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## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Respiratory Therapy Services**

#### **1.1.1 Assessment**

- a. Service may include testing, clinical observation, or both as appropriate for evaluation of pulmonary status, for one or more of the following, and must yield a written evaluation report to be shared with the recipient's PCP/MD.
- b. Collection of specimen for arterial blood gas (ABG) analysis.
- c. Pulmonary function studies.
- d. Breath sounds.
- e. Respiratory status (such as ABGs, pulse oximetry, pulmonary function studies, sputum cultures, apnea-bradycardiac monitors).
- f. Recipients with acute or chronic lung disease.
- g. Ventilator-dependent recipients.

#### **1.1.2 Treatment**

Service may include one or more of the following, as appropriate;

- a. Bronchodilator and aerosol therapy.
- b. Oxygen therapy.
- c. Sterile and non-sterile suctioning techniques.
- d. Tracheostomy care.
- e. Chest vibrations, postural drainage, and breathing techniques.
- f. Ventilator care.

For recipients with asthma the focus of the care must be recipient and caregiver education.

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

NC Medicaid (Medicaid) recipients must be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

The services included in this Independent Practitioners Respiratory Services policy are not covered for NC Health Choice (NCHC) recipients.

## 2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

### 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

### \*\*EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid and NC Health Choice Billing Guide:***

<http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

### **2.3 Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Recipients ages 6 through 18 years of age**

**EPSDT does not apply to NCHC recipients.** If a NCHC recipient does not meet the clinical coverage criteria within **Section 3.0** of the clinical coverage policy, the NCHC recipient will be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes will be covered for NCHC recipients.

## **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### **3.1 General Criteria**

Procedures, products, and services related to this policy are covered when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### **3.2 Specific Criteria**

Medicaid accepts the following medical necessity criteria for respiratory therapy treatment provided through the Independent Practitioner (IP) Program to Medicaid recipients ages birth to 21 years.

Prior approval is required for all treatment services. Refer to **Subsection 5.1** of this policy.

#### **3.2.1 Asthma Guidelines**

Medical necessity is determined by a diagnosis and treatment of asthma that is consistent with the most current National Institutes of Health (NIH) Guidelines for the Diagnosis and Management of Asthma at:

<http://www.nhlbi.nih.gov/guidelines/asthma/>.

Service delivery requires the following elements.

#### **Evaluation**

Evaluate in concert with the PCP/MD and as appropriate the following through interview, observation, and clinical testing:

- a. Recipient's history of episodic symptoms and how treated including allergic rhinitis.
- b. Need for oral steroids more than once in a 6 month period.
- c. Missed school, caregivers missed work or interruption in routine.

- d. Family history of asthma or allergies.
- e. History of eczema, nasal allergies, food allergies.
- f. Physical assessment [heart rate (HR), respiratory rate (RR), bilateral breath sounds (BBS)], skin color and tone, accessory muscle use.
- g. SA 02 Oximetry.
- h. Peak expiratory flow (PEF) measurement.
- i. Medication regimen and history if available.
- j. Medication/treatment compliance.
- k. Inhaler technique.
- l. Perception of symptoms.
- m. Lifestyle (such as days missed from school or day care) and limitations to normal activities.
- n. Recipient–provider communication and recipient satisfaction.
- o. Environmental Factors (e.g., exposure to tobacco smoke).
- p. Exposure to Animals.
- q. Home Heating Systems (e.g., exposure to wood burning stoves, fireplaces, kerosene heaters).
- r. Other triggers i.e. allergic rhinitis, viral infections.
- s. Colds, exercise, change in temperature , change in seasons,
- t. Strong emotional response.
- u. Menstrual cycle.
- v. Idling cars or bus .

Evaluation outcomes should include both ICD-9-CM code(s) and specific functional limitation(s), which must be measurable and quantified. Criteria can be found in the NIH Guidelines.

### Care Plan

Characteristics of the care plan must have a focus of educating the recipient and caregiver along with an anticipated discharge date. The characteristics of the care plan include:

- a. The development of the care plan with the recipient, family, and PCP/MD to determine severity level and pharmacological treatment along with the discharge date.
- b. The short-term goals: for example, “improve respiratory status as defined in functional limitations.” Educate recipient and caregiver. Amelioration of symptoms. No authorization is given without PCP/MD participation.
- c. All care plans must be reviewed and signed off by the recipient’s PCP/MD.

