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 (PT), occupational therapy (OT), speech-language pathology (SLP), 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 the Children’s Services chapter (Ch. 9) and rehabilitative services provided by home health agencies are addressed in the Home Care Services chapter (Ch. 24).

Definitions

**Audiologist:** A health care professional who:

- Maintains office space at own expense;
- Has a master’s or doctoral degree;
- Is registered with the Minnesota Department of Health; and EITHER:
  - Holds a Certificate of Clinical Compliance (“CCC” requirement) from the American Speech Hearing and Language Association (ASHA); OR
  - Meets the following clinical practicum (“Practicum” requirement) standards:
    - 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);
    - Has performed not less than nine months of supervised full-time audiology services after obtaining a master’s or doctoral degree; and
    - Has successfully completed a national exam in audiology approved by the Secretary.

An out-of-state audiologist is a healthcare professional who:

- Maintains office space at their own expense;
- Has a master’s or doctoral degree;
- Is licensed or registered to provide audiology services in their state; OR, if the state does not license the providers of audiology services, meets the “CCC” or “Practicum” requirement above.

**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 persons, 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 or occupational therapist who instructs the physical or occupational therapist assistant, 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 recipient when treatment is provided by an assistant and meets the other supervisory requirements of Minnesota Rules 5601.1500 and 5601.1600, and MS 148.6432.

**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 recipient 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 Department of Health as a hearing instrument dispenser (or their trainee).

**Long Term Care Facility (LTC):** Nursing facility (NF), skilled nursing facility (SNF), or intermediate care facility for the mentally retarded (ICF/MR).

**Occupational Therapist (OT):** A person certified by the National Board for Certification of Occupational Therapy as an occupational therapist and, where applicable, licensed by the state in which he/she practices.

**Occupational Therapist Assistant (OTA):** A person who has successfully completed all academic and fieldwork requirements of an occupational therapy assistant program approved or accredited by the Accreditation Council for Occupational Therapy Education and is currently certified by the National Board for Certification of Occupational Therapy as an occupational therapy assistant, 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 or eligible for board certification.

**Physical Therapist (PT):** A person who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent. Physical therapists must meet the state licensure requirements of MS 148 and Minnesota Rules 5601.
**Physical Therapist Assistant (PTA):** A person graduated from a physical therapy assistant educational program accredited by the American Physical Therapy Association or a comparable accrediting agency.

**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 Minnesota Rules 4658.0525.

**Restorative Therapy:** A health service specified in the recipient’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 recipient’s functional status to a level consistent with the recipient’s physical or mental limitations.

**Specialized Maintenance Therapy:** A health service specified in the recipient’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 recipient’s functional status at a level consistent with the recipient’s physical or mental limitations, and that may include treatments in addition to rehabilitative nursing services, as defined in Minnesota Rules 4658.0525.

**Speech-language Pathologist (SLP):** A person who has a certificate of clinical competence in speech-language pathology from the American Speech and Hearing Association and meets the state registration requirements. Speech language providers are required by MHCP to hold current registration with the Minnesota Department of Health.

**Eligible Providers**
- Audiologist
- CORF
- Hearing aid service provider
- Long term care facility
- Occupational therapist
- Otolaryngologist
- Physical therapist
- Rehabilitation agency
- Speech-language pathologist

**Enrollment Requirements**

An individual is eligible to enroll as a therapist in private practice if they are either a physical therapist or an occupational therapist as defined in this chapter and are not employees of a hospital, CAH, skilled nursing facility, HHA, hospice, CORF, physician clinic, CMHC, a
rehabilitation agency or Public Health Agency. A therapist in private practice 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: A therapist in private practice may not furnish covered services in a skilled nursing facility. Therefore, if a therapist wished to locate their private office on site at a nursing facility, the private office space may not be part of the Medicare participating SNF’s space and the therapist’s services may only be furnished within the therapist’s private office space.

Speech-language pathologists, 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 speech language pathologist.

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

**Use of Physical and Occupational Therapist Assistants**

MHCP reimburses providers for the services of a PTA or an OTA when services are provided under the direction (defined above) of a therapist. The therapist must provide on-site observation of the treatment and documentation of its appropriateness at least every sixth treatment session when the therapist assistant provides services. Therapists will not be reimbursed for assistants providing evaluations or reevaluations.

**Supervision During Fellowship Year of Speech-Language Pathology and Audiology**

- 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.
- Services provided by another SLP employed by the SLP in private practice are not reimbursed by MHCP unless the employee is an SLP completing a clinical fellowship year.
- A person completing the clinical fellowship year required for certification as an audiologist may provide services under the supervision of an audiologist.
- Services performed by either a 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.
- See specific requirements regarding supervision of fellows in MS 148.515, subd. 5.

**Eligible Recipients**

- MA recipients and MinnesotaCare recipients.
- GAMC recipients may only receive rehabilitative services from outpatient hospitals/clinics, physician clinics, community and public health clinics, or rehabilitation agencies. (PT, OT, SLP or audiology providers in private practice are not reimbursed for services provided to GAMC recipients.)
• Recipients who are eligible for both MHCP and Medicare may not receive services from speech-language pathologists in private practice because these providers may not enroll as a provider with Medicare.

**Plan of Care**

Rehabilitative, therapeutic, specialized maintenance therapy, and audiology services must be provided under a written treatment plan that states with specificity the recipient’s condition, functional level, treatment objectives, 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, revised and signed as medically necessary by the recipient’s physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law at least once every 60 days. If the service is a Medicare covered service, and is provided to a recipient 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 recipient’s plan of care:

- The medical diagnosis and any contraindications to treatment;
- A description of the recipient’s functional status;
- The objectives of the rehabilitative and therapeutic service;
- A description of the recipient’s progress toward the objectives; and
- Additional documentation requirements as specified in the [*Health Care Programs and Services chapter* (Ch.2)].

**Recipient’s Record of Services**

Providers must document all evaluations, services provided, client progress, attendance records, and discharge plans. Documentation must be kept in recipient’s records. The record of services must contain the following:

- The date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient;
- The name or names and titles of the persons providing each rehabilitative and therapeutic service; and
- A statement, every 30 days by the therapist providing or supervising the services provided by a long term care recipient, that the therapy’s nature, scope, duration and intensity are appropriate to the medical condition of the recipient in accordance with Minnesota Statutes (not required for an initial evaluation).
- See documentation requirements as specified in the [*Health Care Programs and Services chapter* (Ch. 2)].

**Covered Services**

To be covered as a rehabilitative and therapeutic service:
• 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.

