Chapter 17

Rehabilitative Services: Physical Therapy, Occupational Therapy, Speech-Language Pathology, and Audiology Services

This chapter provides policy and billing information for providers of physical therapy, occupational therapy, speech-language pathology, rehabilitation agency services (including therapy services provided by nursing home employees or contractors, physician clinics, outpatient hospitals, and community or public health clinics), audiology, and hearing aids.

Individual education plan (IEP) services provided in schools are addressed in Chapter 9, Children's Services, and rehabilitative services provided by home health agencies are addressed in Chapter 24A, Home Care Services.

Definitions

Audiologist: A health care professional who engages in the practice of audiology, meets the qualifications required by MN Stat. secs. 148.511-148.5196, and is licensed by the Minnesota Department of Health (MDH), or where applicable, licensed or registered by the state in which he/she practices. If the state does not license providers of audiology services, the applicant for enrollment with Minnesota Health Care Programs (MHCP) must demonstrate that he/she meets the Certificate of Clinical Compliance (CCC) and practicum requirement listed below:

1. Holds a CCC from the American Speech-Language-Hearing Association (ASHA); **or**
2. Meets the following clinical practicum (practicum requirement) standards:
   a. Has demonstrated a successful completion of a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating such experience);
   b. Has performed not less than nine months of supervised full-time audiology services after obtaining a master's or doctoral degree; and
   c. Has successfully completed a national exam in audiology approved by the Secretary.

Audiologic Evaluation: An assessment administered by an audiologist or otolaryngologist to evaluate communication problems caused by hearing loss.

Comprehensive Outpatient Rehabilitation Facility (CORF): A non-residential facility that is established and operated exclusively to provide diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick people, at a single fixed location, by or under the direction of a physician and that meets the conditions of participation. Additionally, a facility that qualifies as a CORF may be enrolled to provide mental health services.

Direction: The actions of a physical therapist (PT) or occupational therapist (OT) who instructs the physical or occupational therapist assistant (PTA/OTA), monitors the assistant's provision of services, and provides on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session for each member when treatment is provided by an assistant and meets the other supervisory requirements of MN Rules Chap. 5601 and MN Stat. sec. 148.6432 and the therapy disciplines' respective licensure requirements.

Functional Status: The ability to carry out the tasks associated with daily living.

Hearing Aid: A monaural hearing aid, set of binaural hearing aids, or other device worn by the member to improve access to and use of auditory information.

Hearing Aid Accessory: Chest harnesses, tone and ear hooks, carrying cases, and other accessories necessary to use the hearing aid, but not included in the cost of the hearing aid.

Hearing Aid Services: Services to dispense hearing aids and provide hearing aid accessories and repairs.

Hearing Aid Service Provider: A person who has been certified by the MDH as a hearing instrument dispenser (or his/her trainee).

Long-Term Care Facility (LTCF): A nursing facility, Skilled Nursing Facility (SNF), or Intermediate Care Facility for the Developmentally Disabled (ICF/DD).

Occupational Therapist (OT): A person who is certified by the National Board for Certification in Occupational Therapy, Inc. (NBCOT) and maintains State licensure as an OT (MN Stat. sec. 148.6408).

Occupational Therapist Assistant (OTA): A person who has successfully completed all academic and fieldwork requirements of an OTA program approved or accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) and is currently certified by NBCOT as an OTA and, where applicable, is licensed by the state in which he/she practices.

Otolaryngologist: A physician specializing in diseases of the ear and larynx who is certified by the American Board of Otolaryngology (ABOto) or eligible for board certification.

Physical Therapist (PT): A person who is a graduate of a physical therapy program approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association (AMA) and the American Physical Therapy Association (APTA) or its equivalent, is licensed by the State, and meets the requirements in MN Stat. sec. 148.70 – 148.78 and MN Rules part 5601.

Physical Therapist Assistant (PTA): A person who is a graduate of a PTA education program accredited by the APTA or a comparable accrediting agency. A PTA performs selected physical therapy treatments and related duties as delegated by the PT (MN Rules part 5601.0100).

Rehabilitative Agency: A provider certified by Medicare to provide restorative, specialized maintenance therapy, and social or vocational adjustment services.

Rehabilitative and Therapeutic Services: Restorative therapy, specialized maintenance therapy, and rehabilitative nursing services.

Rehabilitative Nursing Services: Rehabilitation nursing care as specified in MN Rules part 4658.0525.

Restorative Therapy: A health service specified in the member's plan of care, ordered by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law, and that is designed to restore the member's functional status to a level consistent with the member's physical or mental limitations.

Specialized Maintenance Therapy: A health service specified in the member's plan of care by a physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law, that is necessary for maintaining a member's functional status at a level consistent with the member's physical or mental limitations, and that may include treatments in addition to rehabilitative nursing services, as defined in MN Rules part 4658.0525.

Speech-Language Pathologist (SLP): A person who has a certificate of clinical competence in speech-language pathology from ASHA and meets the state registration requirements. Speech-language providers are required by IMCare to hold current registration with MDH.

Eligible Providers

1. Audiologist
2. CORF
3. Hearing aid service provider
4. Indian Health Service (IHS)
5. LTCF
6. Medicare-certified rehabilitation agencies
7. OT
8. Outpatient hospitals
9. PT
10. Rural Health Clinic (RHC)
11. SLP

Enrollment Requirements

Occupational Therapists (OTs)

An individual is eligible to enroll as an OT if he/she maintains applicable State licensure or is in compliance with State regulatory requirements in states that do not license.

OTs employed by outpatient hospitals, SNFs, CORFs, physician clinics, Medicare-certified rehabilitation agencies, IHS, or RHCs may enroll with IMCare. To enroll with IMCare, OTs must comply with the requirements of MN Rules part 9505.0195 and must be enrolled by Medicare.

Physical Therapists (PTs)

An individual is eligible to enroll as a PT if he/she meets the following requirements:
1. Maintains applicable State licensure requirements or is in compliance with State regulatory requirements in states that do not license
2. Graduated after successful completion of a PT education program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE), or its equivalent
3. Passed an examination for PTs approved by the State in which the PT services are provided

PTs employed by outpatient hospitals, SNFs CORFs, physician clinics, Medicare-certified rehabilitation agencies, IHS, or RHCs may enroll with MHCP. To enroll with MHCP, PTs must comply with the requirements of MN Rules part 9505.0195 and must be enrolled by Medicare.

Physical Therapists/Occupational Therapists (PTs/OTs)

An individual is eligible to enroll as an independently enrolled therapist if he/she is either a PT or an OT as defined in this chapter and not an employee of a hospital, Critical Access Hospital (CAH), SNF, home health agency, hospice, CORF, physician clinic, Community Mental Health Center (CMHC), a rehabilitation agency, or public health agency.

An independently enrolled therapist must maintain a private office even if services are furnished in a patient's home. A private office is space that is leased, owned, or rented by the practice and used for the exclusive purpose of operating the practice. For example: an independently enrolled therapist may not furnish covered services in an SNF. Therefore, if a therapist wishes to locate his/her private office on-site at an NF, the private office space may not be part of the Medicare participating SNF space and the therapist's services may be furnished only within the therapist's private office space.

Physical Therapist Assistants (PTAs) and Occupational Therapist Assistants (OTAs)

IMCare reimburses providers for the services of a PTA or an OTA when services are provided under the direction of a PT or OT. The PT or OT must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session when the PTA or OTA provides services. PTs/OTs will not be reimbursed for PTAs/OTAs providing evaluations or re-evaluations.

MHCP reimburses providers for the services of a PTA or an OTA when services are provided under the supervision of a qualified therapist as indicated below.

PTA

PTAs must do the following:

1. Have successfully completed all academic and field work requirements of a PTA program accredited by the Commission on Accreditation in Physical Therapy Education
2. Maintain State licensure requirements or be in compliance with State regulatory requirements in states that do not license PTAs

Supervision of a PTA

A qualified PT must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session when services are provided by a PTA. A PT may delegate patient treatment procedures only to a PTA who has sufficient didactic and clinical preparation. The PT may not delegate the following activities to the PTA or to other supportive personnel: patient evaluation or reevaluation, treatment planning, initial treatment, change of treatment, and initial or final documentation. A licensed PT may supervise no more than two PTAs at any time.

OTA

OTAs must do the following:

1. Be certified by the National Board for Certification of Occupational Therapy as an OTA
2. Must maintain applicable State licensure requirements or be in compliance with State regulatory requirements in states that do not license OTAs

Supervision of an OTA

An OT must determine the frequency and manner of supervision of an OTA performing treatment procedures based on the condition of the member, the complexity of the treatment procedure, and the proficiencies of the OTA.

Face-to-face collaboration between the OT and the OTA must occur, at a minimum, every two weeks, during which time the OT is responsible for the following:

1. Planning and documenting an initial treatment plan and discharge from treatment
2. Reviewing treatment goals, therapy programs, and member progress
3. Supervising changes in the treatment plan
4. Conducting or observing treatment procedures for selected members and documenting appropriateness of treatment procedures. Members will be selected based on the OT services provided to the member and the role of the OT and the OTA in those services

5. Ensuring the service competency of the OTA in performing delegated treatment procedures

Face-to-face collaboration must occur more frequently than every two weeks if necessary to meet the above requirements.

Evaluations and reevaluations will not be reimbursed if provided by OTAs.

The OT must document supervision compliance in the member's file or chart.