**Discharge**

Therapy will be discontinued when one of the following criteria is met:

- a. Recipient/ is able to follow prescribed therapy program independently or with assistance
- b. A physician orders discharge
- c. Recipient reaches age 21

**Follow-up**

At discharge, the respiratory therapist should identify indicators for potential follow-up care, such as changes in functional status, living situation, childcare, or caregiver and shared with the recipient’s PCP/MD. Any case reopened after a period of 12 consecutive months requires assessment of condition by PCP/MD.

**3.2.2 Chronic Respiratory Condition Guidelines**

The following guidelines are for chronic respiratory conditions other than asthma (such as recipients who are ventilator dependent or have a tracheostomy).

Level and Action	Characteristics
Level I—Assessment	<ul style="list-style-type: none"> <li>● Occasional day and/or night symptoms</li> <li>● Ability to clear secretions</li> <li>● Clear breath sounds</li> <li>● Mildly limited physical activity</li> </ul>
Level II—Assessment and Treatment	<ul style="list-style-type: none"> <li>● Daily and nightly symptoms</li> <li>● Ability to clear secretions</li> <li>● Clear breath sounds</li> <li>● Limited physical activity</li> </ul>
Level III—Assessment and Treatment	<ul style="list-style-type: none"> <li>● Daily and nightly symptoms</li> <li>● On-going use of inhaled short-acting beta<sub>2</sub>-agonist</li> <li>● Exacerbations affect activity</li> <li>● Exacerbations &gt;2 times a week; may last days</li> <li>● Limited physical activity or bedridden</li> </ul>
Level IV—Assessment and Treatment	<ul style="list-style-type: none"> <li>● Continual symptoms</li> <li>● Daily and nightly symptoms</li> <li>● Limited physical activity/bedridden/house-confined</li> <li>● Frequent exacerbations</li> <li>● Limited physical activity or bedridden</li> </ul>

Service delivery requires the following elements.

### **Evaluation**

Evaluate the following through the review of history, interview, observation, and clinical testing:

- a. Recipient's history.
- b. Physical assessment (HR, RR, BBS).
- c. Pulmonary assessment.
- d. Oximetry.
- e. Pulmonary function test (PFT) (if applicable).
- f. ABG (if applicable).
- g. Radiological findings.

Evaluation outcomes should include both ICD-9-CM code(s) and specific functional limitation(s), which must be measurable and quantified. Examples include the following:

- a. Inability to remove secretions by means of spontaneous cough/suctioning technique.
- b. PFTs below acceptable levels for 2 weeks.
- c. Inability to clean and maintain tracheostomy.
- d. Inability to maintain oxygen (O<sub>2</sub>) saturation at 94% or better.
- e. Inability to exert without shortness of breath.
- f. Inability to perform pursed-lip and diaphragmatic breathing.
- g. Inability to wean from mechanical life support.

### **Care Plan**

Characteristics of the care plan include the following:

- a. Development with the recipient, family, and medical provider (PCP/MD) or Respiratory Physician Specialist to determine treatment goals and outcomes
- b. Education and training of caregivers and other professional staff
- c. Short-term goals: for example, "improve respiratory status as defined in functional limitations"
- d. Long-term goals: for example, "decrease or eliminate functional deficit"

All care plans must be reviewed and signed off by the recipient's PCP/MD.

### **Discharge**

Therapy will be discontinued when one of the following criteria is met:

- a. Recipient has achieved functional goals and outcomes
- b. Recipient or family is able to follow prescribed therapy program independently or with assistance
- c. A physician orders discharge
- d. Recipient reaches age 21

At discharge, the respiratory therapist should identify indicators for potential follow-up care, such as changes in functional status, living situation, school or childcare, or caregiver and share with the recipient's medical provider (PCP/MD or Respiratory Physician Specialist)

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Non-Covered Criteria

Respiratory therapy services **are not covered** when the guidelines in this policy are not met. All services must be provided on an individualized basis (not concurrently).