• Speech-language pathology and audiology services must be provided:
  - 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 long-term care facility resident on the written order of a physician; and
  - 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 MS 148.515, subd. 4.

• Occupational therapy and physical therapy must require the skills of a PT, OT, or therapy assistant who is under the direction of a PT or an OT. The therapist 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.

• Treatment must be specified in a plan of care that is reviewed and revised as medically necessary by the recipient’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 60 days (see Plan of Care section in this chapter for additional requirements).

• The recipient’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 recipient’s plan of care within a 60-day period.

To be a covered GAMC service, therapy must be provided in an outpatient hospital, physician clinic, community and public health clinic, rehabilitative agency or long term care facility that has been certified by Medicare to provide rehabilitative services.

Services provided by rehabilitation agencies must be provided at a site surveyed by the Minnesota Department of Health 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 recipient’s residence. However, if services are provided to Medicare eligible recipients, providers must comply with Medicare’s site requirements.

**Specialized Maintenance Therapy**

Specialized maintenance therapy is covered only when it is provided by a PT, OT, therapy assistant, or speech-language pathologist, specified in a plan of care that meets the requirements of this chapter, and is provided to recipients whose condition cannot be maintained or treated only through rehabilitative nursing services, as defined in Minnesota Rules 4658.0525, or services of other care providers, or by the recipient because the recipient’s physical, cognitive or psychological deficits result in:

• Spasticity or severe contracture that interferes with the activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the recipient’s previous level of function; or
• 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, activities of daily living, cardiovascular function, integumentary status, or positioning necessary for completion of the recipient’s activities of daily living, or decreased abilities relevant to the recipient’s current environmental demands.

**Specialized maintenance therapy** must have expected outcomes that are:

• Functional,
• Realistic,
• Relevant,
• Transferable to the recipient’s current or anticipated environment, such as home, school, community, work,
• Consistent with community standards.

**Specialized maintenance therapy** must meet at least one of the following characteristics:

• Prevent deterioration and sustain function;
• Provide interventions, in the case of a chronic or progressive disability, that enable the recipient to live at the recipient’s highest level of independence; or
• Provide treatment interventions for recipients who are progressing but not at a rate comparable to the expectations of restorative care.

**Work Hardening Programs**

Work conditioning/harding programs are intensive, highly structured, and job oriented. Individualized treatment plans are designed to restore an individual’s physical, behavioral and vocational functions within an interdisciplinary model. The treatment plan must be based on an assessment of the recipient’s work setting or job demands and must incorporate the goals of expeditious and physically appropriate tasks to return to employment.

If the recipient was injured at work, MHCP will not cover work conditioning/work hardening programs. All work conditioning/work hardening programs require authorization and must have been referred by a vocational rehabilitation counselor.

Include the following on the authorization form or on an attachment:

• Referral from vocational rehabilitation counselor;
• Personnel involved (who make up the multi-disciplinary team);
• If mental health services will be provided, state what is required, the basis for the need, and what type of mental health professional will provide the service;
• Assessment results (including work conditioning assessment, vocational rehabilitation assessment and appropriate documentation as to whether the recipient has ever been treated for chemical dependency, how long ago, etc.);
• Duration of program;
• Describe development of program goals in relation to specific job requirements;
• Define specific work goals and timetables; and
• Describe set frequency and hours of attendance.

Requested number of billings are to reflect the number of hours to be covered by the authorization request for each discipline that is to provide services. Authorizations not including this information will be returned.

When the recipient has been discharged or terminated from the work conditioning or work hardening program, the provider must notify DHS and the referral source and include the following documentation:
• Reasons for program termination;
• Clinical and functional status;
• Recommendations regarding return to work; and
• Recommendations for follow-up service.

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 recipient 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.

• Augmentative communication devices are obtained from MHCP enrolled medical equipment and supply providers and manufacturers of augmentative communication devices.
• Technical services, such as repairs, are covered. Bill repairs with the augmentative communication device HCPCS code and the repair modifier (RP). Labor time (number of hours) for repairs is billed with the HCPCS labor code.
• Indirect time spent programming, upgrading, modifying or setting up an augmentative communication device or communication/picture book for a recipient is not billable. Only direct time spent with the recipient 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

All points must be addressed for the authorization to be considered.
• A description of the current medical status and history.
• An assessment of the verbal and physical capabilities in relation to need and use of an augmentative communication device (electronic and non-electronic).
• A detailed description of the therapeutic history in the areas of physical and occupational therapy and speech-language pathology. The nature, frequency, and duration of total therapeutic history provided to the recipient. Speech-language treatment approaches in relation to the need and use of an augmentative communication device must be detailed.
• An explicit evaluation of each augmentative communication device or method of communication tried by the recipient and information on the effectiveness of each device. All
parameters of device selection must be addressed (e.g., interactive ability in all situational contexts; school, home, community, vocational, work, and social environments). A trial period of the device is requested when there is no device currently being used.

- A detailed description of the recipient’s ability to use the proposed device, including speed and accuracy. Situation references dependent upon the mobility level of the recipient must be addressed (e.g., How will the device be adapted to meet the needs of a recipient who uses a walker? Is the communication device less obtrusive than other methods when mobility levels are considered?). Empirical data regarding the trial period of use with the device is required (e.g., frequency of device use in various settings).
- A description of the level of communication initiation with the selected communication device and indicate whether or not the equipment is used accurately and spontaneously. If the pattern of initiation is different from past history, provide an explanation and justification for the change.
- A detailed description and plan for the proposed nature, frequency, and duration of therapeutic intervention in relation to the augmentative communication device. Include all therapeutic intervention necessary.

For additional authorization policies and procedures, refer to the Authorization chapter (Ch. 5).

**Non-covered Services Relating to Augmentative Communication Devices**

- Environmental control devices such as switches, control boxes or battery interrupters;
- Modification, construction, programming, or adaptation of communication systems;
- 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. (MHCP does not cover facilitated communication by any provider.);
- Personal computers and laptop computers that are not dedicated communication devices;
- Telephones; and
- Carry cases when a mounting device has been purchased.

**Augmentative Communication Device Billing Procedures**

- 92597:* 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 device
- 92606:* Therapeutic service(s) for the use of non-speech generating device, including programming and modification
- 92607:* Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
- 92608:* Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
• 92609:* Therapeutic services for the use of speech-generating device, including programming and modification

* 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 MHCP recipients living in the community or long term care facility.

• Service thresholds for OT, PT and SLP are one-time only. Medically necessary services needed beyond the one-service thresholds require authorization.