Speech-Language Pathologists (SLPs)

SLPs, as defined in this chapter, are eligible to enroll as independent providers if they maintain an office at their own expense. An individual completing the clinical fellowship year required for certification is not eligible to enroll as an independent SLP. An individual is eligible to enroll as an SLP if he/she meets the following requirements:

1. Maintains applicable State licensure requirements or is in compliance with State regulatory requirements in states that do not license
2. Has a Certificate of Clinical Competence in speech-language pathology from the American Speech-Language-Hearing Association, or is completing the clinical fellowship year required for certification as an SLP

SLPs employed by outpatient hospitals, SNFs, CORFs, physician clinics, Medicare-certified rehabilitation agencies, IHS, or RHCs may enroll with IMCare.

Speech-Language Pathology Assistants (SLPA)

A speech-language pathology assistant (SLPA) must satisfactorily complete either of the following education requirements:

1. An associate degree from a speech-language pathology assistant program that is accredited by the Higher Learning Commission of the North Central Association of Colleges or its equivalent as approved by the commissioner
2. A bachelor's degree in the discipline of communication sciences or disorders with additional transcript credit in the area of instruction in assistant-level service delivery practices and completion of at least 100 hours of supervised fieldwork experience as a speech-language pathology assistant student

Delegated duties

A speech-language pathology assistant may perform only those duties delegated by a licensed speech-language pathologist and must be limited to duties within the training and experience of the speech-language pathology assistant.

Duties may include the following as delegated by the supervising speech-language pathologist:

1. Help with speech-language and hearing screenings
2. Implement documented treatment plans or protocols developed by the supervising speech-language pathologist
3. Document member performance
4. Help with assessments of members
5. Help with preparing materials and scheduling activities as directed
6. Perform checks and maintenance of equipment
7. Support the supervising speech-language pathologist in research projects, in-service training, and public relations programs
8. Collect data for quality improvement

Prohibited services

A speech-language pathology assistant may **not** do any of the following:

1. Perform standardized or non-standardized diagnostic tests, perform formal or informal evaluations, or interpret test results
2. Screen or diagnose clients for feeding or swallowing disorders, including using a checklist or tabulating results of feeding or swallowing evaluations, or demonstrate swallowing strategies or precautions to members or the members' families
3. Participate in parent conferences, case conferences, or any interdisciplinary team without the presence of the supervising speech-language pathologist or other licensed speech-language pathologist as authorized by the supervising speech-language pathologist
4. Provide member or family counseling or consult with the member or the family about the member status or service
5. Write, develop, or modify a member's individualized treatment plan or individualized education program
6. Select members for service
7. Discharge members from service
8. Disclose clinical or confidential information either orally or in writing to anyone other than the supervising speech-language pathologist
9. Make referrals for additional services

A speech-language pathology assistant must not sign any formal documents, including treatment plans, education plans, reimbursement forms, or reports. The speech-language pathology assistant must sign or initial all his/her own treatment notes.

Supervision requirements

A supervising speech-language pathologist must authorize and accept full responsibility for the performance, practice, and activity of a speech-language pathology assistant.

A supervising speech-language pathologist must meet the following:

1. Be licensed under Minnesota Statutes 148.511 – 148.5196
2. Hold a certificate of clinical competence from the American Speech-Language-Hearing Association or its equivalent as approved by the commissioner
3. Have completed at least one continuing education unit in supervision

Supervision of an SLPA

A qualified speech-language pathologist must supervise a speech-language pathology assistant according to the following schedule:

1. For the first 90 work days, the SLP must supervise 30 percent of the work the SLP assistant performs within a 40-hour work week, and must directly supervise* at least 20 percent of the work.
2. For the work period after the initial 90-day period, the SLP must supervise 20 percent of the work the SLP assistant performs within a 40-hour work week, and at least 10 percent of the work performed must be under direct supervision*

* Direct supervision must be on-site, in-view observation and guidance by the supervising speech-language pathologist while the SLPA is performing a delegated duty. The supervision requirements described in this section are minimum requirements. The supervising speech-language pathologist may impose additional supervision requirements.

A supervising speech-language pathologist must be available to communicate with a speech-language pathology assistant at any time the assistant is in direct contact with a member.

A supervising speech-language pathologist must document activities the assistant performs that the supervising speech-language pathologist directly supervises. At a minimum, the documentation must include the following:
1. Information about the quality of the speech-language pathology assistant's performance of the delegated duties
2. Verification that any delegated clinical activity was limited to duties the speech-language pathology assistant is authorized to perform under this section

A supervising speech-language pathologist must review and cosign all informal treatment notes signed or initialed by the speech-language pathology assistant.

A full-time speech-language pathologist may supervise no more than one full-time speech-language pathology assistant or the equivalent of one full-time assistant.

Notification
Any agency or clinic that intends to use the services of a speech-language pathology assistant must provide written notification to the member or, if the member is younger than 18 years old, to the member's parent or guardian before a speech-language pathology assistant may perform any of the duties described in this section.

Private Practice Therapists (PPT)

Occupational therapists, physical therapists, speech-language pathologists, and audiologists are considered in private practice if they maintain a private office space at their own expense and provide services in that space or in a member's home.

Alternatively, a private practice therapist (PPT) may be employed by another supplier and furnish services in facilities provided at the expense of that supplier.

A private office is space that the practice leases, owns, or rents and uses for the exclusive purpose of operating the practice. For example, a private practice therapy practitioner may not furnish covered services in a skilled nursing facility (SNF). If a private practice therapy practitioner wishes to locate his/her private office on-site at a nursing facility, the private office space may not be part of the Medicare-participating SNF space and the therapist may provide services only within the therapist's private office space.

Private practice also includes therapists who are practicing therapy as employees of another supplier, professional corporation, or other incorporated therapy practice. Private practice does not include individuals when they are working as employees of an institutional provider

Audiologists

Audiologists, as defined in this chapter, are eligible to enroll as independent providers if they maintain an office at their own expense.

An individual is eligible to enroll as an audiologist if he/she maintains State licensure and registration requirements. If the State does not license providers of audiology services, the applicant for enrollment with IMCare must demonstrate that he/she either holds a Certificate of Clinical Compliance (CCC) from the American Speech-Language-Hearing Association (ASHA) or meets all the following clinical practicum standards:
1. Doctoral degree with an emphasis in audiology, or its equivalent as determined by the commissioner, from an accredited educational institution
2. Clinical experience as required by ASHA, the American Board of Audiology, or an equivalent as determined by the commissioner

3. Passing the national examination in audiology

Practitioners with Temporary License

A person completing the clinical fellowship year required for certification may provide audiology services or speech-language pathology services under the supervision of an audiologist or SLP but is not eligible to enroll as a provider. See specific requirements regarding supervision during clinical fellowship year. SLPs or audiologists who hold a valid temporary license to practice are not eligible to enroll as IMCare providers

Therapy Students Providing Care

Only the direct one-to-one patient contact services of the qualified therapist as defined in this section are billable when a student is involved in the delivery of services. IMCare does not reimburse for services a student performs even if the student provides the service under "line of sight" supervision of a qualified therapist. Qualified therapists may bill and be paid for providing services in the following scenarios:

1. A qualified therapist is present and in the room for the entire session. The student participates in the delivery of services when the qualified therapist is directing the treatment, making the skilled judgment, and taking responsibility for the assessment and treatment.
2. A qualified therapist is present in the room guiding the student in service delivery when the therapy student is participating in providing services, and the therapist is not engaged in treating another patient or doing other tasks at the same time. Documentation of the therapy service must clearly indicate the qualified therapist was present in the room, guiding the student in the delivery of the service(s) and not simply "on the premises." The focus of the therapist must be on the services the student is providing and not on other activities or other patients.
3. The student may complete the documentation as part of his or her education or hands-on training, but the qualified therapist is responsible for the delivery of services and the documentation and must sign all the documentation. In signing the documentation, the therapist indicates he or she has read it and is responsible for its contents. Documentation must clearly indicate the student provided the services under the therapist's direction. The student may also sign the documentation but it is not required for payment.

PTs with a valid temporary permit (MN Stat. sec. 148.71) to practice and OTs with a valid temporary license (MN Stat. sec. 148.6418) to practice may provide services under the supervision of a licensed PT/OT, but may not enroll as IMCare providers.

Supervision during Fellowship Year of Speech-Language Pathology and Audiology

1. A person completing the clinical fellowship year required for certification may provide speech-language services under the supervision of an SLP but is not eligible to enroll as a provider.
2. Services provided by another SLP employed by the SLP in private practice are not reimbursed by IMCare unless the employee is an SLP completing a clinical fellowship year.
3. A person completing the clinical fellowship year required for certification as an audiologist may provide services under the supervision of an audiologist.
4. Services performed by either an SLP or audiologist completing the clinical fellowship year required for certification are billed under the supervising SLP or audiologist and are paid the same rate as services delivered by the SLP or audiologist.
5. See specific requirements regarding supervision of fellows in MN Stat. sec. 148.515.

Eligible Members

All IMCare members are eligible. Refer to *Benefits* section for coverage determination.

Plan of Care

Rehabilitative, therapeutic, and specialized maintenance therapy and audiology services must be provided under a written treatment plan that states with specificity the member's condition, functional level, treatment objectives, and the physician's order, plans for continuing care, modifications to the plan, and the plans for discharge from treatment.

The plan of care must be reviewed and revised as medically necessary by the member's physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under State law at least once every 90 days. If the service is a Medicare-covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

The following must be documented in the member's plan of care:
1. The medical diagnosis and any contraindications to treatment
2. A description of the member's functional status/limitations
3. Treatment plan including interventions to be provided
4. Outcomes of the rehabilitative and therapeutic services, including treatment goals that are functional, measurable, and time-specific
5. Projected frequency and duration of treatment
6. Plans for discharge from treatment
7. A description of the member's progress toward the outcomes for subsequent plan of care: Home program teaching, collaboration with other professionals and services, progress toward goals with updates as indicated, modification to the initial plan of care, plans for continuing care

Member's Record of Services

Providers must document all evaluations, services provided, member progress, attendance records, and discharge plans. Documentation must be kept in member's records. The record of services must contain the following:
1. The date, type, length, and scope of each rehabilitative and therapeutic service provided to the member
2. The name or names and titles of the people providing or supervising each rehabilitative and therapeutic service
3. A statement every 30 days by the therapist providing or supervising the services provided to a long-term care member that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the member in accordance with Minnesota Statutes (not required for an initial evaluation)

See documentation requirements as specified in Chapter 2, Health Care Programs and Services.