Respiratory therapy services for asthma recipients **are not covered** for the following:

- a. for more than two visits at the initial request;
- b. when one of the two visits is not provided in the home;
- c. for reauthorization, when the PCP/MD does not develop the plan of care; and justification is not provided as to why the additional visits are necessary to educate the recipient's family and caregivers.

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 5.1 Prior Approval

Prior approval is required for all treatment services. For all non asthma cases after 52 visits in a period of six consecutive months approval is required for continued treatment. For asthma cases two visits are initially authorized. Reauthorization is required when additional visits are necessary after the initial two visits. The provider shall submit the request for reauthorization to DMA's vendor including:

- a. the PCP/MD developed plan of care and the justification provided by the PCP/MD as to why the additional visits are necessary to educate the recipient's family and caregivers; and
- b. the care plan must include an anticipated discharge date.

Detailed information and instructions for registering and submitting requests is available on the Carolinas Center of Medical Excellence (CCME) website:

<http://www.medicaidprograms.org/nc/therapyservices>.

Submit a request to the DMA vendor to start the approval process.

**Note:** If approval is granted, it is for medical approval only and does not guarantee payment or ensure recipient eligibility on the date of service.

## 5.2 Prior Approval Requirements

The provider(s) shall submit to DMA's designee the following:

- a. the prior approval request;
- b. all health care records and any other records that support the recipient has met the specific criteria in **Subsection 3.2** of this policy; and
- c. if the Medicaid recipient is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

## 5.3 Recipient's Location

IP respiratory therapy services may be rendered in the school, office or home. A maximum of two RT visits during a consecutive 365-day period (beginning at any point) may be provided. One of these two visits must be provided in the home. If one visit is provided in the school then one school visit remains for this consecutive 365 day period to provide staff training if reauthorization is obtained.

## 5.4 Treatment Services

The process for providing treatment, regardless of the place of service, consists of the following steps and requirements:

- a. All Respiratory Therapy services must be provided according to a written plan. All care plans must be reviewed and signed off by the recipient's PCP/MD.
- b. The written plan for services must include defined goals. For all respiratory services management, the plan must include both an education component for the recipient and the parent or caregiver and a targeted discharge date. The recipient must be present for all services.
- c. Each plan must include a specific content, frequency, and length of visits. A verbal or a written order must be obtained for services\* prior to the start of the services. Backdating is not allowed. The order must be written by the recipient's PCP/MD. The signature date must be the date the PCP/MD signs the order. Backdating is not allowed.
- d. **For non-asthma recipients** service providers must review and renew or revise plans and goals as needed, no less often than every 6 months. Review and renewal must include obtaining another dated physician signature from the recipient's PCP/MD for the renewed or revised orders as well as documented participation in developing the plan.

**For asthma recipients** a maximum of two visits in a consecutive 365 day period will be authorized as outlined in **Subsection 5.3**. A request for reauthorization must include the PCP/MD developed plan of care and the justification provided by the PCP/MD as to why the additional visits are necessary to educate the recipient's family and caregivers. Reauthorization is given for only 6 months.

For all RT services any break in service must be documented with the reason for the break and documentation of report to the PCP/MD. The current care plan must be discontinued. In order for services to resume, a new evaluation and care plan must be written that reflects family and caregiver involvement and includes the service order and signature of the PCP/MD as well as PCP/MD assessment.

There will be no reimbursement for services rendered more than the allotted time.

- e. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet. “Verbal Orders” are acceptable and must include the following components:  
Documentation must state that order was provided verbally. Date verbal order received and who received it: The order would be effective from the date it was received, unless the order specified a later effective date; ideally, verbal orders must be documented the date they were received but may be documented the following day. Faxed orders and faxed signatures are permissible and serve the same purposes for documentation as an original signature on an original form or orders sheet. Electronic signatures and printed dates are acceptable. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper/unauthorized use, and reconstruction of records in the event of a system breakdown. Stamped signatures are not permitted.