• Audiology service thresholds are by calendar year (see Rehabilitation Services Billing Threshold Chart in this chapter).

• Recipients may require a greater number of evaluations, modalities or procedures than the initial service threshold. Recipients may receive additional medically necessary services with authorization.

• Medicare crossover claims for the payment of recipient’s coinsurance and/or deductible are not included or counted in the threshold limits; but

• Third-party liability claims sent to DHS for payment after other coverage paid will go toward the threshold limits.

• A unit can be per session or a timed unit. Each unit will decrement against the threshold.

**Non-covered Services**

• 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;

• 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;

• * Services for contracture that are not severe and do not interfere with the recipient’s functional status or the completion of nursing care as required for licensure of the LTC facility;

• * Ambulation of a recipient who has an established functional gait pattern;

• * Services for conditions of chronic pain that do not interfere with the recipient’s functional status and that can be treated by routine nursing measures;

• * Services for activities of daily living when performed by the therapist, therapy assistant or therapy aide;

• * Bowel and bladder retraining programs;

• Art and craft activities for the purpose of recreation;

• Services not medically necessary;

• Services not documented in the recipient’s health care record;
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- Services not part of the recipient’s plan of care;
- Services specified in a plan of care that is not reviewed and revised as medically necessary by the recipient’s attending physician;
- Services that are not designed to improve or maintain the functional status of a recipient with a physical impairment or a cognitive or psychological deficit;
- 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 recipient’s IEP;
- A rehabilitative and therapeutic service that is denied Medicare payment because of the provider’s failure to comply with Medicare requirements;
- Vocational or educational services, including functional evaluations, except as provided under IEP-related services;
- Services provided by a therapy aide or therapy student;
- Psychosocial services;
- Record keeping documentation and travel time (the transport and waiting time of a recipient to and from therapy sessions);
- Services provided by a rehabilitation agency that take place in a sheltered workshop, Day Training and Habilitation center (DT&H), Day Activity Center (DAC), or a residential or group home which is an affiliate of the rehabilitation agency;
- *Yearly assessments of LTC residents to meet OBRA regulations; and
- Training or consultation provided by an audiologist to an agency, facility, or other institution.

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

Authorization Criteria and Documentation

Submit the following with the authorization form:
- Readable, photocopied material;
- Arranged in chronological order;
- Documentation matching requested services; and
- Reasons why the skills of a physical therapist are required.

Send only requested documentation, not the entire file.

Initial Evaluation:
- Treatment diagnosis and date of onset, including any contraindications to treatment;
- Origin and rationale for referral, including a copy of physician’s order or referral;
- Summary of previous therapy, including all evaluation or assessment reports or summary of initial findings signed by the therapist providing services;
- Current and prior functional status, including baseline evaluation and brief history indicating medical necessity;
- Documentation of when current function was lost;
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• All tests performed and interpretation of results;
• Identified problems; and
• Corresponding short and long term goals that are functional, objective and measurable.

CDMI will retain copies of the initial evaluation for future authorization requests.

Care Plans
• Treatment plan, including procedure codes and modifiers used;
• Frequency of treatment and duration of each session: The record must show the date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient (the number of units requested must match the documentation - double check your calculations);
• The objective or rehabilitative and therapeutic services stated in short and long term goals which are functional, objective, and measurable;
• Functional status;
• Recipient’s progress toward treatment goals for current treatment program (be specific - simply stating the recipient is making progress is not sufficient);
• Anticipated duration of future treatment including specific discharge plans; and
• Documentation supporting the need for the level of service/skill requested including the name(s) and title(s) of persons providing the service, and the name and title of the therapist supervising or directing the services.

Therapy Groups
• Description of the purpose of the group;
• Number of patient and staff members in group;
• Ratio of staff to patients;
• Duration of each session;
• Specifics regarding the medical necessity for PT or OT;
• Number of group sessions requested; and
• All items under “Initial Evaluation” and “Care Plans” (above).

Service/Supplies
• Brief history indicating medical necessity; and
• Itemized statement of supplies.

Authorization Termination
DHS will terminate reimbursement when services are discontinued by the referral source or when the recipient has:
• Met the goals of the program;
• Developed behavioral or vocational problems that are not being addressed and that interfere with return to work;
• Failed to comply with the requirements of participation;
• Developed medical contraindications; or
• Reached a plateau prior to meeting goals.

Billing
• See the Billing Policy chapter (Ch. 4) for specific CMS-1500 and UB-92 requirements.
• An independently enrolled SLP or an OT or PT in private practice may not bill for the service of another therapist.
• Services provided by PT or OT in private practice, or an independently enrolled SLP must be billed by the individual therapist, using his/her provider number.
• Services provided by therapists employed by a rehabilitation agency, LTC facility, physician clinic, CORF, CAH, Public Health Agency, hospice, or outpatient hospital, must be billed using the facility or agency’s provider number.
• Services provided by a therapy assistant, when the therapist is not on the premises, must be billed using modifier U7 on the claim and are reimbursed at a reduced rate.
• Claims for services delivered to a recipient by two or more therapists in the same block of time (co-therapy session): Providers must split the time so that the total time billed does not exceed the actual length of the session.
• Use modifier UC to signify that the therapy service provided was specialized maintenance therapy. Modifier UC is intended to be used only for specialized maintenance therapy claims and documentation in the patient’s record must support the service was specialized maintenance therapy. Any other use of modifier UC is improper. Independent Speech Language Pathologists must advise dually eligible Medicare/Medicaid recipients to seek treatment from providers enrolled with both Medicare and MHCP. Independently enrolled audiologist may bill for services provided in his/ her own office, the recipient’s home, LTC facility, or at Day Training and Habilitation Center(s).
• 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 pre-fabricated supplies that can be obtained from a medical supplier.
• The provider that bills for and receives 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.
• Always follow Medicare guidelines for MHCP recipients who are dually eligible for Medicare and Medicaid when providing Medicare covered services.
• For dates of service on or after May 1, 2004, the claims processing system will look for the national CPT/HCPCS codes and modifiers to decrement the service(s) against the appropriate rehabilitative service thresholds. Claims submitted without the appropriate codes and modifiers will be denied.
• MHCP will define outpatient rehabilitative services codes as defined by CPT/HCPCS. Codes described by CPT/HCPCS as billable in timed units (15 minutes, 30 minutes, 1 hour) must be billed as such for the outpatient rehabilitative services thresholds. CPT/HCPCS codes that do not have a timed component/unit must be billed as one unit per visit, regardless of the time spent.
• No more than one unit may be billed for any date of service that is a “per visit/session” code.
• Effective for dates of service on or after May 1, 2004, all outpatient rehabilitative services and authorization requests must use the following modifiers to indicate which discipline delivered the service:
  – GN - speech-language pathology
  – GO - occupational therapy
  – GP - physical therapy
  – UC - replaces local modifier XC (specialized maintenance therapy)
  – U7 - replaces local modifier WW (service provided by a physical or occupational therapy assistant)
• Use modifier UC on claims and authorization requests, in addition to the required modifiers to indicate specialized maintenance therapy. Patient records must reflect the services are maintenance therapy.
• Use modifier U7 on claims (but not required on authorization requests), in addition to the required modifiers to indicate the service was provided by a physical or occupational therapy assistant.

