

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 [Children's Services, chapter 9](#), and rehabilitative services provided by home health agencies are addressed in [Home Care Services, chapter 24-A](#).

Definitions

Audiologist: A health care professional who engages in the practice of audiology, meets the qualifications required by MS 148, and is licensed by the Minnesota Department of Health, or where applicable, licensed or registered by the state in which he/she practices. If the state does not license providers of audiology services, the applicant for enrollment with Minnesota Health Care Programs (MHCP) must demonstrate that he/she meets the Certificate of Clinical Compliance (CCC) and practicum requirement listed below:

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

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

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

Direction: The actions of a physical 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 member when treatment is provided by an assistant and meets the other supervisory requirements of MN Rules [5601](#) and MS [148.6432](#) and the therapy disciplines' respective licensure requirements.

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

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

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

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

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

Long-Term Care (LTC) Facility: Nursing facility (NF), Skilled Nursing Facility (SNF), or intermediate care facility for the developmentally disabled (ICF/DD).

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 MN Rules [5601](#).

Physical Therapist Assistant (PTA): A graduate 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 MN Rules [4658.0525](#).

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

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

Eligible Providers

1. Audiologist
2. CORF
3. Hearing aid service provider
4. LTC facility
5. Occupational therapist
6. Otolaryngologist
7. Physical therapist
8. Rehabilitation agency
9. Speech-language pathologist

Enrollment Requirements

Physical Therapists/Occupational Therapists

An individual is eligible to enroll as an independently enrolled therapist if he/she is either a physical therapist or an occupational therapist as defined in this chapter and not an employee of a hospital, Critical Access Hospital (CAH), Skilled Nursing Facility (SNF), Home Health Agency (HHA), hospice, CORF, physician clinic, Community Mental Health Center (CMHC), a rehabilitation agency, or Public Health Agency.

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

Physical 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.

Speech-Language Pathologists

SLPs, as defined in this chapter, are eligible to enroll as independent providers if they maintain an office at their own expense. An individual completing the clinical fellowship year required for certification is not eligible to enroll as an independent speech language pathologist.

Audiologists

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

Supervision during Fellowship Year of Speech-language Pathology and Audiology

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

Eligible Members

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

Plan of Care

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

The plan of care must be reviewed, revised, and signed as medically necessary by the member's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 60 days. If the service is a Medicare-covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

The following must be documented in the member's plan of care:

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

The plan of care must be signed by the prescribing/ordering physician or licensed practitioner of the healing arts.

Member's Record of Services

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

1. The date, type, length, and scope of each rehabilitative and therapeutic service provided to the member
2. The name or names and titles of the people providing or supervising each rehabilitative and therapeutic service
3. A statement, every 30 days by the therapist providing or supervising the services provided to a long-term care member that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the member in accordance with Minnesota Statutes (not required for an initial evaluation)

See documentation requirements as specified in the [Health Care Programs and Services, chapter 2](#).

Covered Services

To be covered as a rehabilitative and therapeutic service:

1. Physical therapy and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law.
2. Speech-language pathology and audiology services must be provided:
 - a. upon written referral by a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law, or in the case of a LTC facility resident, on the written order of a physician; and
 - b. by an SLP, audiologist, or a person completing the clinical fellowship year required for certification as an SLP or audiologist under the supervision of an SLP or audiologist as specified in MS [148.515](#), subd. 4.
3. Occupational therapy and physical therapy must require the skills of a PT, OT, or therapy assistant that is under the direction of a PT or an OT. The 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.
4. Treatment must be specified in a plan of care that is reviewed and revised as medically necessary by the member's attending physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 60 days (see *Plan of Care* section in this chapter for additional requirements).
5. The member's functional status must be expected by the physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law to progress toward or achieve the objectives in the member's plan of care within a 60-day period.

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 member's residence. However, if services are provided to Medicare-eligible members, providers must comply with Medicare's site requirements.

Specialized Maintenance Therapy

Specialized maintenance therapy is covered only when it is provided by a PT, OT, therapy assistant, or SLP, specified in a plan of care that meets the requirements of this chapter, and provided to members whose condition cannot be maintained or treated only through rehabilitative nursing services, as defined in MN Rules [4658.0525](#), or services of other care providers, or by the member because the member's physical, cognitive or psychological deficits result in:

1. Spasticity or severe contracture that interferes with the activities of daily living or the completion of routine nursing care, or decreased functional ability compared to the member's previous level of function; or
2. A chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance movement patterns, activities of daily living, cardiovascular function, integumentary status, or positioning necessary for completion of the member's activities of daily living, or decreased abilities relevant to the member's current environmental demands.