**Treatment services** are defined as therapeutic procedures that address the observed needs of the recipient and that are performed and evaluated by the qualified service provider. As one component of the treatment plan, specific objectives involving face-to-face instruction to the family, caregivers, other service providers, in the presence of the recipient, **should be included** in order to facilitate carry-over of treatment objectives into the child’s daily routine. All treatment services must be provided on an individualized basis (not concurrently).

Treatment services **do not include** consultation activities, specific objectives involving English as a second language, or treatment plans dealing primarily with maintenance or monitoring activities. Time spent for preparation, writing reports, processing claims, documentation regarding billing or service provision, and travel is not billable to the Medicaid program or to any other payment source. These administrative and overhead expenses were considered in the determination of the rate per unit of service. Only time spent in direct face to face treatment is billable.

## 5.5 Assessment Services

**Assessment services** are defined as the administration of an evaluation protocol that involves testing, clinical observation, or both, as appropriate for chronological or developmental age, that results in the generation of a written evaluation report. This protocol may include interviews with family, caregivers, other service providers, or any combination of these as a means to collect assessment data from inventories, surveys, questionnaires, or any combination of these.

Assessment services **do not include** interpretive conferences, educational placement or care planning meetings, or mass or individual screenings aimed at selecting children who may have special needs. Time spent for preparation, writing reports, processing claims, documentation regarding billing or service provision, and travel is not billable to the Medicaid program or to any other payment source. These administrative and overhead expenses were considered in the determination of the rate per unit of service.

Each written evaluation report should contain a final summary listing the diagnosis or a statement of the problem, including the primary medical diagnosis, if known, and a secondary treatment-related diagnosis, as well as the recommendations for treatment. The diagnosis should include a statement concerning the degree of severity of each condition exhibited by the recipient. The summary should also indicate whether the child has received any known assessments within the past 6 months for the type of service being billed.

The assessment must be current when treatment is begun. When continued treatment is requested for non asthma recipients, a reassessment summary of the child's status and performance must be done. For asthma recipients, if there has been a break in service within a period of 12 consecutive months, the evaluation must be completed before the start of services, along with a reassessment of the recipient's condition by PCP/MD.

## **5.6 Limitations**

Services may not be billed at the same time as those of another Medicaid provider who can provide the same services such as, Private Duty Nurses, CAP C Nurses etc. In the case of medically fragile children who are on life sustaining devices such as oxygen, mechanical ventilation CPAP etc an initial training of 1 – 2 hours with each nurse caring for the recipient with a follow-up each quarter may be provided if needed. The purpose of the respiratory therapy visit is to teach and train caregivers and licensed nursing staff, as needed, regarding the recipient's care. Ongoing respiratory therapy visits during nursing services is considered duplication of care. The Nursing agency is responsible for ensuring the competency of nursing staff.

## **6.0 Providers Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Limitations or Requirements**

For reimbursement under this policy, assessment and treatment services must be provided by a respiratory therapist licensed under the provisions of the North Carolina General Statutes, Chapter 90, Article 38 - Respiratory Care Practice Act. The provider of the service must be the biller of the service or be listed as the attending provider on the claim form if a group practice is billing.

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

## 7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

## 7.2 Documenting Services

Each provider must maintain, and allow DMA to access, the following documentation for each recipient:

- a. The recipient's name and Medicaid identification number;
- b. A copy of the treatment plan with the signature of PCP/MD;
- c. A copy of the PCP/MD order for treatment services;
- d. Description of services performed (intervention and outcome or recipient response) and dates of service; This element must be present in a note for each billed date of service.
- e. The duration of service (length of assessment or treatment session in minutes as well as time in and time out); This element must be present in a note for each billed date of service.
- f. The signature and credentials of the person providing each service. Each billed date of service must be individually documented and signed by the person providing the service. A copy of each test performed or a summary listing all test results, and the written evaluation report; Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of records and the unique signature, sanctions against improper and unauthorized use, and reconstruction of records in the event of a system breakdown;
- g. A copy of each test performed or a summary listing all test results, and the written evaluation report; and
- h. Documenting of Services should include regular sharing of appropriate clinical information with the PCP/MD. PCP/MD involvement outlined in all parts of the policy must be well documented. Parental or primary caregiver education must be documented.