Rehabilitative services provided in a LTC facility: Long-term care facilities may provide rehabilitative services to their residents and members of the community, utilizing either their own staff or by contracting with an outside service vendor (rehab agency). Services must be provided on the premises. MHCP will not make separate reimbursement for therapy services for residents of an LTC facility that includes therapy as part of the per diem rate. Use the following criteria to determine the correct billing method to use.
• Employees of the LTC Facility: PT, OT, or SLP services provided by employees of the LTC facility must be billed by the LTC facility on either the CMS-1500 or UB-92.
• Rehabilitation Agency: PT, OT, or SLP services provided by a rehab agency at an LTC facility can be billed by either party. However; the party designated to do the billing must bill for all rehabilitative services. When services are billed by the rehab agency:
  – Use either the UB-92 or CMS-1500 ;
  – Enter the rehab agency’s 9-digit MHCP provider number; and
  – Enter the LTC facility’s 9-digit provider number in FL 83. When using MN-ITS to bill, enter information for additional provider types in the OTHER PROVIDER TYPES section. See MN-ITS User Guide for detailed information on electronic billing.

When services are billed by the LTC facility:
  – Use either the CMS-1500 or UB-92; and
  – Enter the LTC facility’s 9-digit provider number.
• Independent SLP and Private Practice PT and OT: Services provided to MHCP recipients can be billed by either the LTC facility or the contracted independent SLPs, and PTs and OTs in private practice. However, the party designated to do the billing must bill for all rehabilitative services. The services can be billed one of two ways:
  Independent SLPs or private practice PTs or OTs under contract with the LTC facility may:
− Use either the CMS-1500 or UB-92; and
− Enter the therapist’s individual 9-digit MHCP provider number.

**LTC facilities may:**
− Use either the CMS-1500 or UB-92; and
− Enter the LTC facility’s 9-digit MHCP provider number.

The provider that bills for and receives 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. If Medicare requires the LTC facility to bill for Medicare covered rehabilitative services for dually eligible recipients, follow Medicare’s requirements until Medicare benefits are exhausted.

**Therapy Services Provided in Physician Clinics, Outpatient Hospitals, Community or Public Health Clinics**

- Services provided by a PT, OT, SLP or audiologist employed by physicians, outpatient hospitals, community or public clinics must be billed by those organizations.
- Outpatient hospital services may only be provided in an outpatient hospital facility.

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline modifier GN, GO, GP</th>
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</thead>
<tbody>
<tr>
<td>90901</td>
<td>GO, GP</td>
<td>Biofeedback training by any modality*</td>
<td>GO: OT threshold, 200 units, any combination with other codes in OT threshold</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GP: PT threshold, 30 treatment sessions, any combination with other modalities in same threshold</td>
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<tr>
<td>90911</td>
<td></td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry*</td>
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<tr>
<td>92506</td>
<td>GN</td>
<td>Medical evaluation of speech*</td>
<td>GN: 1 SLP evaluation</td>
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<tr>
<td>92507</td>
<td>GN</td>
<td>Individual speech, language or hearing treatment*</td>
<td>GN: SLP threshold, 80 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>92508</td>
<td>GN</td>
<td>Group speech language or hearing treatment*</td>
<td></td>
</tr>
<tr>
<td>92510</td>
<td>GN</td>
<td>Aural rehabilitation following cochlear implant*</td>
<td></td>
</tr>
<tr>
<td>92526</td>
<td>GN</td>
<td>Treatment of swallowing dysfunction and/or oral function for feeding*</td>
<td></td>
</tr>
<tr>
<td>92597</td>
<td>GN</td>
<td>Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech*</td>
<td></td>
</tr>
<tr>
<td>92605</td>
<td>GN</td>
<td>Evaluation for prescription of non-speech generating augmentative and alternative communication devices*</td>
<td>GN: 2 SLP treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>92607</td>
<td>GN</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</td>
<td></td>
</tr>
<tr>
<td>92608</td>
<td></td>
<td>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)</td>
<td></td>
</tr>
</tbody>
</table>
### PT, OT, and SLP Service Thresholds (continued)
**Effective for dates of service on or after May 1, 2004**

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>92610</td>
<td>GN, GO</td>
<td>Evaluation of oral and pharyngeal swallowing function*</td>
<td>GO: OT threshold, 200 units, any combination with other codes in OT threshold</td>
</tr>
<tr>
<td>92611</td>
<td>GN, GO</td>
<td>Motion fluoroscopic evaluation of swallowing function by cine or video recording*</td>
<td>GN: 4 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>92612</td>
<td>GN</td>
<td>Flexible fiber optic endoscopic evaluation of swallowing by cine or video recording*</td>
<td></td>
</tr>
<tr>
<td>92614</td>
<td>GN</td>
<td>Flexible fiber optic endoscopic evaluation, laryngeal sensory testing by cine or video recording*</td>
<td></td>
</tr>
<tr>
<td>92616</td>
<td>GN</td>
<td>Flexible fiber optic endoscopic evaluation of swallowing*</td>
<td></td>
</tr>
<tr>
<td>95831</td>
<td>GP, GO</td>
<td>Muscle testing manual extremity*</td>
<td>GP: 2 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>95832</td>
<td>GP, GO</td>
<td>Hand*</td>
<td>GO: OT threshold, 200 units, any combination with other codes in OT threshold</td>
</tr>
<tr>
<td>95833</td>
<td>GP, GO</td>
<td>Total evaluation of body, excluding hands*</td>
<td></td>
</tr>
<tr>
<td>95834</td>
<td>GP, GO</td>
<td>Total evaluation of body, including hands*</td>
<td></td>
</tr>
<tr>
<td>95851</td>
<td>GP, GO</td>
<td>Range of motion measure and report; each extremity (excluding hand) or each trunk section*</td>
<td>GP: 12 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>95852</td>
<td>GP, GO</td>
<td>Range of motion measurement – hand with or without comparison to normal side*</td>
<td>GO: OT threshold, 200 units, any combination with other codes in OT threshold</td>
</tr>
<tr>
<td>97001</td>
<td>GP</td>
<td>Physical therapy evaluation, initial*</td>
<td>3 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>97002</td>
<td>GP</td>
<td>Physical therapy re-evaluation, periodic*</td>
<td></td>
</tr>
<tr>
<td>97003</td>
<td>GO</td>
<td>Occupational therapy, evaluation, initial*</td>
<td>2 treatment sessions, any combination of these codes</td>
</tr>
<tr>
<td>97004</td>
<td>GO</td>
<td>Occupational therapy, re-evaluation, initial*</td>
<td></td>
</tr>
</tbody>
</table>