Specialized maintenance therapy must have expected outcomes that are:

1. Functional
2. Realistic
3. Relevant
4. Transferable to the member's current or anticipated environment, such as home, school, community, work
5. Consistent with community standards

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

1. Prevent deterioration and sustain function;
2. Provide interventions, in the case of a chronic or progressive disability, that enable the member to live at his/her highest level of independence; or
3. Provide treatment interventions for members who are progressing but not at a rate comparable to the expectations of restorative care.

Standards for Augmentative Communication Devices (E2500 – E2599)

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

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

Criteria for Authorization of Augmentative Communication Devices

Refer to [Equipment and Supplies, chapter 23](#), of this *Provider Manual* for specific information about authorization criteria for Augmentative Communication Devices.

Non-covered Services Relating to Augmentative Communication Devices

1. Augmentative communication/speech-generating devices requested for the sole purpose of education
2. Environmental control devices such as switches, control boxes, or battery interrupters
3. Modification, construction, programming, or adaptation of communication systems
4. Repairs, cleaning, or other services for devices that are not dedicated communication devices

5. Upgrading to new technology that is not proven to be medically necessary
6. Replacing devices based on the manufacturer's recommended replacement schedule
7. Facilitated communication: a technique by which a "facilitator" provides physical and other supports in an attempt to assist a person with a significant communication disability to point to pictures, objects, and printed works or letters (PrimeWest Health does not cover facilitated communication by any provider)
8. Personal computers, laptop computers, iPods, and other personal media players that are not dedicated communication devices
9. Telephones
10. Carry cases

Augmentative Communication Device Billing Procedures

1. 92597* : Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
2. 92605* : Evaluation for prescription of non-speech generating augmentative and alternative communication device
3. 92606* : Therapeutic service(s) for the use of non-speech generating device, including programming and modification
4. 92607* : Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour
5. 92608* : Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)
6. 92609* : Therapeutic services for the use of speech-generating device, including programming and modification
7. 92618* : Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)

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

Rehabilitation Services Thresholds

The following instructions apply to rehabilitative, therapeutic, and audiology services provided to PrimeWest Health members living in the community or an LTC facility.

1. PrimeWest Health follows DHS service thresholds for OT, PT, and SLP. Currently these thresholds are applied annually (from January – December). Medically necessary services needed beyond the service thresholds require authorization.
2. Audiology service thresholds are by calendar year (see *Rehabilitation Services Billing Threshold Chart* in this chapter).
3. Members may require a greater number of evaluations, modalities, or procedures than the initial service threshold. Members may receive additional medically necessary services with authorization.
4. Medicare crossover claims for the payment of member's coinsurance and/or deductible are not included or counted in the threshold limits; but
5. Third-party liability claims sent to PrimeWest Health for payment after other coverage paid will go toward the threshold limits.
6. A unit can be per session or a timed unit. Each unit will decrement against the threshold.
7. All PrimeWest Senior Health Complete (HMO SNP)[±] and Prime Health Complete (HMO SNP)[¥] members will have the Medicare therapy cap (dollar limit) when they have Medicare coverage (including members residing in a nursing home). Once the dollar limit is reached on the therapy cap, if the provider evaluates

[±]This is PrimeWest Health's Minnesota Senior Health Options (MSHO) program for members who have both Medicaid and Medicare coverage through PrimeWest Health

[¥]This is PrimeWest Health's Special Needs BasicCare (SNBC) program for members who have both Medicaid and Medicare coverage through PrimeWest Health

the member and determines that there is continued need for skilled therapy, PrimeWest Health will continue to cover under the Medicare rates as long as the code is accompanied by the KX modifier, following the Medicare Improvements for Patients and Providers Act of 2008, which extended the exceptions process through December 31, 2009.

- a. The Temporary Extension Act of 2010, enacted on March 2, 2010, extends the therapy cap exceptions process through December 31, 2010, retroactive to January 1, 2010. Outpatient therapy service providers may now submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2010 through December 31, 2010. This therapy cap extension act has been extended into 2012 and will be reviewed by Congress in the next legislative session.
- b. The therapy caps are determined on a calendar year basis, so all members began a new cap January 1, 2010.
- c. The KX modifier is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record. Reimbursement for therapy will be at the Medicare rate effective January 1, 2011. If the member is in MSC+ and Medicare is his/her primary insurance, PrimeWest Health is not the payer for the Medicare portion. You will need to follow Medicare rules on therapy caps.

