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Related Clinical Coverage Policies

Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:

- 3G, Private Duty Nursing
- 3K-1, Community Alternatives Program for Children (CAP/C)
- 5A, Durable Medical Equipment
- 10A, Outpatient Specialized Therapies

1.0 Description of the Procedure, Product, or Service

Respiratory therapy services are services provided by a licensed Respiratory Care Practitioner according to the NC state laws. Respiratory therapy services consist of an assessment and treatment related to pulmonary dysfunction secondary to a chronic respiratory condition.

Respiratory therapy is a service prescribed by a physician (Doctor of Medicine) and provided by an Independent Practitioner Provider (IPP) that relates to impairment of respiratory function and other deficiencies of the cardiopulmonary system. IPP within this policy refers to a licensed respiratory therapist who is an Independent Practitioner Provider.

The beneficiary's Primary Care Provider (PCP), shall be a Doctor of Medicine (MD) as defined under General Statute **§ 90-648(9)**, and for the purpose of this policy, is designated as the PCP-MD throughout the policy.

For a beneficiary, who has either asthma or an unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified, the IPP's primary service objective is to provide education to the beneficiary and legal parent(s), legal guardian(s) or foster care provider(s). The education must enable the beneficiary and legal parent(s), legal guardian(s), or foster care provider(s) to independently follow and comply with the beneficiary's written Action Plan (AP).

1.1 Definitions

1.1.1 Assessment

Assessment services are defined as the administration of an assessment protocol, involving testing and clinical observation as appropriate for chronological or developmental age, which results in the generation of a written assessment report. The IPP shall collaborate with legal parent(s) or legal guardian(s), foster care provider(s), caregivers, other service providers, and teachers as a means to collect assessment data from inventories, surveys, and questionnaires. The IPP shall provide the written assessment report to the PCP-MD for continuum of care.

The IPP's written assessment report must contain one or more of the following components for a beneficiary with asthma, unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified, chronic respiratory condition or ventilator dependency:

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a. collection of specimen for arterial blood gas (ABG) analysis;
b. pulmonary function studies;
c. Spirometry [measures the forced vital capacity (FVC), the maximal amount of air expired from the point of maximal inhalation, and the forced expiratory volume in one second (FEV_1)];
d. breath sounds; or
e. respiratory status (such as ABGs, oxygen saturation by pulse oximetry (SpO_2), sputum cultures, apnea monitors).

1.1.2 Treatment

Treatment services are therapeutic procedures that address the observed needs of an individual beneficiary and are performed and evaluated by the IPP. Specific objectives, involving face-to-face instruction to the legal parent(s) or legal guardian(s), foster care provider(s), or caregivers, in the presence of the beneficiary, must be completed and documented by the IPP in order to facilitate carry-over of treatment objectives into the child's daily routine.

Respiratory therapeutic procedure means one or more of the following, as appropriate;
a. Bronchodilator or aerosol therapy;
b. Oxygen therapy;
c. Sterile and non-sterile suctioning techniques;
d. Tracheostomy care;
e. Chest vibrations, postural drainage, and breathing techniques; or
f. Ventilator care.

1.1.3 Action Plan

The Action Plan (AP) for beneficiaries diagnosed with Asthma, Unspecified Disease of Respiratory System, Respiratory Disease (chronic) Not Otherwise Specified and Chronic Respiratory Condition must be developed and revised with the beneficiary, legal parent(s), legal guardian(s), or foster care provider(s) and PCP-MD. The Action Plan is to help families become proactive and anticipatory with respect to the beneficiary's current respiratory condition. The AP is used as an education and communication tool between the PCP-MD, IPP, beneficiary, legal parent(s) or legal guardian(s). The beneficiary, legal parent(s),legal guardian(s) or foster care provider(s) shall demonstrate an understanding of the plan and the appropriate use of pharmacological treatments. The AP must document the following:
a. the beneficiary's name and Medicaid identification number;
b. PCP-MD's determination of respiratory severity classification (http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/quick-reference);
c. beneficiary's triggers;
d. instructions for exercise limitations or modifications for the beneficiary, legal parent(s),legal guardian(s) or foster care provider(s) to follow;
e. beneficiary's symptoms that would illicit procedures or prescribed actions;

f. respiratory procedures to be followed by beneficiary, legal parent(s), legal guardian(s) or foster care provider(s);
g. actions prescribed by IPP to be followed by beneficiary, legal parent(s), legal guardian(s) or foster care provider(s);
h. pharmacological treatment prescribed by the PCP-MD;
i. when the beneficiary, legal parent(s), legal guardian(s) or foster care provider(s) shall seek emergency assistance.