* Each treatment session (modality) counts as 1 unit against the threshold, regardless of time spent with the patient.*

### PT & OT Service Thresholds
**Effective for dates of service on or after May 1, 2004**

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>97010</td>
<td>GP, GO</td>
<td>Hot or cold packs*</td>
<td></td>
</tr>
<tr>
<td>97012</td>
<td>GP, GO</td>
<td>Traction*</td>
<td></td>
</tr>
<tr>
<td>97014</td>
<td>GP, GO</td>
<td>Electrical stimulation*</td>
<td></td>
</tr>
<tr>
<td>97016</td>
<td>GP, GO</td>
<td>Vasopneumatic devices*</td>
<td></td>
</tr>
<tr>
<td>97018</td>
<td>GP, GO</td>
<td>Paraffin bath*</td>
<td></td>
</tr>
<tr>
<td>97020</td>
<td>GP, GO</td>
<td>Microwave*</td>
<td></td>
</tr>
<tr>
<td>97022</td>
<td>GP, GO</td>
<td>Whirlpool*</td>
<td></td>
</tr>
<tr>
<td>97024</td>
<td>GP, GO</td>
<td>Diathermy*</td>
<td></td>
</tr>
<tr>
<td>97026</td>
<td>GP, GO</td>
<td>Infrared*</td>
<td></td>
</tr>
<tr>
<td>97028</td>
<td>GP, GO</td>
<td>Ultraviolet*</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GO: OT threshold, 200 units, any combination with other codes in OT threshold</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GP: PT threshold, 30 treatment sessions, any combination with other modalities in same threshold</td>
</tr>
<tr>
<td>Code</td>
<td>Required modifier</td>
<td>Description</td>
<td>Threshold based on discipline</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>97032</td>
<td></td>
<td>Application of a modality to one or more areas; electrical stimulation – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97033</td>
<td></td>
<td>Iontophoresis – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97034</td>
<td></td>
<td>Contrast bath – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97035</td>
<td></td>
<td>Ultrasound – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97036</td>
<td></td>
<td>Hubbard tank – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97110</td>
<td></td>
<td>Therapeutic procedure, exercises – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97112</td>
<td></td>
<td>Neuromuscular – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97113</td>
<td></td>
<td>Aquatic therapy – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97116</td>
<td></td>
<td>Gait training – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97124</td>
<td></td>
<td>Massage – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97140</td>
<td></td>
<td>Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97504</td>
<td></td>
<td>Orthotics fitting and training; upper and lower extremity – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97520</td>
<td></td>
<td>Prosthetics, initial – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97530</td>
<td></td>
<td>Therapeutic activities – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97532</td>
<td>GO, GP</td>
<td>Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct patient contact by provider – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97533</td>
<td></td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by provider – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97535</td>
<td></td>
<td>Self care home management training, e.g., ADLs compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97537</td>
<td></td>
<td>Community work reintegration training, e.g. shopping, transportation, money management, vocational activities – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97542</td>
<td></td>
<td>Wheelchair management propulsion training – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97601</td>
<td></td>
<td>Active Wound Care Management: Removal of devitalized tissue, from wound(s); selective debridement, without anesthesia (e.g., high pressure water jet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care*</td>
<td></td>
</tr>
</tbody>
</table>

GO: OT threshold, 200 units, any combination with other codes in OT threshold
GP: PT threshold, 120 15-minute units, any combination with other codes in this group of codes
### PT & OT Service Thresholds (continued)
Effective for dates of service on or after May 1, 2004

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>97602</td>
<td></td>
<td>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*</td>
<td></td>
</tr>
<tr>
<td>97703</td>
<td></td>
<td>Orthotic/prosthetic use – 15 minutes</td>
<td></td>
</tr>
</tbody>
</table>

* Each treatment session (modality) counts as 1 unit against the thresholds, regardless of time spent with the patient.

### Evaluative/Therapeutic/Rehabilitative
Effective for dates of service on or after May 1, 2004

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>92606</td>
<td>GN</td>
<td>Therapeutic service(s) for the use of non-speech generating device, including programming and modification*</td>
<td></td>
</tr>
<tr>
<td>92609</td>
<td></td>
<td>Therapeutic services for the use of speech-generating device, including programming and modification*</td>
<td></td>
</tr>
<tr>
<td>92700</td>
<td></td>
<td>Unlisted otorhinolaryngological service or procedure*</td>
<td></td>
</tr>
<tr>
<td>97039</td>
<td></td>
<td>Unlisted modality*</td>
<td></td>
</tr>
<tr>
<td>97139</td>
<td></td>
<td>Unlisted therapeutic procedure – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97150</td>
<td>GP, GO</td>
<td>Therapeutic procedures group, two or more persons*</td>
<td>GN, GO or GP: Always require authorization</td>
</tr>
<tr>
<td>97545</td>
<td></td>
<td>Work hardening/conditioning, initial 2 hours</td>
<td></td>
</tr>
<tr>
<td>97546</td>
<td></td>
<td>Work hardening, each additional hour</td>
<td></td>
</tr>
<tr>
<td>97750</td>
<td></td>
<td>Physical performance test or measurement (functional capacity) – 15 minutes</td>
<td></td>
</tr>
<tr>
<td>97799</td>
<td></td>
<td>Unlisted physical med/rehab service*</td>
<td></td>
</tr>
</tbody>
</table>

* Each treatment session (modality) counts as 1 unit against the threshold, regardless of time spent with the recipient.