Covered Services

To be covered as a rehabilitative and therapeutic service:
1. Physical therapy and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law.
2. Speech-language pathology and audiology services must be provided:
   a. Upon written referral by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law, or in the case of a LTCF resident, on the written order

of a physician; and
   b. By an SLP, audiologist, or a person completing the clinical fellowship year required for certification as an SLP or audiologist under the supervision of an SLP or audiologist as specified in MN Stat. sec. 148.515, subd. 4.
3. Occupational therapy and physical therapy must require the skills of a PT, OT, or therapy assistant that is under the direction of a PT or an OT. The PT or OT must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session when the therapy assistant provides services.
4. Treatment must be specified in a plan of care that is reviewed and revised as medically necessary by the member's attending physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days (see *Plan of Care* section in this chapter for additional requirements).
5. The member's functional status must be expected by the physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law to progress toward or achieve the objectives in the member's plan of care within a 90-day period.

Members who are eligible for both IMCare and Medicare may not receive services from SLPs in private practice because these providers may not enroll as a provider with Medicare. Private practice SLPs must refer dually eligible members to Medicare-eligible providers.

Services provided by rehabilitation agencies must be provided at a site surveyed by MDH and certified according to Medicare standards, or at a site that meets State Fire Marshall standards, as documented in the providers' records, or at the member's residence. However, if services are provided to Medicare-eligible members, providers must comply with Medicare's site requirements.

Specialized Maintenance Therapy

Specialized maintenance therapy coverage is limited to IMCare members ages 20 and under. Specialized maintenance therapy is covered only when it is provided by a PT, OT, therapy assistant, or SLP, specified in a plan of care that meets the requirements of this chapter, and provided to members whose condition cannot be maintained or treated only through rehabilitative nursing services, as defined in MN Rules part 4658.0525, or services of other care providers, or by the member because the member's physical, cognitive or psychological deficits result in:
1. Spasticity or severe contracture that interferes with the activities of daily living (ADL) or the completion of routine nursing care, or decreased functional ability compared to the member's previous level of function; or
2. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, ADLs, cardiovascular function, integumentary status, or positioning necessary for completion of the member's ADLs, or decreased abilities relevant to the member's current environmental demands.

Specialized maintenance therapy must have expected outcomes that are:
1. Functional
2. Realistic
3. Relevant
4. Transferable to the member's current or anticipated environment, such as home, school, community, work
5. Consistent with community standards

Specialized maintenance therapy must meet at least one of the following characteristics:
1. Prevent deterioration and sustain function;
2. Provide interventions, in the case of a chronic or progressive disability, that enable the member to live at

his/her highest level of independence; or
3. Provide treatment interventions for members who are progressing but not at a rate comparable to the expectations of restorative care.

Standards for Augmentative Communication Devices (E2500 – E2599)

Augmentative Communication Device: A device dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a member with severe expressive communication disorders (e.g., communication picture books, communication charts and boards, and mechanical/electronic devices). Devices requested for the sole purpose of education will not be approved.

1. Augmentative communication devices are obtained from medical equipment and supply providers and manufacturers of augmentative communication devices.
2. Technical services, such as repairs, are covered. Bill repairs with the augmentative communication device Healthcare Common Procedure Coding System (HCPCS) code and the repair modifier (RB). Labor time (number of hours) for repairs is billed with the HCPCS labor code. Include device model number and itemized statement describing each element of the repair service.
3. Indirect time spent programming, upgrading, modifying, or setting up an augmentative communication device or communication/picture book for a member is not billable. Only direct time spent with the member is billable and documentation in the patient's records must support the need for face-to-face involvement.

Criteria for Authorization of Augmentative Communication Devices

Refer to Chapter 23, Equipment and Supplies, for specific information about authorization criteria for Augmentative Communication Devices.

Non-Covered Services Relating to Augmentative Communication Devices

1. Augmentative communication/speech-generating devices requested for the sole purpose of education
2. Environmental control devices such as switches, control boxes, or battery interrupters
3. Modification, construction, programming, or adaptation of communication systems
4. Repairs, cleaning, or other services for devices that are not dedicated communication devices
5. Upgrading to new technology that is not proven to be medically necessary
6. Replacing devices based on the manufacturer's recommended replacement schedule (i.e., every five years)
7. Facilitated communication: a technique by which a "facilitator" provides physical and other supports in an attempt to assist a person with a significant communication disability to point to pictures, objects, and printed works or letters (IMCare does not cover facilitated communication by any provider)
8. Personal computers, laptop computers, electronic tablets such as, iPods and iPads, and other personal media players that are not dedicated communication devices
9. Telephones
10. Carry cases when a mounting system has been provided

Augmentative Communication Device Billing Procedures*

1. 92597: Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
2. 92605: Evaluation for prescription of non-speech-generating augmentative and alternative communication device
3. 92606: Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
4. 92607: Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
5. 92608: Evaluation for prescription for speech-generating augmentative and alternative communication

device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
6. 92609: Therapeutic services for the use of speech-generating device, including programming and modification
7. 92618: Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)

*Refer to the speech-language pathology thresholds in this chapter for information on the number of units available without authorization.

Rehabilitation Services Thresholds

The following instructions apply to rehabilitative, therapeutic, and audiology services provided to IMCare members living in the community or an LTCF.
1. Audiology service thresholds are by calendar year (see *Rehabilitation Services Billing Threshold Chart* in this chapter).
2. Medicare crossover claims for the payment of member's coinsurance and/or deductible are not included or counted in the threshold limits; but
3. Third-party liability claims sent to IMCare for payment after other coverage paid will go toward the threshold limits.
4. A unit can be per session or a timed unit. Each unit will decrement against the threshold.
5. All IMCare Classic (HMO SNP) members will have the Medicare therapy cap (dollar limit) when they have Medicare coverage (including members residing in a nursing home). Once the dollar limit is reached on the therapy cap, if the provider evaluates the member and determines that there is continued need for skilled therapy, IMCare will continue to cover under the Medicare rates as long as the code is accompanied by the KX modifier, following the Medicare Improvements for Patients and Providers Act of 2008.
    a. The KX modifier is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record. If the member is in Minnesota Senior Care Plus (MSC+) and Medicare is his/her primary insurance, IMCare is not the payer for the Medicare portion. You will need to follow Medicare rules on therapy caps.

Non-Covered Services

1. Physical or occupational therapy that is provided without a prescription from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law
2. Speech-language or audiology services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law
3. Services for contracture that are not severe and do not interfere with the member's functional status or the completion of nursing care as required for licensure of the LTCF*
4. Ambulation of a member who has an established functional gait pattern*
5. Services for conditions of chronic pain that do not interfere with the member's functional status and that can be treated by routine nursing measures*
6. Services for ADLs when performed by the therapist, therapy assistant, or therapy aide*
7. Bowel and bladder retraining programs*
8. Art and craft activities for the purpose of recreation
9. Services not medically necessary
10. Services not documented in the member's health care record
11. Services not part of the member's plan of care
12. Services specified in a plan of care that is not reviewed and revised as medically necessary by the member's attending physician

13. Services that are not designed to improve or maintain the functional status of a member with a physical impairment or a cognitive or psychological deficit
14. Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's IEP
15. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements
16. Vocational or educational services, including functional evaluations and IEP-related services
17. Services provided by a therapy aide or therapy student (see the ***Therapy Students Providing Care*** section)
18. Psychosocial services
19. Record keeping documentation and travel time (the transport and waiting time of a member to and from therapy sessions)
20. Services provided by a rehabilitation agency that takes place in a sheltered workshop, Day Training and Habilitation (DT&H) center, Day Activity Center (DAC), or a residential or group home that is an affiliate of the rehabilitation agency
21. Yearly assessments of long-term care (LTC) residents to meet Omnibus Budget Reconciliation Act (OBRA) regulations*
22. Training or consultation provided by an audiologist to an agency, facility, or other institution
23. Work Hardening Programs

*These items are considered rehabilitative nursing and are part of the LTCF per diem payment.

Authorization

A Service Authorization is always required prior to providing the following services:
1. Analysis of a cochlear implant done by an SLP (92601 GN, 92602 GN, 92603 GN, 92604 GN).
2. Physical performance test to determine functional evaluation (97750). We do not cover functional capacity assessments for vocational or educational purposes.
3. Providing an augmentative communication device (see Chapter 23, Equipment and Supplies).
4. Once the threshold has been met for audiology services, authorization must be obtained before providing services beyond the threshold.

Authorization Criteria and Documentation

Documentation submitted with the authorization form should:
1. Be readable, photocopied material
2. Be arranged in chronological order
3. Match requested services

Billing

See Chapter 4, Billing Policy, for specific billing requirements.

Rehab Billing Entity

Use the organization's National Provider Identifier (NPI) as the pay-to-provider and report the individual NPI of the therapist providing the service as the rendering or treating provider on the claim.

Independently Enrolled Providers

1. Independently enrolled PTs, OTs, SLPs, or audiologists: Bill only for services you provide.

2. Use your individual NPI to bill for services.
3. Independently enrolled SLPs: Advise dual eligible Medicare/Medicaid members to seek treatment from providers enrolled with both Medicare and MHCP.
4. Independently enrolled audiologists: bill for services provided in your own office, the member's home, LTCF(s), or at DT&H center(s).