1.1.4 Legal Parent(s)

Legal parent(s) are either biological parent(s) or adoptive parent(s).

1.1.5 Foster Care Provider(s)

A foster care provider must be licensed under NC General Statute 131D-10.3.

1.1.6 Discharge

For the purpose of this clinical coverage policy, discharge means discontinuation of respiratory therapy services.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

a. <u>Medicaid</u>

Medicaid beneficiaries under 21 years of age are eligible for Respiratory Therapy Services by an IPP.

b. NCHC

None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. 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 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 beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

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

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover procedures, products, and services related to this policy 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 beneficiary'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 beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

a. Additional Criteria covered for Asthma and Unspecified Disease of Respiratory System, Respiratory Disease (chronic) Not Otherwise Specified

1. Medicaid and NCHC shall use the current National Institutes of Health (NIH) Guidelines for the Diagnosis and Management of Asthma at: http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/ to determine medical necessity for respiratory therapy services by IPPs.
2. Medicaid and NCHC shall cover medically necessary respiratory therapy services by an IPP to a beneficiary diagnosed with either asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified when **ALL of the following are completed:**

A. Assessment

Collaborative assessment with the PCP-MD that addresses all of the following aspects of the beneficiary's respiratory condition, treatment history, environment and caregiver support as applicable:

i. presence of episodic symptoms and management;
ii. need for oral steroids more than once in a six (6) consecutive month period;
iii. missed school or day care by beneficiary, missed work by legal guardian(s),legal parent(s) or foster care provider(s) or interruption in daily routine;
iv. family history of asthma or allergies;
v. beneficiary and family history of eczema, nasal allergies, food allergies;
vi. physical assessment [heart rate (HR), respiratory rate (RR), bilateral breath sounds (BBS), skin color and tone, and accessory muscle use];
vii. oxygen saturation by pulse oximetry;
viii. peak expiratory flow (PEF) measurement;
ix. medication regimen and history;
x. medication and treatment compliance;
xi. inhaler technique;
xii. beneficiary and legal parent(s), legal guardian(s) or foster care provider(s) perception of asthma regarding triggers, treatment and use of medication;
xiii. lifestyle limitations to normal daily activities;
xiv. environmental factors [such as exposure to tobacco smoke, exposure to animals, air pollution, exposure to home heating systems (wood burning stoves, fireplaces, or kerosene heaters)];
xv. nonspecific symptoms such as a history of recurrent bronchitis, bronchiolitis, or pneumonia; a persistent cough with colds; recurrent croup or chest rattling;
xvi. other triggers (such as respiratory infection, exercise, change in temperature or change in seasons); and
xvii. training required by legal parent(s), legal guardian(s) or foster care provider(s).

The written assessment report must document the assessment results, the current diagnosis and specific measurable and quantified functional limitations. The report must identify all education needed to complete transfer of care to beneficiary and legal parent(s), legal guardian(s) or foster care provider(s) and promote discharge of care.

B. Treatment Services

Medicaid shall cover treatment services provided to a beneficiary on an individualized basis. Medicaid shall not cover services provided to a group of two or more beneficiaries occurring at the same time in the same location. Only time spent in direct face-to-face treatment of an individual beneficiary is covered.