### Speech-Language Screening

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5362</td>
<td>GN</td>
<td>Speech screening (articulation)*</td>
<td>GN: 1 SLP treatment session, each code</td>
</tr>
<tr>
<td>V5363</td>
<td></td>
<td>Language screening (receptive or expressive)*</td>
<td></td>
</tr>
<tr>
<td>V5364</td>
<td></td>
<td>Dysphagia screening*</td>
<td></td>
</tr>
</tbody>
</table>

* Each treatment session (modality) counts as 1 unit against the threshold, regardless of time spent with the recipient.
# Application of Casts & Strapping

(Effective for dates of service on or after May 1, 2004, these codes replace the previous X4511)

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline</th>
</tr>
</thead>
<tbody>
<tr>
<td>29065</td>
<td></td>
<td>Application, cast; shoulder to hand (long arm)</td>
<td></td>
</tr>
<tr>
<td>29075</td>
<td></td>
<td>Elbow to finger (short arm)</td>
<td></td>
</tr>
<tr>
<td>29085</td>
<td></td>
<td>Hand and lower forearm (guantlet)</td>
<td></td>
</tr>
<tr>
<td>29086</td>
<td></td>
<td>Finger (e.g., contracture)</td>
<td></td>
</tr>
<tr>
<td>29105</td>
<td></td>
<td>Application of long arm splint (shoulder to hand)</td>
<td></td>
</tr>
<tr>
<td>29125</td>
<td></td>
<td>Application of short arm splint (forearm to hand); static</td>
<td></td>
</tr>
<tr>
<td>29126</td>
<td></td>
<td>Dynamic</td>
<td></td>
</tr>
<tr>
<td>29130</td>
<td></td>
<td>Application of finger splint; static</td>
<td></td>
</tr>
<tr>
<td>29131</td>
<td></td>
<td>Dynamic</td>
<td></td>
</tr>
<tr>
<td>29200</td>
<td></td>
<td>Strapping; thorax</td>
<td></td>
</tr>
<tr>
<td>29220</td>
<td></td>
<td>Low back</td>
<td></td>
</tr>
<tr>
<td>29240</td>
<td></td>
<td>Shoulder (e.g., Velpeau)</td>
<td></td>
</tr>
<tr>
<td>29260</td>
<td></td>
<td>Elbow or wrist</td>
<td></td>
</tr>
<tr>
<td>29280</td>
<td></td>
<td>Hand or finger</td>
<td></td>
</tr>
<tr>
<td>29345</td>
<td>GO, GP</td>
<td>Application of long leg cast (thigh to toes)</td>
<td>GO or GP: Always require authorization</td>
</tr>
<tr>
<td>29355</td>
<td></td>
<td>Walker or ambulatory type</td>
<td></td>
</tr>
<tr>
<td>29365</td>
<td></td>
<td>Application of cylinder cast (thigh to ankle)</td>
<td></td>
</tr>
<tr>
<td>29405</td>
<td></td>
<td>Application of short leg cast (below knee to toes)</td>
<td></td>
</tr>
<tr>
<td>29425</td>
<td></td>
<td>Walking or ambulatory type</td>
<td></td>
</tr>
<tr>
<td>29445</td>
<td></td>
<td>Application of rigid total contact leg cast</td>
<td></td>
</tr>
<tr>
<td>29505</td>
<td></td>
<td>Application of long leg splint (thigh to ankle or toes)</td>
<td></td>
</tr>
<tr>
<td>29515</td>
<td></td>
<td>Application of short leg splint (calf to foot)</td>
<td></td>
</tr>
<tr>
<td>29520</td>
<td></td>
<td>Strapping; hip</td>
<td></td>
</tr>
<tr>
<td>29530</td>
<td></td>
<td>Knee</td>
<td></td>
</tr>
<tr>
<td>29540</td>
<td></td>
<td>Ankle and/or foot</td>
<td></td>
</tr>
<tr>
<td>29550</td>
<td></td>
<td>Toes</td>
<td></td>
</tr>
<tr>
<td>29580</td>
<td></td>
<td>Unna boot</td>
<td></td>
</tr>
<tr>
<td>29590</td>
<td></td>
<td>Denis-Browne splint strapping</td>
<td></td>
</tr>
</tbody>
</table>
Casting & Splinting Supplies
(Effective for dates of service on or after May 1, 2004, these codes replace the previous X5511)

<table>
<thead>
<tr>
<th>Code</th>
<th>Required modifier</th>
<th>Description</th>
<th>Threshold based on discipline modifier GO, GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4017</td>
<td></td>
<td>Cast supplies; long arm splint, adult (11 years +), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4018</td>
<td></td>
<td>Long arm splint, adult (11 years +), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4019</td>
<td></td>
<td>Long arm splint, pediatric (0-10 years), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4020</td>
<td></td>
<td>Long arm splint, pediatric (0-10 years), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4021</td>
<td></td>
<td>Short arm splint, adult (11 years +), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4022</td>
<td></td>
<td>Short arm splint, adult (11 years +), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4023</td>
<td></td>
<td>Short arm splint, pediatric (0-10 years), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4024</td>
<td>GP, GO</td>
<td>Short arm splint, pediatric (0-10 years), fiberglass</td>
<td>GP or GO: Up to $32.00 per year without authorization</td>
</tr>
<tr>
<td>Q4041</td>
<td></td>
<td>Long leg splint, adult (11 years +), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4042</td>
<td></td>
<td>Long leg splint, adult (11 years +), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4043</td>
<td></td>
<td>Long leg splint, pediatric (0-10 years), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4044</td>
<td></td>
<td>Long leg splint, pediatric (0-10 years), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4045</td>
<td></td>
<td>Short leg splint, adult (11 years +), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4046</td>
<td></td>
<td>Short leg splint, adult (11 years +), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4047</td>
<td></td>
<td>Short leg splint, pediatric (0-10 years), plaster</td>
<td></td>
</tr>
<tr>
<td>Q4048</td>
<td></td>
<td>Short leg splint, pediatric (0-10 years), fiberglass</td>
<td></td>
</tr>
<tr>
<td>Q4049</td>
<td></td>
<td>Finger splint, static</td>
<td></td>
</tr>
<tr>
<td>Q4051</td>
<td></td>
<td>Splint supplies, misc. (includes thermoplastics, strapping, fasteners, padding and other supplies)</td>
<td></td>
</tr>
</tbody>
</table>

Hearing Aids

Hearing services are an MHCP 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 recipient with a hearing aid. After ruling out contraindications, the physician then refers the recipient 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 recipient 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:

- Hearing aid repairs;
- Accessories;
- Ear molds for hearing aids;
- Batteries; and
- Ear Impressions.