Therapy Services Provided in Facility Settings

For therapy purposes, a facility setting includes a physician clinic, outpatient hospital, Community Public Health Clinic, rehabilitation agency, CORF, and CAH.

1. Bill physical therapy, occupational therapy, speech-language pathology, and audiology services provided by employees in a facility setting using the facility or agency's NPI.
2. Outpatient hospital services may only be provided in an outpatient hospital facility.

Rehabilitative Services Provided in a Long-Term Care Facility (LTCF)

LTCFs may provide rehabilitative services to their residents and members of the community, using either their own staff or by contracting with an outside service vendor (rehabilitation agency).

Rehabilitative services are not covered by all major programs. Services must be provided on the premises.

IMCare will not make separate reimbursement for therapy services for residents of an LTCF that includes therapy as part of its per diem rate.

Use the following criteria to determine the correct billing method to use.

Employees of the Long-Term Care Facility (LTCF)
The LTCF bills services provided by PT, OT, or SLP employees.
1. Use either the CMS-1500 or UB-04.
2. Enter the LTCF's NPI.
3. If Medicare requires the LTCF to bill for Medicare-covered rehabilitative services for dually eligible members, follow Medicare requirements until Medicare benefits are exhausted.

Contracted Rehabilitation Services
The rehabilitation agency or the LTCF may bill physical therapy, occupations therapy, or speech-language pathology services provided by a rehabilitation agency, or provided by an independently enrolled PT, OT, or SLP at an LTCF. The rehabilitation agency or the LTCF designated to do the billing must bill for all rehabilitative services.

1. When rehabilitation agencies bill for services:
   a. Use the 837P or 837I format
   b. Enter the rehabilitation agency's NPI
   c. Enter the LTCF's NPI in FL 83
2. When LTCFs bill for services:
   a. Use the 837P or 837I format
   b. Enter the LTCF's NPI
   c. If Medicare requires the LTCF to bill for Medicare-covered rehabilitative services for dually eligible members, follow Medicare's requirements until Medicare benefits are exhausted
   d. Services provided by an independently enrolled SLP contracted with a LTCF must be billed by the LTCF

3. When independently enrolled PT/OT bills for services:
   a. Use the 837P or 837I format
   b. Enter the therapist's individual NPI
   c. If Medicare requires the LTCF to bill for Medicare-covered rehabilitative services for dually eligible members, follow Medicare's requirements until Medicare benefits are exhausted

The provider billing for and receiving payment for services is responsible for the accuracy of the claims and for maintaining patient records that fully disclose the extent of the benefits provided.

Codes and Modifiers

1. IMCare uses outpatient rehabilitative services codes as defined in Current Procedural Terminology (CPT)/HCPCS as billable in timed units (15 minutes, 30 minutes, 1 hour). Bill outpatient rehabilitative services with appropriate units.
   a. Bill CPT/HCPCS codes that do not have a timed component/unit as one unit per visit, regardless of the time spent.
   b. Bill only one unit for any date of service (DOS) that is a "per visit/session" code.
   c. Do not bill for services represented by 15-minute timed codes when performed for less than eight minutes on any date of service
   d. Follow billing guidelines in the following table only for services spent directly with the recipient
   e. Bill only direct patient contact by the provider as time the patient is treated
   f. Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.

If the duration for each service performed equals:	**Bill this number of units:**	**Notes:**
8 – 22 minutes	1	Do not bill for services you perform for less than eight minutes. If a service represented by a 15-minute timed code is performed in a single day for at least 8 – 22 minutes, bill that service as one unit. If you perform the same service for at least 23 minutes, bill that service for at least two units, etc. Billable units are not determined by total session time.
23 – 37 minutes	2	
38 – 52 minutes	3	
53 – 67 minutes	4	
68 – 82 minutes	5	
83 – 97 minutes	6	
98 – 112 minutes	7	
113 – 127 minutes	8	

2. Use the correct HCPCS code and appropriate modifier from the *Casting & Splinting Supplies* chart to bill occupational therapy supplies fabricated by the therapist, such as splints, casts, and adaptive aids. Do not bill for ready-made supplies or for prefabricated supplies that can be obtained from a medical supplier.

3. Use the following modifiers to indicate which discipline delivered the service for all outpatient rehabilitative services and authorizations:
   a. GN – speech-language pathology
   b. GO – occupational therapy
   c. GP – physical therapy
4. Use modifier U7 on claims (not required on authorization requests), in addition to the required modifiers to indicate the service was provided by a physical or occupational therapy assistant
5. Use modifier UC only to indicate that the therapy service provided was specialized maintenance therapy. Document specialized maintenance therapy in the patient's record.
6. When services are delivered to a member by two or more therapists in the same block of time (co-therapy session), split the time so that the total time billed does not exceed the actual length of the session.
7. Always follow Medicare guidelines for IMCare members who are dually eligible for Medicare and Medicaid when providing Medicare-covered services.

Occupational Therapy, Physical Therapy, and Speech-Language Pathology		
Code	**Required Modifier**	**Description**
90901	GO, GP	Biofeedback training by any modality. For billing electromyography biofeedback only. Not to be used to bill nerve impulse, blood pressure, blood flow, brain waves, or oculogram biofeedback. Description of service must be included on claim.
90911		Biofeedback training, perineal muscles, anorectal or urethral sphincter, including electromyography (EMG) and/or manometry
92507	GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508		Group, 2 or more individuals
92521	GN	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	GN	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	GN	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	GN	Behavioral and qualitative analysis of voice and resonance
92606	GN	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification
92609	GN	Therapeutic services for the use of speech-generating device, including programming and modification
92526	GN, GO	Treatment of swallowing dysfunction and/or oral function for feeding
92626	GN	Evaluation of auditory rehabilitation status; first hour
92627		Each additional 15 minutes (List separately in addition to code for primary procedure)
92630		Auditory rehabilitation; pre-lingual hearing loss
92633		Post-lingual hearing loss
92700	GN	Unlisted otorhinolaryngological service or procedure
97532	GN, GO, GP	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct patient contact by provider – 15 minutes
97533		Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by provider – 15 minutes
92597	GN	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92605		Evaluation for prescription of non-speech-generating augmentative and alternative communication devices

Occupational Therapy, Physical Therapy, and Speech-Language Pathology		
Code	**Required Modifier**	**Description**
92607		Evaluation for prescription speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
92608		Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
92618	GN	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
92610	GN, GO	Evaluation of oral and pharyngeal swallowing function
92611		Motion fluoroscopic evaluation of swallowing function by cine or video recording
92612	GN	Flexible fiber optic endoscopic evaluation of swallowing by cine or video recording
92614		Flexible fiber optic endoscopic evaluation, laryngeal sensory testing by cine or video recording
92616		Flexible fiber optic endoscopic evaluation of swallowing
95831	GP, GO	Muscle testing manual extremity
95832		Hand
95833		Total evaluation of body, excluding hands
95834		Total evaluation of body, including hands
95851	GP, GO	Range of motion measure and report; each extremity (excluding hand) or each trunk section
95852		Range of motion measurement – hand with or without comparison to normal side
96105	GN	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing [e.g., by Boston Diagnostic Aphasia Examination]) with interpretation and report, per hour
96110	GO, GN, GP	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report
96125		Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96111		Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report
97161	GP	Physical therapy evaluation, low complexity
97162	GP	Physical therapy evaluation, moderate complexity
97163	GP	Physical therapy evaluation, high complexity
97164	GP	Physical therapy re-evaluation, EST plan care
97165	GO	Occupational therapy evaluation, low complexity
97166	GO	Occupational therapy evaluation, moderate complexity
97167	GO	Occupational therapy evaluation, high complexity

Occupational Therapy and Physical Therapy		
Code	**Required Modifier**	**Description**
Unattended Modalities		
97010	GP, GO	Hot or cold packs
97012		Traction
97014		Electrical stimulation
97016		Vasopneumatic devices
97018		Paraffin bath
97022		Whirlpool
97024		Diathermy
97026		Infrared
97028		Ultraviolet
G0283		Electrical stimulation to one or more areas for indication(s) other than wound care, as part of a therapy plan of care – do not bill with 97014
Attended Modalities: Require Constant Attendance of Therapist		
95992	GO, GP	Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day
97032		Application of a modality to one or more areas; electrical stimulation – 15 minutes
97033		Iontophoresis – 15 minutes
97034		Contrast bath – 15 minutes
97035		Ultrasound – 15 minutes
97036		Hubbard tank – 15 minutes
Therapeutic Techniques with Direct Patient Contact		
97110	GO,GP	Therapeutic procedure, exercises – 15 minutes
97112		Neuromuscular (use for Canalith repositioning) – 15 minutes
97113		Aquatic therapy – 15 minutes
97116		Gait training – 15 minutes
97124		Massage – 15 minutes
97140		Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions – 15 minutes
97530		Therapeutic activities – 15 minutes
97532		Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct patient contact by provider – 15 minutes
97533		Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by provider – 15 minutes
97535		Self-care home management training (e.g., ADL compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) – 15 minutes
97537		Community work reintegration training (e.g., shopping, transportation, money management, vocational activities) – 15 minutes
97542		Wheelchair management propulsion training – 15 minutes
Wound Care		
97597	GO,GP	Removal of devitalized tissue from wound(s) selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s) for ongoing to 20 square centimeters