Non-covered Services

1. Physical or occupational therapy that is provided without a prescription from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law
2. Speech-language or audiology services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law
3. Services for contracture that are not severe and do not interfere with the member's functional status or the completion of nursing care as required for licensure of the LTC facility*
4. Ambulation of a member who has an established functional gait pattern*
5. Services for conditions of chronic pain that do not interfere with the member's functional status and that can be treated by routine nursing measures*
6. Services for activities of daily living when performed by the therapist, therapy assistant, or therapy aide*
7. Bowel and bladder retraining programs*
8. Art and craft activities for the purpose of recreation
9. Services not medically necessary
10. Services not documented in the member's health care record
11. Services not part of the member's plan of care
12. Services specified in a plan of care that is not reviewed and revised as medically necessary by the member's attending physician
13. Services that are not designed to improve or maintain the functional status of a member with a physical impairment or a cognitive or psychological deficit
14. Services by more than one provider of the same type for the same diagnosis unless the service is provided by the school district as specified in the member's IEP
15. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements
16. Vocational or educational services, including functional evaluations, except as provided under IEP-related services
17. Services provided by a therapy aide or therapy student
18. Psychosocial services
19. Record keeping documentation and travel time (the transport and waiting time of a member to and from therapy sessions)
20. Services provided by a rehabilitation agency that takes place in a sheltered workshop, Day Training and Habilitation center (DT&H), Day Activity Center (DAC), or a residential or group home that is an affiliate of the rehabilitation agency

21. Yearly assessments of LTC residents to meet Omnibus Budget Reconciliation Act (OBRA) regulations *
22. Training or consultation provided by an audiologist to an agency, facility, or other institution.
23. Work Hardening Programs

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

Authorization Criteria and Documentation

Documentation submitted with the authorization form should:

1. Be readable, photocopied material
2. Be arranged in chronological order
3. Match requested services
4. Include reasons why the skills of a physical therapist are required

Send only requested documentation, not the entire file.

Initial Evaluation

Documentation matching requested services and demonstrating the reasons the skills of an OT, PT, or SLP is required, including the following:

1. Treatment diagnosis and date of onset, including any contraindications to treatment
2. Origin and rationale for referral, including a copy of physician's order or referral. The date of the order/prescription must not be more than 30 days from the requested start of care.
3. Summary of previous therapy, including all evaluation or assessment reports or summary of initial findings signed by the therapist providing services
4. Current and prior functional status, including baseline evaluation and brief history indicating medical necessity
5. Documentation of when current function was lost
6. All tests performed and interpretation of results
7. Identified problems
8. Plan of care: Include all plans of care since services began.
9. Additional documentation may be requested for authorizations to establish medical necessity, including clarification of carry-over therapeutic interventions such as in-home programs, school programs (rehabilitative services provided as part of an IEP), employment, and other settings, such as the following:
 - a. School programs, including frequency and goals. With signed parental consent, outpatient rehabilitative service providers are encouraged to coordinate therapy services with school therapists.
 - b. Community and home programs
 - c. Treatment notes: 60 days if applicable

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

Authorization for Ongoing Services

1. Re-evaluation, including summary of progress
2. Plan of care, every 60 days. Send all plans of care since last authorization.
3. Treatment notes, with verification of units provided since last authorization
4. The first time an authorization is requested, even if the service is already ongoing (e.g., for service beyond the threshold), you must include the documentation under Initial Evaluation

Retro-Authorization

Provide all the information indicated under *Initial Authorization* and *Authorization for Ongoing Services*.

Authorization for Therapy groups

1. Description of the purpose of the group
2. Duration of each session
3. Specifics of medical necessity
4. Number of group sessions requested
5. All items under *Initial Evaluation* and *Plan of Care*

Authorization Termination

PrimeWest Health will terminate reimbursement when services are discontinued by the referral source or when the member has:

1. Met the goals of the plan of care
2. Developed behavioral or vocational problems that are not being addressed and that interfere with the ability to participate in therapy (particularly in pediatric cases);
3. Failed to comply with the requirements of participation;
4. Developed medical contraindications; or
5. Reached a plateau prior to meeting goals.