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**

- An individual may enroll as a hearing aid service provider if he/she is certified by the Minnesota Department of Health as a hearing instrument dispenser.
- Out-of-state hearing aid service providers who sell hearing aids/instruments in Minnesota must be certified by the Minnesota Department of Health.
- 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**

All hearing aids must be purchased directly from manufacturers that contract with DHS. 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:
  - Be new, current production models.
  - Be complete instruments, including all necessary equipment to make it fully functional, carrying case and all items necessary for a proper fit.
  - Use standard commercial batteries and battery sizes.
  - Be accompanied by a live performance graph and invoice at the contracted price.
  - Have a minimum 24-month manufacturer warranty covering parts and labor. The warranty is exclusive of the ear piece, cord, and batteries.
  - Have a one-year loss and damage warranty.

- No extra charge may be made for:
  - specially molded ear piece (ear molds),
  - casing color choice, or
  - hypo-allergenic or soft canal casing.
• 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 recipient at no cost to DHS or the hearing aid dealer.
• The contract price for a hearing aid cannot be further reduced or altered.
  – Orders for DHS contracted hearing aids may not be used to obtain, or grant, additional commercial discounts.
• Manufacturers will not process hearing aid orders unless all authorization requirements are met.
• 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 the information below:

• Reasons the contract aids will not meet the recipient’s needs;
• Reasons the non-contract aid will meet the recipient’s needs (describe extenuating circumstances that eliminate the possible use of a contract aid); and
• The hearing aid service provider who bills for the repair of a non-contract aid must obtain and include the purchase date and the purchase warranty expiration date of the hearing aid from the manufacturer. If the aid is under warranty, MHCP will not reimburse providers or manufacturers for repairs or the cost of returning the aid to the manufacturer.

**Dispensing Fee**

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

• Adjusting the hearing aid to the wearer, including the necessary programming on digital and digitally programmable aids,
• Provision of at least three hearing aid batteries of the type necessary to operate the hearing aid,
• Informing the recipient of the trial period,
• Instructing and counseling the recipient on use and care of the hearing aid,
• A written copy of the manufacturer’s warranty,
• Returning the hearing aid to the manufacturer for repair during the 24-month warranty period for parts and labor; and
• Replacing the aid during the 12-month replacement warranty period.
**Hearing Aid Trial Period**

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 recipient and must extend at least 30 days, but no more than 90 days. The hearing aid service provider must inform the recipient of the beginning and ending dates of the trial period, and refer the recipient to the prescribing audiologist when the aid cannot be adjusted to the recipient’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**

MHCP covers one hearing aid or set of binaural hearing aids within a period of five years for an eligible recipient. 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. MHCP considers the recipient’s physical or mental impairment in determining whether circumstances were beyond the recipient’s control if the aid is lost or broken and will only approve a replacement in those cases.

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

MHCP will not replace a lost or broken hearing aid for an adult 21 years of age or over when MHCP has replaced a hearing aid twice within the five-year period previous to the date of request. In such cases when MHCP does not provide a hearing aid, the hearing aid service provider may provide the eligible recipient with a contract hearing aid at the contract price. The hearing aid and dispensing fee shall be paid by the recipient.

**Hearing Aid Repairs**

MHCP does not cover repairs or the cost of returning the aid to the manufacturer if the aid is under warranty. All claims for hearing aid repairs must include the hearing aid expiration warranty date. To verify the hearing aid warranty has expired, hearing aid service providers must obtain the purchase date and purchase warranty expiration date from the manufacturer and submit with hearing aid repair claims. All hearing aid repairs are required to be warrantied 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. Specific repair warranty information can be found in the [Hearing Aid Volume Purchase Contract](#).

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.

**Ear Impressions**

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

**Ear Molds**

Replacement ear molds for BTE hearing aids are covered.

**Accessories**

Hearing aid accessories such as chest harnesses, telecoils, and tone and ear hooks are covered.

**Telecoils**

If not standard with recommended hearing aid, telecoils are covered:

- One aid per person;
- When the audiologist determines a recipient needs the telecoil to use the telephone; and
- After the audiologist determines that the recipient’s telephone is compatible with the hearing aid’s telecoil by report or direct examination.

**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 recipient is in need of the batteries and has requested them.

**Systems Other Than Personal Hearing Aids**

Authorization is required for all systems other than personal hearing aids. When such systems as 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:

- Why the person cannot use personal hearing aids (e.g., person’s unique inabilities to use auditory information provided via hearing aids); and
- 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).

**Non-covered Services**

- Replacement batteries provided on a scheduled basis regardless of actual need.
Services specified as part of the contract price when billed separately for payment, including charges for repair of hearing aids under warranty.

• Routine screening of individuals or groups for identification of hearing problems.

• Separate reimbursement for postage, handling, taxes, mileage, or pickup and delivery.

• Non-electronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, and battery chargers.

• 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.

• Loaner hearing aid charges.

• Canal type hearing aids.

• Non-contract hearing aids obtained without authorization.

• Services included with the dispensing fee when billed separately.

• Hearing aid services to a resident of an LTC facility 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 LTC facility, or a referral by the resident’s family, guardian or attending physician.

• Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the “safe harbor” exceptions listed in Code of Federal Regulations, title 42, 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.

• 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 LTC facility must result from a request by the recipient, or a referral by facility nursing staff or the recipient’s family, guardian, or attending physician, and be part of the recipient’s plan of care or ordered in writing by the attending physician.

• Audiologic recommendations including:
  – Written recommendation for hearing aid(s) including manufacturer specifications; and
  – Follow-up plan for determining effectiveness of hearing aid use.

• Documentation supporting audiologic recommendations:
  – 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;
  – History of previous appliance use and status of current aid(s), if applicable;
  – 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
– Audiologist’s documentation of need for amplification, this may include interpretation of audiometric data relative to recipient’s communication needs, formal hearing aid evaluation, real ear measurements, sound field, etc.

– 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.

**Billing**

All hearing aid providers must bill services on the Pharmacy/Supply Invoice (DHS-3065) or MN-ITS (837P) Professional or Medical Supply. For further billing instructions, please refer to the [Billing Policy chapter](#) (Ch. 4).

– Claims for hearing aid purchases must include:
  – Correct model number
  – Correct modifiers – NU, LT, RT
  – ICD-9 diagnosis code(s)
  – Monaural aid = 1 unit
  – Binaural aids = 2 units

– Bill the usual and customary charge.
  – Claims may not be submitted before the hearing aid(s) is dispensed.
  – Do not bill accessories included with the initial hearing aid purchase.

– Use the appropriate HCPCS code.

– Bill dispensing fee procedure code for the type of hearing aid dispensed, monaural or binaural.
  – Monaural = 1 unit
  – Binaural = 2 units

  – Dispensing fees require authorization whenever the hearing aid requires authorization.