Occupational Therapy and Physical Therapy		
Code	**Required Modifier**	**Description**
97598	GO, GP	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirl pool, per session; total wounds(s) surface area greater than 20 square centimeters
97602		Removal of devitalized tissues from wound(s), non-selective debridement, without anesthesia (e.g., Wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care
97605		Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), including topical application(s), wound assessment, and instruction(s), wound assessment, and instruction(s) for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters
97606		Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97607		Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing disposable, non-durable medical equipment, including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97608		Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing disposable, non-durable medical equipment, including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
97610		Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instructions for ongoing care, per day
Orthotic/Prosthetic: Assessment and Training		
97760	GO, GP	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk – 15 minutes
97761		Prosthetic training, upper and/or lower extremity(s) – 15 minutes
97799		Unlisted physical medicine/rehabilitation service or procedure – Requires a description or claim attachment
97762		Checkout for orthotic/prosthetic use, established patient – 15 minutes
Evaluative/Therapeutic/Rehabilitative		
92606	GN	Therapeutic service(s) for the use of non-speech generating device, including programming and modification
92609		Therapeutic services for the use of speech-generating device, including programming and modification
92700		Unlisted otorhinolaryngological service or procedure

Occupational Therapy and Physical Therapy		
Code	**Required Modifier**	**Description**
96125	GN, GO	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting the test results and preparing the report.
97039	GO, GP	Unlisted modality – Requires a description or claim attachment; specify type and time if constant attendance
97139		Unlisted therapeutic procedure – 15 minutes
97150		Therapeutic procedures group, two or more people
97545 **Not covered through IMCare**		Work hardening/conditioning, initial 2 hours
97546 **Not covered through IMCare**		Work hardening, each additional hour
97750 **Service authorization required**		Physical performance test or measurement (functional capacity) – 15 minutes
97755		Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional task, and/or maximize environmental accessibility), direct one-to-one contact by provider, with written report, each 15 minutes
97799		Unlisted physical medicine/rehabilitation service or procedure – Requires a description or claim attachment

Speech-Language Screening		
Code	**Required Modifier**	**Description**
V5362	GN	Speech screening (articulation)
V5363		Language screening (receptive or expressive)
V5364		Dysphagia screening

Casting and Strapping Services/Supplies The services listed in *this* grid do **not** have an authorization requirement		
Code	**Required Modifier**	**Description**
29065	GO, GP	Application, cast; shoulder to hand (long arm)
29075		Elbow to finger (short arm)
29085		Hand and lower forearm (gauntlet)
29086		Finger (e.g., contracture)
29105		Application of long arm splint (shoulder to hand)
29125		Application of short arm splint (forearm to hand); static

29126		Dynamic
29130		Application of finger splint; static
29131		Dynamic
29200		Strapping; thorax
29240		Shoulder (e.g., Velpeau)
29260		Elbow or wrist
29280		Hand or finger
29345		Application of long leg cast (thigh to toes)
29355		Walker or ambulatory type
29365		Application of cylinder cast (thigh to ankle)
29405		Application of short leg cast (below knee to toes)
29425		Walking or ambulatory type
29445		Application of short leg cast (below knee to toes)
29505		Application of long leg splint (thigh to ankle or toes)
29515		Application of short leg splint (calf to foot)
29520		Strapping; hip
29530		Knee
29540		Ankle and/or foot
29550		Toes
29580		Unna boot
29581		Application of multi-layer venous would compression system, below knee
29582		Thigh and leg, including ankle and foot, when performed
29583		Upper arm and forearm
29584		Upper arm, forearm, hand, and fingers

Casting and Splinting Supplies

There are no requirements for medical authorization of casting or splinting supplies provided by physical therapists and occupational therapists in the course of providing rehabilitative services.

Code	**Required Modifier**	**Description**
Q4017	GP, GO	Cast supplies; long arm splint, adult (11 years+), plaster
Q4018		Long arm splint, adult (11 years+), fiberglass
Q4019		Long arm splint, pediatric (0 – 10 years), plaster
Q4020		Long arm splint, pediatric (0 – 10 years), fiberglass
Q4021		Short arm splint, adult (11 years+), plaster
Q4022		Short arm splint, adult (11 years+), fiberglass
Q4023		Short arm splint, pediatric (0 – 10 years), plaster
Q4024		Short arm splint, pediatric (0 – 10 years), fiberglass
Q4041		Long leg splint, adult (11 years+), plaster
Q4042		Long leg splint, adult (11 years+), fiberglass
Q4043		Long leg splint, pediatric (11 years+), plaster
Q4044		Long leg splint, pediatric (11 years+), fiberglass
Q4045		Short leg splint, adult (11 years+), plaster
Q4046		Short leg splint, adult (11 years+), fiberglass
Q4047		Short leg splint, pediatric (0 – 10 years), plaster
Q4048		Short leg splint, pediatric (0 – 10 years), fiberglass
Q4049		Finger splint, static
Q4051		Splint supplies, misc. (includes thermoplastics, strapping, fasteners, padding, and other supplies)

Orthotic Procedures	
Procedure Code	**Description**
Orthotic Devices – Cervical-Thoracic-Lumbar-Sacral (CTLSO)	
L0623	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
Spinal Orthosis	
L0999	Addition to spinal orthosis, not otherwise specified; requires authorization always
Lower Limb Hip Orthotic (HO), Knee Orthotic (KO), Ankle-foot Orthotic (AFO)	
L1610	HO, abduction control of hip joints, flexible, prefabricated, includes fitting and adjustment
L1620	HO, abduction control of hip joints, flexible, prefabricated, includes fitting and adjustment
L1650	HO, abduction control of hip joints, static, adjustable, prefabricated, includes fitting and adjustment
L1652	HO, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type
L1660	HO, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment
L1686	HO, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustments
L1690	Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment
L1810	KO, elastic with joints, prefabricated, includes fitting and adjustment
L1820	KO, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment
L1830	KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment
L1831	KO, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
L1832	KO, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes fitting and adjustment
L1836	KO, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment
L1843	KO, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment
L1847	KO, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment
L1850	KO, Swedish type, prefabricated, includes fitting and adjustment
L1902	AFO, ankle gauntlet, prefabricated, includes fitting and adjustment
L1906	AFO, multipligamentus ankle support, prefabricated, includes fitting and adjustment
L1910	AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment
L1930	AFO, plastic or other material, prefabricated, includes fitting and adjustment
L1932	AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment

Orthotic Procedures	
Procedure Code	**Description**
L1951	AFO, spiral, plastic or other material, prefabricated, includes fitting and adjustment
L1971	AFO, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L2005	KAFO, any material, single or double upright, stance control, automatic Lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated
L2035	KAFO, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment
Upper Limb, Shoulder Orthotic (SO)	
L3650	SO, figure of 8 design, prefabricated, includes fitting and adjustment
L3660	SO, figure of 8 design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment
L3670	SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment
L3671	SO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3674	SO, abduction positioning (airplane design), thoracic component and support bar, with or without non-torsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3675	SO, vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment
L3677	SO, hard plastic, should stabilizer, includes fitting and adjustment
Elbow Orthotic (EO)	
L3702	EO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3710	EO, elastic with metal joints, prefab, includes fitting and adjustment
L3720	EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated
L3730	EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated
L3740	EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated
L3760	EO, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments any type
L3762	EO, rigid, without joints includes soft interface material, prefabricated, includes fitting and adjustment
L3763	Elbow-wrist-hand orthotic (EWHO), rigid, without joints may include soft interface, straps, custom fabricated, includes fitting and adjustment

Orthotic Procedures	
Procedure Code	**Description**
L3764	EWHO, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765	Elbow-wrist-hand-finger orthotic (EWHFO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3766	EWHFO, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
Wrist-Hand-Finger Orthotic (WHFO)	
L3806	WHRO, includes one of more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L3807	WHFO, without joint(s), prefabricated, includes fitting and adjustments, any type
L3808	WHFO, rigid without joints, may include soft interface material; straps, custom fabricated includes fitting and adjustment
Dynamic Flexor Hinge, Reciprocal Wrist Extension/Flexion, Finger Flexion/Extension (WHFO)	
L3900	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion;/extension, wrist or finger driven, custom fabricated
L3901	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated
External Power	
L3904	WHFO, external powered, electric, custom fabricated
L3905	Wrist-hand orthotic (WHO), includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
Other – Custom Fitted	
L3906	WHO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3908	WHO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment
L3912	Hand-finger orthotic (HFO), flexion glove with elastic finger control, prefabricated, includes fitting and adjustment
L3913	HFO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3915	WHO, includes one or more non-torsion joints(s), elastic bands, turnbuckles, may include soft interface, straps prefabricated, includes fitting and adjustment
L3917	Hand orthotic (HO), metacarpal fracture orthotic, prefabricated, includes fitting and adjustment
L3919	HS, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3921	HFO, includes one or more non-torsion joints, elastic bands turnbuckles, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3923	HFO, without joints, may include soft interface, straps, prefabricated, includes fitting and adjustment
L3925	Finger orthotic (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), non-torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment

L3927	FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment
L3929	HFO, includes one or more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment
L3931	WHFO, includes one or more non-torsion joint(s), turnbuckles, elastic band/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment
L3933	FO, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3935	FO, non-torsion joint, may include soft interface, custom fabricated, includes fitting and adjustment
L3956	Addition of joint to upper extremity orthosis, any material; per joint
Shoulder-Elbow-Wrist-Hand Orthosis (SEWHO)	
L3960	SEWHO, abduction positioning, airplane design, prefabricated, includes, fitting and adjustment
L3961	SEWHO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3962	SEWHO, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment
L3967	SEWHO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
Additions to Mobile Arm Supports	
L3971	SEWHO, shoulder cap design, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3973	SWEHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3974	SEO, addition to mobile arm support, supinator
L3975	SEWHO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3976	SEWHO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977	SEWHO, shoulder cap design, include one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978	SEWHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface straps, custom fabricated, includes fitting and adjustment
Fracture Orthoses	
L3980	Upper extremity fracture orthotic, humeral, prefabricated, includes fitting and adjustment
L3981	Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments
L3982	Upper extremity fracture orthotic, radius/ulnar, prefabricated, includes fitting and adjustment
L3984	Upper extremity fracture orthotic, wrist, prefabricated, includes fitting and adjustment
L3995	Addition to upper extremity orthotic, sock, fracture or equal, each