## 7.3 Post-Payment Validation Reviews

Medicaid or agents acting on behalf of Medicaid will perform reviews for monitoring utilization, quality, and appropriateness of all services rendered as well as policy compliance. Post-payment validation reviews will be conducted using a statistically valid random sample from paid claims. Overpayments will be determined using monthly paid claims data. Written notice of the finding(s) will be sent to the specialized therapy provider who is the subject of the review and will state the basis of the finding(s), the amount of the overpayment, and the provider's appeal rights. Case reviews may also show the need for an educational notification to the provider.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** October 1, 2002

### Revision Information:

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
6/1/10	Throughout	Initial promulgation as separate policy (previously part of Clinical Coverage Policy 10B, Independent Practitioners). Two visits a school year may be provided in the school to provide staff training. Prior approval is required for all treatment services.
1/1/12	Subsection 1.1.2	The focus of care must be recipient and caregiver education for recipients with asthma
1/1/12	Subsection 3.2.1	Any asthma care reopened after 12 months requires assessment by PCP/MD
1/1/12	Subsection 5.1; 5.2 and 5.3	Updated info. For prior approval only two visits will be approved in consecutive 365 day period initially. Reauthorization must include a plan of care developed by the PCP/MD with justification why additional visits are necessary.
1/1/12	Subsection 5.3	Components of Verbal orders added
1/1/12	Subsection 7.2	Addition of electronic signatures
1/1/12	Attachment A	C. Removed reference to CCI D. Modifiers -applicable ones must be used F. Place of Service- school limit continues
1/1/12	Attachment A	Removed CPT code 94240
3/1/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid and NCHC managed care programs.

### A. Claim Type

Professional (CMS-1500/837P transaction)

Remember prior approval must be requested under the same provider number that services are billed under. Prior approval numbers cannot be changed by CCME unless a new request is submitted.

**Note:** Issuance of prior authorization does **not** preclude compliance with the Medicaid program's stipulation that all claims must be received by FISCAL AGENT within 365 days of the first date of service, in order to be accepted for processing and payment.

### B. Diagnosis Codes

Providers shall include ICD-9-CM diagnosis code V57.0 as a secondary diagnosis on the claim. This does not change the requirement to bill the primary diagnosis that justifies the need for the specialized therapy. **Enter the primary treatment ICD-9-CM diagnosis code first on the claim form. Follow with V57.0.**

### C. Billing Code(s)

Providers are required to select the most specific billing code that accurately describes the service(s) provided.

#### Respiratory Therapy Assessment

CPT Code	Description
94799	Unlisted pulmonary service or procedure

**Respiratory Therapy Treatment**

CPT Code	Description
31502	Tracheotomy tube change prior to establishment of fistula tract
31720	Catheter aspiration (separate procedure); nasotracheal
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
94150	Vital capacity, total (separate procedure)
94200	Maximum breathing capacity, maximal voluntary ventilation
94375	Respiratory flow volume loop
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
94667	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation
94668	Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
99503	Home visit for respiratory therapy care (e.g., bronchodilator, oxygen therapy, respiratory assessment, apnea evaluation)
99504	Home visit for mechanical ventilation care

Send claims electronically to DMA's vendor.

**Note:** Issuance of prior authorization does **not** preclude compliance with the Medicaid program's stipulation that all claims must be received by FISCAL AGENT within 365 days of the first date of service, in order to be accepted for processing and payment.

Refer to the Basic Medicaid Billing Guide for details regarding billing issues.

Refer to **Section 3.0, When the Service is Covered**, and **Subsection 5.4, Treatment Services**, for additional information.

ICD-9 Code	Description
V57.0	Care involving breathing exercises

**D. Modifiers**

Providers are required to follow applicable modifier guidelines.

**E. Billing Units**

For all codes shown in Procedure Codes in this Attachment, 1 unit = 1 event.

**F. Place of Service**

School, Home or Office. Visits in the school are provided as outlined in **Subsection 5.3** of the policy.

**G. Co-payments**

Respiratory therapy services do not require a co-payment.

## **H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>