Billing

See [Billing Policy, chapter 4](#), for specific CMS-1500 and UB-04 requirements.

Independently Enrolled Providers

1. Independently enrolled PT, OT, SLP, or audiologists: Bill only for services you provide.
2. Use your individual NPI number to bill for services.
3. Independently enrolled SLPs: Advise dually eligible Medicare/Medicaid members to seek treatment from providers enrolled with both Medicare and MHCP.
4. Independently enrolled audiologists: bill for services provided in your own office, the member's home, LTC facility, or at Day Training and Habilitation Center(s).

Therapy Services Provided in Facility Settings

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

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

Rehabilitative Services Provided in an LTC Facility

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

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

PrimeWest Health will not make separate reimbursement for therapy services for residents of an LTC facility that includes therapy as part of its per diem rate.

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

Employees of the LTC Facility

The LTC facility bills services provided by PT, OT, or SLP employees.

1. Use either the CMS-1500 or UB-04.
2. Enter the LTC facility's NPI number.
3. If Medicare requires the LTC facility to bill for Medicare covered rehabilitative services for dually eligible members, follow Medicare requirements until Medicare benefits are exhausted.

Contracted Rehab Services

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

1. When rehab agencies bill for services:
 - a. Use the 837P or 837I format
 - b. Enter the rehab agency's NPI number
 - c. Enter the LTC facility's NPI number in FL 83
2. When LTC facilities bill for services:
 - a. Use the 837P or 837I format
 - b. Enter the LTC facility's NPI number
 - c. If Medicare requires the LTC facility to bill for Medicare-covered rehabilitative services for dually eligible members, follow Medicare's requirements until Medicare benefits are exhausted
 - d. Services provided by an independently enrolled SLP contracted with a LTC must be billed by the LTC
3. When independently enrolled PT/OT bills for services:
 - a. Use the 837P or 837I format
 - b. Enter the therapist's individual NPI number
 - c. If Medicare requires the LTC facility to bill for Medicare covered rehabilitative services for dually eligible members, follow Medicare's requirements until Medicare benefits are exhausted

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

Codes and Modifiers

1. PrimeWest Health uses outpatient rehabilitative services codes as defined in CPT/HCPCS as billable in timed units (15 minutes, 30 minutes, 1 hour). Bill outpatient rehabilitative services with appropriate units.
 - a. Bill CPT/HCPCS codes that do not have a timed component/unit as one unit per visit, regardless of the time spent.
 - b. Bill only one unit for any date of service that is a "per visit/session" code.
2. Use the correct HCPCS code and appropriate modifier from the *Casting & Splinting Supplies* chart to bill occupational therapy supplies fabricated by the therapist, such as splints, casts, and adaptive aids. Do not bill for ready-made supplies or for pre-fabricated supplies that can be obtained from a medical supplier.

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

Service Thresholds (effective July 1, 2010)			
Occupational Therapy, Physical Therapy, and Speech-language Pathology			
Code	Required Modifier	Description	Threshold based on Discipline
90901	GO, GP	Biofeedback training by any modality. * For billing electromyography biofeedback only. Not to be used to bill nerve impulse, blood pressure, blood flow, brain waves, or oculogram biofeedback. Description of service must be included on claim.	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold GP: PT threshold, effective 1/1/11, 80 timed and untimed units, any combination with other codes in the same threshold
90911		Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry *	
92506	GN	Evaluation of speech, language, voice, communication, and/or auditory processing*	GN: 1 SLP evaluation
92507	GN	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual*	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold
92508		group, 2 or more individuals *	
92606	GN	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification*	
92609	GN	Therapeutic services for the use of speech-generating device, including programming and modification*	GN: SLP threshold, 50 timed and untimed units, any combination of these codes
92700	GN	Unlisted otorhinolaryngological service or procedure*	GP: PT threshold, 80 timed and untimed units, any combination with other codes in this group of codes
92526	GN, GO	Treatment of swallowing dysfunction and/or oral function for feeding*	
92626	GN	Evaluation of auditory rehabilitation status; first hour	
92627		Each additional 15 minutes (List separately in addition to code for primary procedure)	
92630		Auditory rehabilitation; pre-lingual hearing loss	
92633		Post-lingual hearing loss	