L3999	Upper limb orthosis, not otherwise specified
Specific Repair/Repairs	
L4002	Replacement strap, any orthotic, includes all components, any length, any type
L4205	Repair of orthotic device, labor component, per 15 minutes
L4210	Repair of orthotic device, repair or replace minor parts
L4350	Ankle control orthosis stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment
L4360	Walking boot, pneumatic, and/or vacuum, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4370	Pneumatic full leg splint, prefabricated, includes fitting and adjustment
L4386	Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4392	Replacement soft interface material, static AFO
L4394	Replace soft interface material, foot drop splint
L4396	Static ankle-foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment
L4398	Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment
Additions: Upper Limb	
L6624	Upper extremity addition, flexion/extension and rotation wrist unit

Audiology Service Thresholds		
Code	**Description**	**Threshold**
92506	Evaluation of speech, language, voice, communication, and/or auditory processing	
92531 – 92547	Audiologic function tests	No limit; bill 1 treatment session per test
92550 – 92557		
92560 –92588		
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emission), automated analysis	
92601	Diagnostic analysis of cochlear implant, patient under age 7 years; with programming	
92602	Subsequent reprogramming	
92603	Diagnostic analysis of cochlear implant, age 7 years or over; with programming	
92604	Subsequent reprogramming	
92620	Evaluation of central auditory function, with report; initial 60 minutes	
92621	Each additional 15 minutes	
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	
92700	Unlisted otorhinolaryngological service or procedure.*	No authorization requirement or threshold for audiology providers.

Audiology Service Thresholds		
Code	**Description**	**Threshold**
92590	Monaural hearing aid exam and selection	1 treatment session per calendar year, any combination of codes
92591	Binaural hearing aid exam and selection	1 treatment session per calendar year, any combination of codes
92592	Monaural hearing aid check – service includes cleaning; do not bill cleaning separately. Do not bill with V5011.	4 checks per calendar year; 1 unit maximum per check Claims with DOS prior to 90 days following the dispensing date will deny. May not be billed during trial period.
92593	Binaural hearing aid check – service includes cleaning; do not bill cleaning separately. Do not bill with V5011.	
92594	Electroacoustic evaluation for monaural hearing aid	
92595	Electroacoustic evaluation for binaural hearing aid	
92596	Ear protector attenuation measurement	
92510	Aural rehabilitation following cochlear implant	Counts toward SLP 80 treatment session service threshold

*Each modality equals one treatment session.

Hearing Aids

Hearing services are an IMCare-covered service. Before providers are reimbursed for hearing aid assessments or dispensing, a physician, physician assistant, or nurse practitioner must rule out medical or surgical indications contrary to fitting the member with a hearing aid. After ruling out contraindications, the physician then refers the member for an audiologic evaluation to determine if a hearing aid is necessary. An audiologist or otolaryngologist must provide the audiologic testing and, if a hearing aid is indicated, prescribe a specific hearing aid offered under the hearing aid volume purchase contract. An individual who is enrolled as a hearing aid dispenser, but is not an audiologist or otolaryngologist, may not perform audiologic evaluations or prescribe hearing devices.

The hearing aid service provider must dispense the hearing aid according to the hearing aid exam, selection, and prescription of the otolaryngologist and audiologist. The member is to see an audiologist within the hearing aid trial period so that the audiologist may determine the effectiveness of the hearing aid.

In addition to reimbursement for dispensing hearing aids, hearing aid service providers may bill for the following:

1. Batteries
2. Ear impressions
3. Ear molds for hearing aids
4. Hearing aid checks (programming/reprogramming)
5. Hearing aid repairs
6. Parts and accessories

7. Re-casing, remakes, shell modifications
8. Replacing battery doors and microphone protectors
9. Cochlear implants

Hearing aid service providers are not separately reimbursed for audiologic evaluations, hearing aid exams and selection, hearing aid checks to determine the effectiveness of the hearing aid, or home visits.

Enrolled Hearing Aid Dispensers

1. An individual may enroll as a hearing aid service provider if he/she is certified by MDH as a hearing instrument dispenser.
2. Out-of-state hearing aid service providers who do not sell hearing aids/instruments in Minnesota must comply with licensing or registration requirements of the other state, but are not required to be certified in Minnesota.

Covered Services

Hearing Aid Volume Purchase Contract

Hearing aids must be provided by a contracted hearing aid service provider. Hearing aid service providers are paid the contract price plus a dispensing fee. Terms of the hearing aid contract are outlined below. Hearing aids must:

1. Be new, current production models.
2. Be complete instruments, including all necessary equipment to make it fully functional, carrying case, and all items necessary for a proper fit.
3. Use standard commercial batteries and battery sizes.
4. Be accompanied by a live performance graph and invoice at the contracted price.
5. Have a minimum 24-month manufacturer warranty covering parts and labor. The warranty is exclusive of the ear piece, cord, and batteries.
6. Have a one-year loss and damage warranty.

Hearing aids **do not** include ear molds and accessories not included in the cost of the hearing aid but that are necessary to the member's use of the hearing aid. Ear molds and ear impressions are billable for behind-the-ear (BTE) aids.

No extra charge may be made for specially molded ear pieces or ear molds, casing color choice, or hypo-allergenic or soft canal casing.

Accessories including chest harnesses, tone and ear hooks, carrying cases, T-coils, audio boots, neck loops, etc., are billable when not included in the price of the hearing aid (check the contract for hearing aid features included in the price).

Hearing aids that do not prove satisfactory to a user are to be returned to the manufacturer within 90 days from the date the hearing aid is provided to the member at no cost to IMCare or the hearing aid dealer. IMCare requires that:

1. The contract price for a hearing aid cannot be further reduced or altered.
2. Orders for IMCare hearing aids may not be used to obtain, or grant, additional commercial discounts.
3. Manufacturers will not process hearing aid orders unless requirements are met.
4. The manufacturer may not charge extra for packaging, postage, insurance, or handling while the aid is under warranty.

Hearing Aids Not on Volume Purchase Contract List (Non-Contract Aids)

Hearing aid service providers must provide hearing aids under the terms of the volume purchase contract. If the

audiologist prescribes a non-contract hearing aid, the hearing aid service provider must obtain authorization by providing either:

1. Reasons the contract aids will not meet the member's needs; or
2. Reasons the non-contract aid will meet the member's needs (describe extenuating circumstances that eliminate the possible use of a contract aid).

For repairs of non-contract hearing aids, refer to the *Hearing Aid Repairs* section in this chapter.

Dispensing Fee

IMCare will reimburse the hearing aid service provider one dispensing fee every five calendar years for fitting and dispensing a monaural or set of binaural hearing aids for a member. Claims are not eligible for payment until after the hearing aid has been dispensed. The dispensing fee includes:

1. Adjusting the hearing aid to the wearer, including the necessary programming on digital and digitally programmable aids;
2. Provision of at least three hearing aid batteries of the type necessary to operate the hearing aid;
3. Informing the member of the trial period;
4. Instructing and counseling the member on use and care of the hearing aid;
5. A written copy of the manufacturer's warranty;
6. Returning the hearing aid to the manufacturer for repair during the 24-month warranty period for parts and labor; and
7. Replacing the aid during the 12-month replacement warranty period.

When billing dispensing fees for contralateral routing of signal (CROS) amplification systems from the volume purchase contract, use HCPCS code V5110. CROS and bilateral microphones with contralateral routing of signal (BiCROS) amplification systems now include a hearing aid. Continue to use V5240 for BiCROS systems. When billing a dispensing fee for a frequency modulation (FM) system, use HCPCS code V5090.

Hearing Aid Trial Period

The trial period for new hearing aids is 90 days. Hearing aids obtained under the volume purchase contract that are not satisfactory to the user may be returned to the manufacturer within 90 days after the dispensing date, but no sooner than 30 days.

The trial period consists of consecutive days beginning the day the hearing aid is provided to the member and must extend at least 30 days, but no more than 90 days. The hearing aid service provider must inform the member of the beginning and ending dates of the trial period, and refer the member to the prescribing audiologist when the aid cannot be adjusted to the member's satisfaction. If the audiologist prescribes a hearing aid to replace the unsatisfactory aid, the hearing aid service provider must order the prescribed replacement aid.

Hearing Aid Replacement

IMCare covers one hearing aid or set of binaural hearing aids within a period of five years for an eligible member. If hearing aids must be replaced more often due to change in hearing, or hearing aid loss, theft, or irreparable damage, the provider must request authorization for a new aid. IMCare considers the member's physical or mental impairment in determining whether circumstances were beyond the member's control if the aid is lost or broken and will only approve a replacement in those cases.

Always verify member eligibility and prior receipt of a hearing aid(s) before dispensing or requesting an authorization.

IMCare will not replace a lost or broken hearing aid when IMCare has replaced a hearing aid twice within the five-year period previous to the date of request. In such cases when IMCare does not provide a hearing aid, the hearing aid service provider may provide the eligible member with a contract hearing aid at the contract price. The hearing aid and dispensing fee shall be paid by the member.

Batteries

Hearing aid batteries may not, at one time, be dispensed in a quantity that exceeds a 90-day supply. Hearing aid batteries may not be dispensed unless the member is in need of the batteries and has requested them. Batteries may be dispensed on the same date as the hearing aid is dispensed. However, the dispensing service must include the provision of at least three batteries.