C. Plan of Care (POC)

The Plan of Care (POC) must:

i. be developed with the IPP, beneficiary, legal parent(s), legal guardian(s) or foster care provider(s) and PCP-MD;
ii. document the PCP-MDs determination of the asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified severity level and pharmacological treatment;
iii. document the anticipated discharge date;
iv. be reviewed and signed by the beneficiary's PCP-MD
v. document service goals, service objectives and methods to address educating the beneficiary and legal parent(s),legal guardian(s) or foster care provider(s) to comply with the beneficiary's AP;
vi. address the daily management of the beneficiary's asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified;
vii. document the signature, date of signature and credentials of the IPP;
viii. document the development of the AP with PCP-MD, beneficiary, legal parent(s), legal guardian(s) or foster care provider(s) within the first three respiratory therapy visits as a revision to the POC if not originally included; and
ix. specify respiratory tools provided to the beneficiary within the first three (3) visits.

D. Discharge

The beneficiary shall be discharged from respiratory therapy services by the IPP when one (1) or more of the following criteria occurs:

i. the beneficiary, legal parent(s), legal guardian(s) or foster care provider(s) is able to follow the written Action Plan independently or with assistance;
ii. the beneficiary is discharged by the physician's written order;
iii. the beneficiary is 21 years of age; or
iv. the beneficiary, legal parent(s),legal guardian(s) or foster care provider(s) are non-compliant with one or more instructions or action items on the beneficiary's AP.

E. Follow-up

i. At discharge, the IPP shall identify in writing indicators for potential follow-up care, such as changes in functional status, living situation, school or childcare, caregiver, legal parent(s), legal guardian(s) or foster care provider(s) and provide documentation to the beneficiary's PCP-MD.
ii. After a period of 365 consecutive days beginning with the **discharge date**, a beneficiary requiring additional respiratory therapy services shall have an assessment of their respiratory condition by PCP-MD before an IPP assessment is administered.

b. Additional Criteria Covered for Chronic Respiratory Condition Guidelines

Medicaid and NCHC shall cover Respiratory Therapy Services by an IPP for chronic respiratory conditions other than asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified when the following criteria are met:

1. Severity classification, based on ALL of the following components:
   A. frequency and severity of symptoms;
   B. nighttime awakenings;
   C. use of short-acting beta$_2$ agonist for symptom control; and
   D. interference with normal activity;

   Medicaid and NCHC accepts the American Association for Respiratory Care (AARC) Clinical Practice Guidelines at: http://www.rcjournal.com/cpgs/.

2. The following components must be met:

   A. Assessment

   A collaborative assessment with the PCP-MD of the following:
   i. beneficiary's history of respiratory symptoms and treatment;
   ii. physical assessment (heart rate (HR), respiratory rate (RR), bilateral breath sounds (BBS), skin color and tone, accessory muscle use)
   iii. pulmonary assessment;
   iv. oxygen saturation by pulse oximetry;
   v. Pulmonary Function Test (PFT) (if applicable);
   vi. ABG (if applicable); and
   vii. radiological findings.

   The written assessment report must document the assessment results, the current diagnosis and specific measurable and quantified functional limitations. The written assessment report must identify ALL of the following:
   i. the beneficiary's ability to remove secretions by means of spontaneous cough or suctioning technique;
   ii. the amount of PFTs below acceptable levels for 2 consecutive weeks;
   iii. the beneficiary's, legal parent(s)', legal guardian(s)' or foster care provider(s)' ability to clean and maintain the tracheostomy if applicable;
   iv. the beneficiary's ability to maintain oxygen (O_2) saturation by pulse oximetry at 92 to 97%;
   v. the beneficiary's ability to engage in normal daily activities or desired activities;
   vi. the beneficiary's ability to perform pursed-lip and diaphragmatic breathing; and
   vii. the beneficiary's ability to be weaned from a ventilator if applicable.

   B. Treatment Services

   Medicaid and NCHC shall cover treatment services provided to a beneficiary on an individualized basis. Medicaid and NCHC shall not cover services provided to a group of two or more beneficiaries occurring at the same time in the same location. Only time spent in direct face-to-face treatment of an individual beneficiary is covered.