97532	GN, GO, GP	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct patient contact by provider – 15 minutes	
97533		Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by provider – 15 minutes	
92597	GN	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech*	GN: 2 SLP evaluations, any combination of these codes
92605		Evaluation for prescription of non-speech generating augmentative and alternative communication devices*	
92607		Evaluation for prescription speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	
92608		Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	
92618	GN	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	GN: 2-evaluation threshold
92610	GN, GO	Evaluation of oral and pharyngeal swallowing function*	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold
92611		Motion fluoroscopic evaluation of swallowing function by cine or video recording*	
92612	GN	Flexible fiber optic endoscopic evaluation of swallowing by cine or video recording*	
92614		Flexible fiber optic endoscopic evaluation, laryngeal sensory testing by cine or video recording*	GN: 4 units, any combination of these codes
92616		Flexible fiber optic endoscopic evaluation of swallowing*	
95831	GP, GO	Muscle testing manual extremity*	GP: 2 units, any combination of these codes
95832		Hand*	
95833		Total evaluation of body, excluding hands*	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold
95834		Total evaluation of body, including hands*	
95851	GP, GO	Range of motion measure and report; each extremity (excluding hand) or each trunk section*	GP: 12 units, any combination of these codes
95852		Range of motion measurement – hand with or without comparison to normal side*	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold

96105	GN	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing [e.g., by Boston Diagnostic Aphasia Examination]) with interpretation and report, per hour	8 units, any combination of these codes
96110	GO, GN, GP	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report	
96125		Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report *	
96111		Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report	
97001	GP	Physical therapy evaluation, initial*	3 evaluations/re-evaluations, any combination of these codes
97002		Physical therapy re-evaluation, periodic*	
97003	GO	Occupational therapy, evaluation, initial*	2 evaluations/re-evaluations, any combination of these codes
97004		Occupational therapy, re-evaluation, initial*	

* Each evaluation and treatment code counts as 1 unit against the threshold, regardless of time spent with the patient.

Service Thresholds			
Occupational Therapy and Physical Therapy			
Code	Required Modifier	Description	Threshold based on Discipline
Unattended Modalities			
97010	GP, GO	Hot or cold packs*	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold GP: PT threshold, 20 untimed units, any combination with other modalities in same threshold
97012		Traction*	
97014		Electrical stimulation*	
97016		Vasopneumatic devices*	
97018		Paraffin bath*	
97020		Microwave*	
97022		Whirlpool*	
97024		Diathermy*	
97026		Infrared*	
97028	Ultraviolet*		

G0283		Electrical stimulation* to one or more areas for indication(s) other than wound care, as part of a therapy plan of care – do not bill with 97014	
Attended Modalities: Require Constant Attendance of Therapist			
95992	GO, GP	Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver), per day	GO: OT threshold, 120 timed and untimed units, any combination with other codes in OT threshold GP: PT threshold, 80 timed and untimed units, any combination with other codes in this group of codes
97032		Application of a modality to one or more areas; electrical stimulation – 15 minutes	
97033		Iontophoresis – 15 minutes	
97034		Contrast bath – 15 minutes	
97035		Ultrasound – 15 minutes	
97039		Unlisted modality*	
97036		Hubbard tank – 15 minutes	
Therapeutic Techniques with Direct Patient Contact			
97110	GO,GP	Therapeutic procedure, exercises – 15 minutes	
97112		Neuromuscular (use for Canalith repositioning) – 15 minutes	
97113		Aquatic therapy – 15 minutes	
97116		Gait training – 15 minutes	
97124		Massage – 15 minutes	
97140		Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions – 15 minutes	
97150		Therapeutic procedures group, 2 or more persons*	
97530		Therapeutic activities – 15 minutes	
97532		Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct patient contact by provider – 15 minutes	
97533		Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct patient contact by provider – 15 minutes	
97535		Self-care home management training (e.g., ADLs compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) – 15 minutes	
97537		Community work reintegration training (e.g., shopping, transportation, money management, vocational activities) – 15 minutes	
97542		Wheelchair management propulsion training – 15 minutes	

Wound Care		
97597	GO,GP	Removal of devitalized tissue from wound(s) selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s) for ongoing to 20 square centimeters
97598	GO, GP	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirl pool, per session; total wounds(s) surface area greater than 20 square centimeters
97602		Removal of devitalized tissues from wound(s), non-selective debridement, without anesthesia (e.g., Wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care*
97605		Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), including topical application(s), wound assessment, and instruction(s), wound assessment, and instruction(s) for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters
97606		Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters
Orthotic/Prosthetic: Assessment and Training		
97760	GO, GP	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk – 15 minutes
97761		Prosthetic training, upper and/or lower extremity(s) – 15 minutes
97799		Unlisted physical med/rehab service*
97762		Checkout for orthotic/prosthetic use, established patient – 15 minutes

- * Each evaluation and treatment code counts as 1 unit against the thresholds, regardless of time spent with the patient.

