent handling hearing aid repairs. This service may be performed six times every 12 months.

Ear Impression

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.

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.

Physical Therapy Services

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 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.

Aquatic Therapy

Aquatic therapy refers to any exercise/activity that is performed in a water environment, including whirlpools, Hubbard tanks, underwater treadmills and pools. Aquatic therapy is covered following the general medical necessity guidelines for all therapy services. The exercises/activities in the water must be medically necessary for the 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.
- 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.

Occupational Therapy Services

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 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.

Aquatic Therapy

Aquatic therapy refers to any exercise/activity that is performed in a water environment, including whirlpools, Hubbard tanks, underwater treadmills and pools. Aquatic therapy is covered following the general medical necessity guidelines for all therapy services. The exercises/activities in the water must be medically necessary for the 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.
- 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.

Fabrication of Orthotic

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.

Wrist Hand Finger Orthosis

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

Physical Medicine and Therapy — Age 21 Years and Over

Physical, occupational or speech therapy (PT/OT/ST) may be rendered in an office or outpatient setting. Licensed therapists performing these services must continue to meet the state licensure regulations specified by LLR. Licensed therapists may bill directly and be reimbursed for services rendered. Recipients age 21 years and over who receive services in one of the above listed settings must be pre-authorized by the QIO, KEPRO.

- At a minimum, physical therapy services must improve or restore physical functioning, as well as prevent injury, impairments, functional limitations and disability following disease, injury or loss of limb or body part. Occupational therapy must prevent, improve or restore physical and/or cognitive impairment following disease or injury. Speech language pathology must improve or restore cognitive functioning, communication skills and/or swallowing skills following congenital or acquired disease or injury.
- Medical documentation must be submitted to KEPRO to justify the medical necessity for the physical therapy. Documentation includes, but is not limited to, patient medical history, radiology, pharmacology records and letter of medical necessity which clearly indicates the medical justification for the service being requested. Any requests sent without medical

documentation will be administratively denied. InterQual criteria will be used to make all determinations.

Physicians/nurse practitioners are required to submit the applicable current procedural terminology (CPT) codes as defined in the CPT reference guide for the specified therapy. Therapy procedures are defined in 15-minute sessions, SCDHHS will define 15 minutes as one unit. Therapy sessions are limited to four units/one hour per date of service.

Patients with Medicare or any other payer are only required to obtain a prior authorization if Medicare or the primary carrier did not make a payment or the service is considered not covered.

For children under the age of 21 years, PT/OT/ST services are available through rehabilitation centers certified by SCDHEC and through individual licensed practitioners. Policy guidelines are located in the Private Rehabilitative Therapy and Audiological Service provider manual on our web site located at www.scdhhs.gov.

SCDHHS will require prior authorization for rehabilitative therapy for children. The checkpoint will apply to private rehabilitative providers as well as to those performed in the outpatient hospital clinic. Requests for therapy services for all children that exceed the checkpoints for combined rehabilitative therapy services (105 hours or 420 units) must be submitted to KEPRO for authorization. KEPRO will use InterQual's Outpatient Rehabilitation criteria for medical necessity determinations. Requests for therapy services may be submitted by the primary care physician, nurse practitioner, physician assistant, physical, occupational or speech therapist, but must follow the guidelines outlined in the Private Rehabilitative Therapy and Audiological Services provider manual.

Biofeedback therapy is a non-covered service.

5

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

Referrals

Referral by Other LPHA 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 LPHA 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 LPHAs for the purpose of Medicaid reimbursement of private rehabilitative therapy and audiological services:

- Licensed physician assistant
- Licensed psychologist
- Registered nurse
- Advanced practice registered nurse
- Licensed speech-language pathologist
- Licensed audiologist

- Licensed physical therapist
- Licensed occupational therapist
- Licensed independent social worker
- Licensed master social worker
- Licensed professional counselor
- Licensed marriage and family therapist

Prior Authorization Exceptions 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.

OTHER SERVICE/PRODUCT LIMITATIONS

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 EPSDT examination and be pre-approved by SCDHHS.

Private rehabilitative therapy services (speech-language pathology therapy, occupational therapy or physical therapy) will be limited to a combined total of 105 hours (420 units) per state fiscal year **effective October 1, 2012**. The state fiscal year begins July 1 and ends June 30 of each year. The combined therapy limit will be based on total hours as of July 1, 2012. The limits set on April 1, 2011 will apply to services billed before July 1, 2012. 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 EPSDT examination and be pre-approved by 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.

Requests for therapy services that exceed the fiscal year checkpoint for combined rehabilitative therapy services (105 hours or 420 units) must be submitted to KEPRO for authorization. KEPRO will use InterQual’s outpatient rehabilitation criteria for medical necessity determinations. Providers

will be required to track and request the additional visits prior to the expiration of the combined limit. Requests for therapy services may be submitted by the primary care physician or physical, occupational or speech therapist, but must follow the guidelines outlined in this provider manual.

All applicable forms for requests for prior authorizations are posted to KEPRO's website, <http://scdhhs.kepro.com>. Also posted are upcoming trainings, new policies and procedural changes affecting Medicaid's QIO process and direct links to Medicaid policy guides. If you have questions or concerns with the above process, please contact KEPRO at the following:

KEPRO Customer Service Phone: +1 855 326 5219

KEPRO Fax #: +1 855 300 0082

Provider Issues Email: atrezzoissues@Kepro.com

These new limits apply to private rehabilitative therapy services. School-based rehabilitative therapy services provided under the Individuals with Disabilities Education Act are exempt from yearly frequency limits. Additionally, the checkpoint will apply to private rehabilitative providers as well as to those performed in outpatient hospital clinics. For beneficiaries enrolled in a managed care organization (MCO), please refer to the individual MCO plan regarding its services. Failure to comply with these requirements may result in denial or recoupment of payment.

Should you have any questions regarding this policy, please contact the SCDHHS Provider Service Center at +1 888 289 0709 or submit an online inquiry at <http://www.scdhhs.gov/contact-us>.

6

REPORTING/DOCUMENTATION

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 SCDHHS 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 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
- Progress summary notes, if applicable

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.)

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 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.

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.

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.