C. Plan of Care

The Initial and any Revised Plan of Care (POC) must:

i. be developed with the IPP, beneficiary, legal parent(s), legal guardian(s) or foster care provider(s), and PCP-MD or Pulmonologist;
ii. document PCP-MD's determination of the chronic respiratory condition severity level and pharmacological treatment;
iii. document service goals, service objectives and methods to address educating the beneficiary and legal parent(s), legal guardian(s) or foster care provider(s)to comply with the beneficiary's AP;
iv. be reviewed and signed by the beneficiary's PCP-MD; and
v. address the daily management of the beneficiary's chronic respiratory condition; and
vi. document the AP development with PCP-MD, beneficiary, legal parent(s), legal guardian(s) or foster care provider(s) within the first three respiratory therapy visits.

D. Discharge

The beneficiary shall be discharged from respiratory therapy services by the IPP when one (1) of the following criteria occurs:

i. beneficiary, is able and willing to participate in respiratory care, or has legal parent(s), legal guardian(s) or foster care provider(s) assistance to meet his or her respiratory care needs;
ii. the beneficiary is discharged by the physician's written order;
iii. beneficiary is 21 years of age; or
iv. non-compliance with one or more instructions or action items on the beneficiary's chronic respiratory condition action plan (AP) by beneficiary, legal parent(s), legal guardian(s) or foster care provider(s).

E. Follow-up

i. At discharge, the IPP shall identify in writing indicators for potential follow-up care, such as changes in functional status, living situation, school or childcare, caregiver, legal parent(s), legal guardian(s) or foster care provider(s) and provide documentation to the beneficiary's PCP-MD
ii. After a period of 365 consecutive days beginning with the discharge date, a beneficiary requiring additional respiratory therapy services shall have an assessment of their respiratory condition by PCP-MD before an IPP assessment is administered.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service 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 Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

a. Medicaid and NCHC shall not cover the below assessment services separately:
   1. interpretive conferences,
   2. educational placement meetings,
   3. care planning meetings, and
   4. group or individual screenings aimed at selecting children who may have respiratory therapy needs.
b. Medicaid and NCHC shall not cover time spent for:
   1. preparation;
   2. report writing;
   3. processing of claims;
   4. documentation regarding billing or service provision; and
   5. travel time and expenses.
c. Medicaid and NCHC shall not cover the below treatment services separately, because these administrative and overhead expenses were considered in the determination of the rate per unit of service:
   1. consultation activities,
   2. specific objectives involving English as a second language, or
   3. POC dealing primarily with maintenance or monitoring activities.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid and NCHC shall require prior approval for Respiratory Therapy Services by an IPP.

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

Note: Medicare beneficiaries are exempt from Prior Approval and visit limits in this policy.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

Detailed information and instructions for registering and submitting prior approval requests are available on the Carolinas Center of Medical Excellence (CCME) Choice PA website:
https://www.medicaidprograms.org/NC/ChoicePA/Account/Login.aspx

For Medicaid and NCHC beneficiaries diagnosed with asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified, a maximum of 15 respiratory therapy visits during a six (6) consecutive month time frame can be requested for prior authorization.

Prior approval must be requested under the billing NPI. For any increase in the therapy frequency beyond what was originally approved and what is documented in the POC, a new PA request must be submitted and approval received before implementing the increase in frequency.

When requesting reauthorization, the provider shall submit the prior authorization request to the DHHS Utilization Review Contractor with the following:

a. The justification provided by the PCP-MD explaining why the additional visits are necessary and why previously authorized visit were ineffectual to educate the beneficiary's legal parent(s), legal guardian(s) or foster care provider(s); and
b. The POC must list an anticipated discharge date.

5.3 Limitations or Requirements

Respiratory Therapy Services by the IPP cannot be provided at the same time on the same date of service as those of another Medicaid or NCHC provider who can provide the same services (such as CAP/C nurses or Private Duty nurses). In the case of medically fragile children, refer to clinical coverage policy 3K-1, Community

Alternatives Program for Children (CAP/C) and clinical coverage policy 3G, Private Duty Nursing (PDN) on DMA's website at http://www.ncdhhs.gov/dma/mp/.

The respiratory therapist shall ensure that all respiratory therapy device(s) specified on the Plan of Care and the AP are received by the beneficiary within the first three (3) respiratory therapy visits.