Service Thresholds Speech-Language Screening			
Code	Required Modifier	Description	Threshold
V5362	GN	Speech screening (articulation)*	GN: 1 unit each code
V5363		Language screening (receptive or expressive)*	
V5364		Dysphagia screening*	

- * Each evaluation and treatment code counts as 1 unit against the threshold, regardless of time spent with member.

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

Orthotic Procedures

GO, GP modifiers: \$32.00 per year without authorization, any combination of Orthotic Procedures and/or Casting & Splinting Supplies codes (Q-code chart)

Orthotic Procedures	
Procedure Code	Description
Orthotic Devices – Cervical-Thoracic-Lumbar-Sacral (CTLSO)	
L0621	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
L0623	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
L0625	Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment
L0628	LSO, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closure, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
Spinal Orthosis	
L0999	Addition to spinal orthosis, not otherwise specified; requires authorization always
Lower Limb Hip Orthotic (HO), Knee Orthotic (KO), Ankle-foot Orthotic (AFO)	
L1610	HO, abduction control of hip joints, flexible, prefabricated, includes fitting and adjustment
L1620	HO, abduction control of hip joints, flexible, prefabricated, includes fitting and adjustment
L1650	HO, abduction control of hip joints, static, adjustable, prefabricated, includes fitting and adjustment
L1652	HO, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type
L1660	HO, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment
L1686	HO, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustments
L1690	Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment
L1810	KO, elastic with joints, prefabricated, includes fitting and adjustment
L1820	KO, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment
L1830	KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment
L1831	KO, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment
L1832	KO, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes fitting and adjustment
L1836	KO, rigid, without joint(s), includes soft interface material, prefabricated, includes fitting and adjustment
L1843	KO, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric

	or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment
L1847	KO, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, includes fitting and adjustment
L1850	KO, Swedish type, prefabricated, includes fitting and adjustment
L1902	AFO, ankle gauntlet, prefabricated, includes fitting and adjustment
L1906	AFO, multipligamentous ankle support, prefabricated, includes fitting and adjustment
L1910	AFO, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment
L1930	AFO, plastic or other material, prefabricated, includes fitting and adjustment
L1932	AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment
L1951	AFO, spiral, plastic or other material, prefabricated, includes fitting and adjustment
L1971	AFO, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment
L2005	KAFO, any material, single or double upright, stance control, automatic Lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated
L2035	KAFO, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment
Upper Limb, Shoulder Orthotic (SO)	
L3650	SO, figure of 8 design, prefabricated, includes fitting and adjustment
L3651	SO, single shoulder, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, Lycra)
L3652	SO, double shoulder, elastic, prefabricated, includes fitting and adjustment
L3660	SO, figure of 8 design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment
L3670	SO, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and

	adjustment
L3671	SO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3672	SO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3673	SO abduction positioning(airplane design), thoracic component and support bar, includes non-torsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3675	SO, vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment
L3677	SO, hard plastic, should stabilizer, includes fitting and adjustment
Elbow Orthotic (EO)	
L3700	EO, elastic with stays, prefabricated, includes fitting and adjustment
L3701	EO, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, Lycra)
L3702	EO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3710	EO, elastic with metal joints, prefab, includes fitting and adjustment
L3720	EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated
L3740	EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated
L3760	EO, with adjustable position locking joint(s), prefabricated, includes fitting and adjustments any type
L3762	EO, rigid, without joints includes soft interface material, prefabricated, includes fitting and adjustment
L3763	Elbow-wrist-hand orthotic (EWHO), rigid, without joints may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764	EWHO. Includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765	Elbow-wrist-hand-finger orthotic (EWHFO), rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3766	EWHFO, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
Wrist-Hand Finger Orthotic (WHFO)	
L3806	WHRO, includes one of more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L3807	WHFO, without joint(s), prefabricated, includes fitting and adjustments, any type
L3808	WHFO, rigid without joints, may include soft interface material; straps, custom fabricated includes fitting and adjustment
Dynamic Flexor Hinge, Reciprocal Wrist Extension/Flexion, Finger Flexion/Extension (WHFO)	
L3900	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion;/extension, wrist or finger driven, custom fabricated
L3901	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension,