– 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.
  – 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.

– Claims for hearing aid repairs must include the:
  – Correct model number.
  – Correct modifiers – RP, 22, LT, RT.
  – Hearing aid purchase warranty expiration date entered in the comment section of the claim form using **mm/dd/yy** format.
  – Hearing aid volume purchase contract number in the comment section of the claim form for all contract hearing aids.
  – Repair invoice for repairs of non-contract hearing aids.
- Repairs do not constitute replacement of minor parts or cleaning of a hearing aid.
  - Use the appropriate HCPCS codes to bill these services.
- Bill hearing aid batteries in quantities of one unit per battery.
- Hearing aid dispensing services cannot be billed under a hospital, clinic, or agency provider number. DHS only reimburses individuals enrolled as hearing aid service providers for hearing aid services.

The current listing of manufacturers and hearing aid models is available by viewing the [Minnesota Hearing Aid Volume Purchase Contract](#). If you do not have access to the Internet, copies of the contract can be obtained by contacting the Provider Call Center at (651) 431-2700 or 1-800-366-5411.

### Hearing Aid Services Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Service Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5070</td>
<td>Hearing aid in glasses, air conductive</td>
<td>Always require authorization</td>
</tr>
<tr>
<td>V5080</td>
<td>Hearing aid in glasses, bone conductive</td>
<td></td>
</tr>
<tr>
<td>V5150</td>
<td>Hearing aid in glasses, binaural</td>
<td></td>
</tr>
<tr>
<td>V5190</td>
<td>CROS, in glasses</td>
<td></td>
</tr>
<tr>
<td>V5230</td>
<td>BiCROS, in glasses</td>
<td></td>
</tr>
<tr>
<td>V5274</td>
<td>Assistive listening device, not otherwise specified (for use for FM systems and vibrotactile devices)</td>
<td></td>
</tr>
<tr>
<td>V5090</td>
<td>Dispensing fee, unspecified hearing aid – use when dispensing FM system and vibrotactile device</td>
<td></td>
</tr>
<tr>
<td>V5100</td>
<td>Pocket Talker</td>
<td></td>
</tr>
<tr>
<td>V5110</td>
<td>Pocket Talker dispensing fee</td>
<td></td>
</tr>
<tr>
<td>V5273</td>
<td>Assistive listening device, for use with cochlear implant</td>
<td></td>
</tr>
<tr>
<td>V5030</td>
<td>Monaural, body worn, air conductive</td>
<td>1 monaural or binaural hearing aid per 5 calendar years</td>
</tr>
<tr>
<td>V5040</td>
<td>Monaural, body worn, bone conductive</td>
<td></td>
</tr>
<tr>
<td>V5050</td>
<td>Monaural, ITE</td>
<td></td>
</tr>
<tr>
<td>V5060</td>
<td>Monaural, BTE</td>
<td></td>
</tr>
<tr>
<td>V5120</td>
<td>Binaural, on-the-body</td>
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</tr>
<tr>
<td>V5130</td>
<td>Binaural, ITE</td>
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</tr>
<tr>
<td>V5140</td>
<td>Binaural, BTE</td>
<td></td>
</tr>
<tr>
<td>V5170</td>
<td>CROS, ITE</td>
<td></td>
</tr>
<tr>
<td>V5180</td>
<td>CROS, BTE</td>
<td></td>
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<tr>
<td>V5210</td>
<td>BiCROS, ITE</td>
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<tr>
<td>V5220</td>
<td>BiCROS, BTE</td>
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</tr>
<tr>
<td>V5246</td>
<td>Monaural ITE, digitally programmable analog</td>
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</tr>
<tr>
<td>V5247</td>
<td>Monaural BTE, digitally programmable analog</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Service Thresholds</td>
</tr>
<tr>
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</tr>
<tr>
<td>V5252</td>
<td>Binaural ITE, digitally programmable</td>
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</tr>
<tr>
<td>V5253</td>
<td>Binaural BTE, digitally programmable</td>
<td></td>
</tr>
<tr>
<td>V5256</td>
<td>Monaural ITE, digital</td>
<td></td>
</tr>
<tr>
<td>V5257</td>
<td>Monaural BTE, digital</td>
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</tr>
<tr>
<td>V5260</td>
<td>Binaural ITE, digital</td>
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</tr>
<tr>
<td>V5261</td>
<td>Binaural BTE, digital</td>
<td></td>
</tr>
<tr>
<td>V5160</td>
<td>Dispensing fee, binaural</td>
<td>1 dispensing fee per 5 calendar years</td>
</tr>
<tr>
<td>V5200</td>
<td>Dispensing fee, CROS</td>
<td></td>
</tr>
<tr>
<td>V5240</td>
<td>Dispensing fee, BiCROS</td>
<td></td>
</tr>
<tr>
<td>V5241</td>
<td>Dispensing fee, monaural hearing aid, any type</td>
<td></td>
</tr>
<tr>
<td>V5266</td>
<td>Battery for use in hearing device</td>
<td>Limit, 90 day supply</td>
</tr>
<tr>
<td>V5267</td>
<td>Hearing aid supplies and accessories (e.g. chest harness, telecoils)</td>
<td>If recommended hearing aid requires authorization, parts and accessories also require authorization.</td>
</tr>
<tr>
<td>V5264</td>
<td>Ear mold/insert, not disposable, any type</td>
<td></td>
</tr>
<tr>
<td>V5299</td>
<td>Miscellaneous hearing aid servicing (e.g. removal of ear wax, cleaning)</td>
<td></td>
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</tbody>
</table>

**Legal References**

MS [256B.0625](#), subd. 8; subd. 8a; subd. 8c; subd. 31a
MS [256D.03](#), subd. 4
Minnesota Rules [4658.0525](#)
Minnesota Rules [9505.0175](#)
Minnesota Rules [9505.0210](#)
Minnesota Rules [9505.0220](#)
Minnesota Rules [9505.0385](#)
Minnesota Rules [9505.0386](#)
Minnesota Rules [9505.0390](#)
Minnesota Rules [9505.0391](#)
Minnesota Rules [9505.0392](#)
Minnesota Rules [9505.0410](#)
Minnesota Rules [9505.0411](#)
Minnesota Rules [9505.0287](#) (Hearing Aid Services)
MS [256B.0625](#), subd. 311 (Aug. Communication Devices)
42 CFR 440.110
42 CFR 483.45
42 CFR sub. H, 485.701 to 485.729
42 CFR sub. D, 486.150 to 486.163