Respiratory Therapy treatment visits by the IPP must occur in the beneficiary's primary private residence and focus on legal parent(s), legal guardian(s) or foster care provider(s) education. The IPP may provide two (2) respiratory therapy treatment visits of the allowed 15 treatment visits in either the school or other location (day care) during a six (6) consecutive month time frame to provide staff training.

The beneficiary shall be present and actively participating during each session.

5.4 Providing Respiratory Therapy Services Treatment

The process for providing Respiratory Therapy treatment Services by IPP, regardless of the place of service, consists of the following steps and requirements:

a. All respiratory therapy treatment services must be provided according to a written POC. All POCs must be reviewed and signed by the beneficiary's PCP-MD prior to the first date of treatment and are only valid for a maximum of six (6) consecutive months
b. The written POC for respiratory therapy treatment services must contain measureable respiratory treatment goals, an education component for the beneficiary and the legal parent(s), legal guardian(s) or foster care provider(s) to facilitate independence in following the AP and a targeted discharge date. The beneficiary shall be present for all services.
c. Each POC must contain skilled interventions, frequency of services, duration of the therapy plan, and length of each treatment visit in minutes that are specific to respiratory therapy.
d. For respiratory therapy services, the respiratory therapist must obtain a verbal or written order prior to the start of the service.
    1. verbal orders must be documented by the person receiving the verbal order and the date received. Verbal orders are to be countersigned by the PCP-MD within sixty calendar days. The date the verbal order is received and documented begins the six (6) consecutive month time-frame of physician order vailidity. **Backdating is not allowed.**
    2. written order must be authenticated by the beneficiary's PCP-MD and is valid for a maximum of six (6) consecutive months. The signature date must be the date the PCP-MD signs the order. The signature date begins the six (6) consecutive month time frame of physician order validity. **Backdating is not allowed**.
e. For a beneficiary with chronic respiratory condition (refer to **Subsection 3.2.4**), respiratory therapy providers shall review or revise POC and measureable goals as needed every six (6) months. Any revisions to the existing POC during the six (6) consecutive month authorization period, require another dated physician signature from the beneficiary's PCP-MD documenting his or her participation in revising the

POC. A new physician written order is required every six (6) consecutive months for continued respiratory therapy services.

f. For a beneficiary with asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified a maximum of 15 visits in a six (6) consecutive month time frame can be authorized as outlined in **Subsection 5.2.2.** A request for reauthorization must contain the following: PCP-MD's signature on the collaboratively developed POC, the justification provided by the PCP-MD to explain why the additional visits are necessary and why previously authorized visit were ineffectual to educate the beneficiary's legal parent(s), legal guardian(s) or foster care provider(s). Prior authorization is given for only six (6) consecutive months from the date of physician signature on the written order.

g. Faxed orders and faxed signatures are permissible and serve the same purpose for documentation as an original signature on an original written physician order and POC.

h. Verbal orders are acceptable and must contain the following components:
   1. Documentation must state that order was provided verbally;
   2. Date verbal order received;
   3. Name of the person who documented the verbal order; and
   4. Countersignature of PCP-MD within sixty calendars days.

i. Electronic signatures and printed dates are acceptable. Providers using electronic signatures shall maintain policies regarding the use of electronic documentation addressing the security of health records and the unique signature, sanctions against improper or unauthorized use, and reconstruction of records in the event of a system breakdown. **Stamped signatures are not permitted.**

5.5 Assessment and Reassessment Services

The assessment must be current within 30 calendar days when prior authorization is requested for Respiratory Therapy Services by an IPP. Refer to **Subsection 1.1.1** for the definition and components of a respiratory assessment.

The written assessment or reassessment report must contain:

a. the beneficiary's primary medical diagnosis;

b. the beneficiary's secondary treatment-related diagnosis that contains a statement concerning the degree of severity of each condition;

c. a statement of the beneficiary's respiratory deficits and functional limitations;

d. recommendation for beneficiary's treatment;

e. documentation of PCP-MD visits within the previous six (6) consecutive month time frame pertaining to the chronic respiratory condition;

f. documentation of any previous respiratory therapy assessments and respiratory services;

g. current abilities to manage respiratory care; and

h. methods to incorporate education of beneficiary, legal parent(s), legal guardian(s) or foster care provider(s) into all points of respiratory care.