	cable driven, custom fabricated
External Power	
L3904	WHFO, external powered, electric, custom fabricated
L3905	Wrist-hand orthotic (WHO), includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
Other – Custom Fitted	
L3906	WHO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3908	WHO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment
L3909	Wrist orthotic (WO), elastic, prefabricated, includes fitting and adjustment
L3911	WHFO, elastic, prefabricated, includes fitting and adjustment (e.g. neoprene, Lycra)
L3912	Hand-finger orthotic (HFO), flexion glove with elastic finger control, prefabricated, includes fitting and adjustment
L3913	HFO, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3915	WHO, includes one or more non-torsion joints(s), elastic bands, turnbuckles, may include soft interface, straps prefabricated, includes fitting and adjustment
L3917	Hand orthotic (HO), metacarpal fracture orthotic, prefabricated, includes fitting and adjustment
L3919	HS, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3921	HFO, includes one or more non-torsion joints, elastic bands turnbuckles, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3925	Finger orthotic (FO), proximal interphalangeal (PIP)/distal interphalangeal (DIP), non-torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment
L3927	FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, includes fitting and adjustment
L3929	HFO, includes one or more non-torsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment
L3931	WHFO, includes one or more non-torsion joint(s), turnbuckles, elastic band/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment
L3933	FO, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3935	FO, non-torsion joint, may include soft interface, custom fabricated, includes fitting and adjustment
L3956	Addition of joint to upper extremity orthosis, any material; per joint
Shoulder-Elbow-Wrist-Hand Orthosis (SEWHO)	

L3960	SEWHO, abduction positioning, airplane design, prefabricated, includes, fitting and adjustment
L3961	SEWHO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3962	SEWHO, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment
L3964	Should-elbow orthotic (SEO), mobile arm support attached to wheelchair, balance, adjustable, prefabricated, includes fitting and adjustment
L3965	SEO, mobile arm support attached to wheelchair, balance, reclining, prefabricated, includes fitting and adjustment
L3966	SEO, mobile arm support attached to wheel chair, balanced, reclining, prefabricated, includes fitting and adjustment
L3967	SEWHO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3968	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment
L3969	SEO, mobile arm support monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support, prefabricated, includes fitting and adjustment
Additions to Mobile Arm Supports	
L3970	Shoulder-elbow orthotic (SEO), addition to mobile arm support, elevating proximal arm
L3971	SEWHO, shoulder cap design, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated includes fitting and adjustment
L3972	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
L3973	SWEHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3974	SEO, addition to mobile arm support, supinator
L3975	SEWHO, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3976	SEWHO, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977	SEWHO, shoulder cap design, include one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978	SEWHO, abduction positioning (airplane design), thoracic component and support bar, includes one or more non-torsion joints, elastic bands, turnbuckles, may include soft interface straps, custom fabricated, includes fitting and adjustment
Fracture Orthoses	

L3980	Upper extremity fracture orthotic, humeral, prefabricated, includes fitting and adjustment
L3982	Upper extremity fracture orthotic, radius/ulnar, prefabricated, includes fitting and adjustment
L3984	Upper extremity fracture orthotic, wrist, prefabricated, includes fitting and adjustment
L3995	Addition to upper extremity orthotic, sock, fracture or equal, each
L3999	Upper limb orthosis, not otherwise specified
Specific Repair/Repairs	
L4002	Replacement strap, any orthotic, includes all components, any length, any type
L4205	Repair of orthotic device, labor component, per 15 minutes
L4210	Repair of orthotic device, repair or replace minor parts
L4350	Ankle control orthosis stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment
L4360	Walking boot, pneumatic, and/or vacuum, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4370	Pneumatic full leg splint, prefabricated, includes fitting and adjustment
L4380	Pneumatic knee splint, prefabricated includes fitting and adjustment
L4386	Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4392	Replacement soft interface material, static AFO
L4394	Replace soft interface material, foot drop splint
L4396	Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment
L4398	Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment
Additions: Upper Limb	
L6624	Upper extremity addition, flexion/extension and rotation wrist unit