Ear Impressions

Ear impressions needed for the purpose of custom making an in-the-ear (ITE) hearing aid and ear molds for BTE hearing aids are reimbursed as a separate service from the dispensing fee.

Ear Molds

Replacement ear molds for BTE hearing aids are covered.

Hearing Aid Checks (Programming/Reprogramming)

Hearing aid checks, including setting and resetting volume, programming and reprogramming, and other adjustments of digital and digitally programmable hearing aids, are billable services only after the hearing aid trial period. Hearing aid checks are limited to four checks per year. Claims for hearing aid checks with DOS prior to 90 days following the day of service for dispensing new aids will deny.

Hearing Aid Repairs

IMCare does not cover repairs or the cost of returning the aid to the manufacturer if the aid is under warranty. All claims **(including non-contract hearing aid claims)** for hearing aid repairs must include the purchase date and hearing aid warranty expiration date. The hearing aid service provider who bills for the repair must verify if the hearing aid warranty has expired by obtaining and submitting the following with the hearing aid repair claims:

1. Purchase date from the manufacturer
2. Purchase warranty expiration date of the hearing aid from the manufacturer

All hearing aid repairs are required to be warranted for a minimum of six months, whether sent to the manufacturer or performed by the hearing aid service provider. Most manufacturers on the volume purchase contract are providing a one-year repair warranty. However, some provide repair warranties as long as 24 months. Providers are responsible for checking the manufacturers repair warranty information listed on the contract from which the hearing aid was obtained. Specific repair warranty information is in the hearing aid volume purchase contract.

If the aid is under warranty, IMCare will not reimburse providers or manufacturers for repairs or the cost of returning the aid to the manufacturer.

The hearing aid repair rate is determined by the hearing aid volume purchase contract under which the aid was purchased. The hearing aid volume purchase contracts require manufacturers to honor the contracted repair rate for a period of three years following the expiration of the contract.

For **non-contract hearing aids**, those that were purchased outside the volume purchase contract, parts and labor, including manufacturer fees, constitute one repair charge.

Hearing aid repairs do not include re-casing, remakes, or shell modifications. Do not bill a hearing aid repair when the device requires a re-casing, a remake, or shell modification.

Parts and Accessories

Hearing aid accessories including chest harnesses, tone and ear hooks, carrying cases, T-coils, audio boots, neck loops, etc., are billable when not included in the price of the hearing aid (check the contract for hearing aid features included in the price).

Telecoils

Telecoils are covered if not standard with recommended hearing aid in the following circumstances:

1. One aid per person;
2. When the audiologist determines a member needs the telecoil to use the telephone; and
3. After the audiologist determines that the member's telephone is compatible with the hearing aid's telecoil by report or direct examination.

Re-casing, Remakes, Shell Modifications

Re-casing, remakes, and shell modifications are billable services. Providers must include a description of the service provided. For example, when billing a shell modification, the provider must describe the following:

1. Materials used (e.g., description and amount of compound to fill hole in shell)
2. Service provided (e.g., filled hole in shell, built up shell to adjust fit, or ground down shell to adjust fit)
3. Amount of time

When billing a re-case or remake, the provider must provide the manufacturer's invoice with the claim.

Replacing Battery Doors and Microphone Protectors

Battery door and microphone protector replacements are billable. Providers must provide a description of the service delivered on the claim.

Systems Other Than Personal Hearing Aids

Authorization is required for all systems other than personal hearing aids. When such systems as frequency modulation (FM) systems, vibrotactile devices, or personal communicators (e.g., pocket talkers) are requested, justification is needed, just as for non-contract aids. The audiologist must also address the following points:

1. Why the person cannot use personal hearing aids (e.g., person's unique inabilities to use auditory information provided via hearing aids); and
2. Documentation of expectation of person's ability to recognize and use vibrotactile information, specific to vibrotactile instruments (e.g., response to environmental vibratory information or low frequency bone conducted vibratory information).

Cochlear Implants

A cochlear implant is a prosthetic device that may help provide hearing to those who have profound deafness and would receive little or no benefits from hearing aids.

Cochlear Implant Service		**Provider Type**
L8614	Cochlear device, includes all internal and external components	Hospital, physician
Replacement cochlear components		
L8615	Headset/headpiece for use with cochlear implant device, replacement	Hospital, physician, audiologist, hearing instrument dispenser, medical supplier
L8616	Microphone for use with cochlear implant device, replacement	
L8617	Transmitting coil for use with cochlear implant device, replacement	
L8618	Transmitter cable for use with cochlear implant device, replacement	
L8619	Cochlear implant, external speech processor and controller, integrated system, replacement	
L8627	Cochlear implant, external speech processor, component, replacement	
L8628	Cochlear implant, external controller component, replacement	
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	
Batteries		
L8621	Zinc air battery for use with cochlear implant devices, replacement	
L8622	Alkaline battery for use with cochlear implant devices, any size, replacement, each	
L8623	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	
L8624	Lithium ion battery for use with cochlear implement device speech processor, ear level, replacement, each	

Payment for cochlear implantation and programming

Payment for cochlear implantation and programming will be considered when the following criteria are met.

Authorization: All cochlear implant purchases and replacement devices (L8614, L8619, L8627, L8628, and L8629) require authorization.

Adults

The following criteria must be met:

1. There must be a diagnosis of total sensorineural deafness that cannot be mitigated by use of a hearing aid in members whose auditory cranial nerves are stimulable
2. The member must have the cognitive ability to use auditory clues and a willingness to undergo an extended programs of rehabilitation
3. The member must have post-lingual deafness
4. The member must have reached adulthood, defined as at least age 18
5. The member must be free of middle ear infection, have an accessible cochlear lumen that is structurally suited to implantation, and have freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
6. The member must not have any contraindications to surgery

Children

The following criteria must be met

1. Children must be at least 12 months old
2. There must be a diagnosis of bilateral profound sensorineural deafness with little or no benefit from a hearing (or vibrotactile) aid in patients whose auditory nerves are stimulable
3. The member must be free of middle ear infection, have an accessible cochlear lumen that is structurally suited to implantation, and have freedom from lesions in the auditory nerve and acoustic area of the central nervous system
4. The member must not have any contraindication to the implant, including those described in the product's FDA-approved package insert
5. The child must be teachable/trainable (i.e., able to participate in the extensive rehabilitation post-operation)

Required documentation

1. All diagnosis with the appropriate ICD code
2. Medical history pertaining to the cochlear implant
3. Reports
4. Audiology: including the final report from any pre-cochlear implant hearing training (children)
5. Speech: including test results of age-appropriate closed-set work identification tasks and other tests
6. Psychology: including a clear statement as to the individual's cognitive ability to participate in the post-surgical rehabilitation program

IMCare follows Medicare guidelines for members enrolled in IMCare Classic (HMO SNP). CMS policy indicates cochlear implants may not be performed by an SLP.

Non-Covered Services

1. Replacement batteries provided on a scheduled basis regardless of actual need.
2. Services specified as part of the contract price when billed separately for payment, including charges for repair of hearing aids under warranty.
3. Routine screening of individuals or groups for identification of hearing problems.
4. Separate reimbursement for postage, handling, taxes, mileage, or pickup and delivery.
5. Disposable hearing aids, non-electronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, moisture guards, wax filters, wax guards, retention cords, and safety clips such as Otoclips and Critter Clips, battery chargers, etc.
6. Ear care and comfort creams, cleansers or cleaning solutions, wax removal kits/systems, and hearing aid pads.
7. Regularly scheduled maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian, or attending physician.
8. Loaner hearing aid charges.
9. Canal type hearing aids.
10. Non-contract hearing aids obtained without authorization.
11. Services included with the dispensing fee when billed separately.
12. Hearing aid services to a resident of an LTCF if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the LTCF, or a referral by the resident's family, guardian, or attending physician.
13. Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in Title 42 United States Code (USC) Section 1320a-7b, subject to the "safe harbor" exceptions listed in Title 42 Code of Federal Regulations (CFR) Part 1001, Section 952.

Hearing Services Documentation Requirements and Approval Criteria

The following documentation requirements for medical records apply regardless of whether or not the hearing

aid requires authorization. This information must also be attached to authorization forms, if authorization is required.

1. Physician's medical clearance stating no contraindication for hearing aid use. This may include general support for amplification, if needed, to determine medical necessity. Hearing services for a resident of an LTCF must result from a request by the member or a referral by facility nursing staff or the member's family, guardian, or attending physician, and be part of the member's plan of care or ordered in writing by the attending physician.
2. Authorization requests for replacement aid(s) due to loss or damage must include the following:
   a. Documentation from the member's primary care provider of the member's physical or mental impairment that demonstrates the loss or damage was beyond the member's control
   b. A copy of the member's care plan that outlines steps that will be taken to prevent future losses for members residing in a nursing home (both long- and short-term stay), assisted living facility, group residential housing, Intermediate Care Facility (ICF), or other group housing
   c. A statement from the member's parents or other caregivers (including daycare providers) demonstrating steps that will be taken to safeguard the replacement hearing instrument when authorization is sought to replace a child's hearing instrument(s); (e.g., use of safety clips, headband, or other retention devices; storing the instruments in a secure location when child is sleeping/napping, etc.)
3. Audiologic recommendations including:
   a. Written recommendation for hearing aid(s) including manufacturer specifications; and
   b. Follow-up plan for determining effectiveness of hearing aid use.
4. Documentation supporting audiologic recommendations:
   a. Audiogram – air and bone thresholds, speech thresholds, word recognition scores for each ear or reason why this data was not obtained and report of substitute data (e.g., sound field, informal tests) – internal consistency of data needed;
   b. History of previous appliance use and status of current aid(s), if applicable;
   c. When evidence of middle ear dysfunction exists (e.g., abnormal tympanometry or audiometric conductive loss), audiologist must give rationale for recommending hearing aid use prior to documentation of normal middle ear function (e.g., previous diagnosis of inoperable otosclerosis); **and**
   d. Audiologist's documentation of need for amplification, this may include interpretation of audiometric data relative to member's communication needs, formal hearing aid evaluation, real ear measurements, sound field, etc.
5. An adult's pure-tone average (PTA) must be 25 dB HL and a child's PTA must be 20 dB HL or greater in the fitted ear to qualify for a hearing aid under this program, or authorization is required. The PTA is the average air-conduction threshold for 1000 and 2000 Hz, and 3000 Hz measured with an earphone.