When continued treatment is requested for a beneficiary with a chronic respiratory condition, a reassessment report of the beneficiary's respiratory status and functional performance measures must be documented.

When continued treatment is requested for a beneficiary with asthma or unspecified disease of respiratory system, respiratory disease (chronic) not otherwise specified, a reassessment report of the beneficiary's respiratory status and functional performance measures must be documented.

When there has been any interruption in obtaining prior authorization for respiratory therapy service, the IPP shall:

a. complete an assessment prior to requesting prior authorization;
b. provide PCP-MD's most current assessment of the beneficiary's respiratory condition; and
c. complete and submit a new prior authorization request along with a. and b. above.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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 Provider Qualifications and Occupational Licensing Entity Regulations

Assessment and treatment services must be provided by a licensed respiratory therapist under the provisions of North Carolina General Statutes, Chapter 90, Article 38 - Respiratory Care Practice Act.

The following laws and regulations apply to Respiratory Therapists:

a. Qualified respiratory therapist defined under 42 CFR § 440.185;
b. The respiratory therapist shall comply with G.S. Chapter 90, Article 38 also known as the Respiratory Care Practice Act, Article 648(11) and Article 648 (12); and
c. Title 21 NCAC Chapter 61 Respiratory Therapy.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documenting Services

The IPP shall maintain, and allow DMA to access, the following documentation for each beneficiary:

a. The beneficiary's name and Medicaid or NCHC identification number;
b. A copy of the POC with the signature of PCP-MD;
c. A copy of the PCP-MD written order or PCP-MD countersigned verbal order for treatment services;
d. Description of services performed (skilled intervention and outcome or beneficiary response) and dates of service; this element must be present in a note for each 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 date of service;
f. Each date of service must be individually documented and contain the signature and credentials of the person providing each service;
g. A copy of each test performed or a summary listing **all** test results pertaining to the beneficiary's respiratory condition, and the written assessment report;
h. Date(s) of communication and information communicated with the PCP-MD;
i. Description of education and training provided to the beneficiary, legal parent(s), legal guardian(s) or foster care provider(s);
j. A copy of the educational materials provided to beneficiary, legal parent(s), legal guardian(s) or foster care provider(s); and
k. Beneficiary's, legal parent(s)', legal guardian(s)' or foster care provider(s)' skill level, competence and compliance with actions specified on the AP.

7.3 Post-Payment Reviews

Medicaid, NCHC and DHHS Utilization Review Contractor(s) shall perform reviews for monitoring utilization, quality, and appropriateness of all services rendered as well as compliance with all applicable clinical coverage policies. Post-payment validation reviews are conducted using a statistically valid random sample from paid claims. Program Integrity reviews may be conducted in order to address specific complaint(s). Program Integrity or its Utilization Review Contractor may select records of the complainant and those of several other Medicaid or NCHC beneficiaries when the claim appears similar in nature to the services billed on behalf of the complainant for post payment review. Overpayments are determined from review of the paid claims data selected for review or based on the statistically valid random sampling methodology approved for use by DMA.

The findings of the post payment review or utilization review are sent to the respiratory therapy provider who is the subject of the review in writing. Notices of error findings, Educational/Warning Letters and Tentative Notices of Overpayment findings contain a description of the findings, the basis for the findings, the tentative overpayment determination and information regarding the provider's appeal rights.