Eligible Providers

1. Audiologists
2. Hearing aid service providers (if certified by MDH as a hearing instrument dispenser or an audiologist licensed by MDH)
3. Otolaryngologists
4. Outpatient hospitals, clinics, corporations or partnerships, and other health care providers who employ audiologists, otolaryngologists, and/or hearing instrument dispensers and have the legal control and responsibility for claims for reimbursement for hearing instrument dispensing services

Before providers are reimbursed for hearing aid assessments or dispensing, a physician, physician assistant, or nurse practitioner must rule out medical or surgical indications contrary to fitting the member with a hearing aid. The medical clearance must be performed within six months prior to dispensing. After ruling out contraindications, the physician then refers the member for an audiologic evaluation to determine if a hearing aid is necessary. An audiologist or otolaryngologist must provide the audiologic testing and, if a hearing aid is indicated, prescribe a specific hearing aid offered under the hearing aid volume purchase contract. An

individual who is enrolled as a hearing aid dispenser, but is not an audiologist or otolaryngologist, may not perform audiologic evaluations or prescribe hearing devices.

The hearing aid service provider must dispense the hearing aid according to the hearing aid exam, selection, and prescription of the otolaryngologist and audiologist. The member shall see an audiologist within the hearing aid trial period so that the audiologist may determine the effectiveness of the hearing aid.

Out-of-state hearing aid service providers (including audiologists) who do not sell hearing aids/instruments in Minnesota must comply with licensing/certification requirements of the other state, but are not required to be certified in Minnesota.

Billing

Claims for hearing services can be submitted on either the 837I or the 837P format. For further billing instructions, please refer to Chapter 4, Billing Policy.

Hearing aid claims require the use of either the NU modifier for purchase or the RB modifier for repair. Hearing aid claims will reject if submitted with RA or RP modifiers, as they are not allowed on hearing aid claims.

Audiologists and hearing instrument dispensers in private practice	Claims are payable to the provider in private practice (i.e., audiologist or hearing instrument dispenser). • Enter the NPI of the provider in private practice as the pay-to-provider and rendering provider.
Group practice/facility billing: For purposes of billing hearing instrument dispensing services, group practice or facility are defined as outpatient hospitals, clinics, corporations or partnerships, and other health care providers who employ audiologists, otolaryngologists, and/or hearing instrument dispensers. See definition under *Eligible Providers*.	Claims are payable to the group practice/facility. • Enter the NPI of the outpatient hospital, clinic, corporation or partnership, or other health care provider as the pay-to-provider. • Enter the NPI of the audiologist, otolaryngologist, or hearing instrument dispenser as the rendering provider.
Note: Follow the billing instructions above for services provided by audiologists or hearing instrument dispensers in private practice who also work part-time in a facility setting. Determine the setting where the dispensing services were provided and follow the instructions for either private practice or group practice/facility billing.	

1. Claims for hearing aid purchases must include:
   a. The prescribing audiologist's NPI
   b. Correct model number
   c. Correct modifiers – NU, LT, RT
   d. ICD-10 diagnosis code(s)
   e. Monaural aid = 1 unit
   f. Binaural aids = 1 unit

   Do not bill accessories included with the initial hearing aid purchase.

Binaural Hearing Aids

Billing Examples	Billing Instructions
Member's binaural hearing aid consists of matching hearing aid models	Bill the binaural set using the appropriate **binaural** code, **1 unit**, and other required modifiers (NU) and billing information
Member's binaural hearing aid consists of two different hearing aid models dispensed on the same day	Bill each hearing aid model with appropriate **monaural** procedure code, **1 unit**, and other required modifiers (LT, RT, NU) and billing information
Member's binaural hearing aid consists of two different hearing aids dispensed on different DOS. Authorization is required for the second aid (and dispensing fee) if the DOS are more than six months apart.	Bill each aid with appropriate **monaural** code, **1 unit**, and required modifiers (LT, RT, NU). Second claim will deny due to exhaustion of member's benefits. Contact the Provider Contact Center for assistance if DOS is fewer than six months from the provision of the first hearing aid. Authorization is required for the second aid (and dispensing fee) if the DOS are more than six months apart.

2. Dispensing fee claims:
   a. Bill the usual and customary charge.
   b. Claims may not be submitted before the hearing aid(s) is dispensed.
   c. Use the appropriate HCPCS code.
   d. Bill dispensing fee procedure code for the type of hearing aid dispensed: monaural or binaural. Always bill the binaural dispensing fee when binaural hearing aid(s) are dispensed, whether the binaural unit consists of matching hearing aids or not.
      i. Monaural = 1 unit
      ii. Binaural = 1 unit
   e. Dispensing fees require authorization whenever the hearing aid requires authorization.
   f. The dispensing fee is a professional service. Do NOT bill the dispensing fee with modifier NU.

3. Replacement claim for unsatisfactory hearing aid(s)
   a. If the provider has billed for an unsatisfactory hearing aid, the provider must submit a replacement claim for both the replacement hearing aid and all but one-half of the dispensing fee. Both the replacement hearing aid and dispensing fee require authorization.
   b. If the provider has not billed for the unsatisfactory aid and dispensing fee and it is the first hearing aid claim in five years, the new aid may be provided immediately without requesting authorization.
4. Claims for hearing aid repairs must include the following
   a. Correct model number
   b. Correct modifiers (RB, LT, RT, and 22, when appropriate)
      i. When billing repairs for both hearing aids, bill two lines with the binaural hearing aid, one unit on each line, and include the RB modifier on both lines with the corresponding RT/LT modifier (one on each line)
   c. Hearing aid purchase warranty expiration date entered in the comment section of the claim form using **mm/dd/yy** format
   d. Hearing aid volume purchase contract number in the comment section of the claim form for all contract hearing aids
   e. Repair invoice for repairs of non-contract hearing aids

5. Use **Code V5014** for billing the following:
   a. Battery door replacement
   b. Re-casing and/or re-plating (hearing aid is sent to manufacturer). However, if re-casing/re-plating is

done in conjunction with other repairs, use the appropriate hearing aid code, model number, and appropriate modifiers, and submit the repair invoice with the claim.

c. Shell modification (service performed by dispenser/audiologist in office – minor repairs to shell). Send invoice with claim listing time and materials and describe service performed.

Repairs do not constitute replacement of minor parts or cleaning of a hearing aid.

Use the appropriate HCPCS codes to bill these services.

Hearing aid batteries: Bill hearing aid batteries in quantities of one unit per battery. Use code V5266 for billing a battery for use in a hearing device (limit: 90-day supply).

Hearing aid dispensing services cannot be billed under a hospital, clinic, or agency provider number. The Minnesota Department of Human Services (DHS) only reimburses individuals enrolled as hearing aid service providers for hearing aid services.

Hearing Aid Contract Vendors, Models, Prices, and Codes

Legal References

MN Stat. secs. 148.511-148.5196 – Speech-Language Pathologists and Audiologists
MN Stat. sec. 148.515, subd. 4 – Qualifications for Licensure: Supervised graduate or doctoral clinical experience required
MN Stat. sec. 148.515 – Qualifications for Licensure
MN Stat. sec. 148.6418 – Temporary Licensure
MN Stat. sec. 148.6432 – Supervision of Occupational Therapy Assistants
MN Stat. sec. 148.71 – Temporary Permits
MN Stat. sec. 256B.0625, subd. 8 – Physical therapy
MN Stat. sec. 256B.0625, subd. 8a – Occupational therapy
MN Stat. sec. 256B.0625, subd. 8c – Care management; rehabilitation services
MN Stat. sec. 256B.0625, subd. 31a – Augmentative and alternative communication systems
MN Rules part 4658.0525 – Rehabilitation Nursing Care
MN Rules Chap. 5601 – Physical Therapy
MN Rules part 9505.0175 – Definitions
MN Rules part 9505.0210 – Covered Services; General Requirements
MN Rules part 9505.0220 – Health Services Not Covered by Medical Assistance
MN Rules part 9505.0287 – Hearing Aid Services
MN Rules part 9505.0385 – Rehabilitation Agency Services
MN Rules part 9505.0386 – Comprehensive Outpatient Rehabilitation Facilities
MN Rules part 9505.0390 – Rehabilitative and Therapeutic Services MN Rules part 9505.0391 – Therapists Eligible to Enroll as Providers MN Rules part 9505.0392 – Compliance with Medicare Requirements
MN Rules part 9505.0410 – Long-Term Care Facilities; Rehabilitative and Therapeutic Services to Residents MN Rules part 9505.0411 – Long-Term Care Facilities; Rehabilitative and Therapeutic Services to Nonresidents
42 CFR 440.110 – Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
42 CFR 483.45 – Specialized rehabilitative services

42 CFR 485, subp. H – Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
42 CFR 1001.952 – Exceptions
42 USC 1320a-7b – Criminal penalties for acts involving Federal health care programs