7.4 Prepayment Claims Review

Respiratory Therapy Providers may be subject to Prepayment Claims Review under NC General Statutes **§ 108C-7.**

8.0 Policy Implementation and History

Original Effective Date: October 1, 2002

History:

Date	Section Revised	Change
06/01/2010	All sections and attachment(s)	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.
01/01/2012	Subsection 1.1.2	The focus of care must be recipient and caregiver education for recipients with asthma
01/01/2012	Subsection 3.2.1	Any asthma care reopened after 12 months requires assessment by PCP/MD
01/01/2012	Subsection 5.1; 5.2 and 5.3	Updated info. For prior approval only two visits will be approved in consecutive365 day period initially. Reauthorization must include a plan of care developed by the PCP/MD with justification why additional visits are necessary.
01/01/2012	Subsection 5.3	Components of Verbal orders added
01/01/2012	Subsection 7.2	Addition of electronic signatures
01/01/2012	Attachment A	C. Removed reference to CCI D. Modifiers -applicable ones must be used F. Place of Service- school limit continues
01/01/2012	Attachment A	Removed CPT code 94240
03/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
09/01/2015	Subsection 1.0	Entire section rewritten for clarification
09/01/2015	Subsection 2.1.2	Added: "Medicaid Beneficiaries under 21 years of age are eligible for respiratory therapy services
09/01/2015	Subsection 3.2	Entire section rewritten for clarification
09/01/2015	Subsection 4.2	Removed section and added "None Apply"
09/01/2015	Subsection 4.3	Entire section rewritten for clarification
09/01/2015	Subsection 5.1	Entire section rewritten for clarification
09/01/2015	Subsection 5.2	Entire section rewritten for clarification

Date	Section Revised	Change
09/01/2015	Subsection 5.3	Entire section rewritten for clarification
09/01/2015	Subsection 5.4	Entire section rewritten for clarification
09/01/2015	Subsection 5.5	Entire section rewritten for clarification
09/01/2015	Subsection 5.6	Entire section rewritten for clarification
09/01/2015	Subsection 6.1	Added: "The following are laws and regulations for Respiratory Therapist: Qualified respiratory therapist defined under 42 CFR § 440.185 The respiratory therapist shall comply with G.S. Chapter 90, Article 38 also know as the Respiratory Care Practice Act, Article 648(11) and Article 648 (12) Title 21 NCAC Chapter 61 Respiratory Therapy"
09/01/2015	Subsection 7.2	Entire section rewritten for clarification
09/01/2015	Subsection 7.3	Entire section rewritten for clarification
09/01/2015	Attachment A	Entire section rewritten for clarification
09/01/2015	Subsection 2.1.2b	Added coverage criteria for NCHC
09/01/2015	Subsection 3.2.1	Added specific criteria covered for NCHC beneficiaries with Asthma and unspecified Disease of Respiratory System, Respiratory Disease (chronic) Not Otherwise Specified.
09/01/2015	Subsection 3.2.1	Added specific criteria covered for NCHC beneficiaries Chronic Respiratory Condition
09/01/2015	Subsection 4.2.1	Added specific criteria not covered for NCHC beneficiaries.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

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

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall select the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), ICD-10-CM procedure codes, and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description as it is no longer documented in the policy.

The assessment CPT code 94799 must only be billed by the IPP for the following:

a. the initial assessment prior to the initial prior authorization request;
b. when there has been a significant measurable change in the beneficiary's respiratory status; and
c. a reassessment prior to submitting a request for reauthorization.

Each assessment must elicit a written assessment report that complies with the requirements in **Subsections 1.1.1, 3.2.2(1), 3.2.3(1)**, and **5.5**.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Respiratory Therapy Assessment

CPT Code(s)
94799

Respiratory Therapy Treatment

CPT Code(s)
31502
31720
94010
94060
94150
94200
94375
94664
94667
94668
94760
99503
99504

Note: Send claims electronically to DHHS Fiscal Contractor.

Unlisted Procedure or Service CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

Refer to *NCTracks Provider Claims and Billing Assistance Guide*: **https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html** for details regarding billing. Refer to **Section 3.0**, When the Procedure, Product, or Service is Covered, and **Subsection 5.4**, Providing Respiratory Therapy Services Treatment, for additional information.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
For all codes shown in CPT Codes in this Attachment(C), 1 unit = 1 event.

F. Place of Service

Primary Private Residence (POS code 12), Other (POS code 99),
School (POS code 03) or Office (POS code 11): Refer to **Subsection 5.3** of this policy regarding respiratory therapy treatment visits allowed in either the school or other (day care) location.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: http://www.ncdhhs.gov/dma/fee/