Audiology Service Thresholds		
Code	Description	Threshold
92506	Evaluation of speech, language, voice, communication, and/or auditory processing	2 evaluations per calendar year
92531 – 92547	Audiologic Function Tests	No limit; bill 1 treatment session per test
92551 – 92557		
92560 – 92588		
92601		
92602	Subsequent reprogramming	
92603	Diagnostic analysis of cochlear implant, age 7 years or	

	older; with programming	
92604	Subsequent reprogramming	
92620	Evaluation of central auditory function, with report; initial 60 minutes	
92621	Each additional 15 minutes	
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	
92590	Monaural hearing aid exam and selection	1 treatment session per calendar year, any combination of codes
92591	Binaural hearing aid exam and selection	
92594	Electroacoustic evaluation for monaural hearing aid	
92595	Electroacoustic evaluation for binaural hearing aid	
92596	Ear protector attenuation measurement	
92592	Monaural hearing aid check – service includes cleaning; do not bill cleaning separately. Do not bill with V5011.	4 checks per calendar year; 1 unit maximum per check
92593	Binaural hearing aid check – service includes cleaning; do not bill cleaning separately. Do not bill with V5011.	
92510	Aural rehabilitation following cochlear implant	Counts toward SLP 80 treatment session service threshold

* Each modality equals one treatment session.

Hearing Aids

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

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

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

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

6. Parts and accessories
7. Re-casing, remakes, shell modifications
8. Replacing battery doors and microphone protectors

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

Enrolled Hearing Aid Dispensers

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

Covered Services

Hearing Aid Volume Purchase Contract

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

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

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

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

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

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

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

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

Hearing aid service providers must provide hearing aids under the terms of the volume purchase contract. If the audiologist prescribes a non-contract hearing aid, the hearing aid service provider must obtain authorization by providing either:

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

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

Dispensing Fee

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

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

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

Hearing Aid Replacement

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

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

PrimeWest Health will not replace a lost or broken hearing aid for an adult 21 years of age or over when PrimeWest Health has replaced a hearing aid twice within the five-year period previous to the date of request. In such cases when PrimeWest Health does not provide a hearing aid, the hearing aid service provider may provide

the eligible member with a contract hearing aid at the contract price. The hearing aid and dispensing fee shall be paid by the member.

Batteries

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

Ear Impressions

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

Ear Molds

Replacement ear molds for BTE hearing aids are covered.

Hearing Aid Checks (Programming/Reprogramming)

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

Hearing Aid Repairs

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

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

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

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

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

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

Parts & Accessories

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

Telecoils

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

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

Re-casing, Remakes, Shell Modifications

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

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

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

Replacing Battery Doors and Microphone Protectors

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

Systems Other Than Personal Hearing Aids

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

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

Non-covered Services

1. Replacement batteries provided on a scheduled basis regardless of actual need.
2. Services specified as part of the contract price when billed separately for payment, including charges for repair of hearing aids under warranty.
3. Routine screening of individuals or groups for identification of hearing problems.
4. Separate reimbursement for postage, handling, taxes, mileage, or pickup and delivery.
5. Disposable hearing aids, non-electronic hearing aids, telephone amplifiers, vibrating bed alarms, phone handsets, visual telephone ringers, swim molds, ear plugs, dry aid kits, moisture guards, wax filters, retention cords, and safety clips such as Otoclips and Critter Clips, battery chargers, etc.
6. Ear care and comfort creams, cleansers or cleaning solutions, wax removal kits/systems, and hearing aid pads.

7. Regularly scheduled maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian, or attending physician.
8. Loaner hearing aid charges.
9. Canal type hearing aids.
10. Non-contract hearing aids obtained without authorization.
11. Services included with the dispensing fee when billed separately.
12. Hearing aid services to a resident of an 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.
13. 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.

1. Physician's medical clearance stating no contraindication for hearing aid use. This may include general support for amplification, if needed, to determine medical necessity. Hearing services for a resident of an LTC facility must result from a request by the member or a referral by facility nursing staff or the member's family, guardian, or attending physician, and be part of the member's plan of care or ordered in writing by the attending physician.
2. Audiologic recommendations including:
 - a. Written recommendation for hearing aid(s) including manufacturer specifications; and
 - b. Follow-up plan for determining effectiveness of hearing aid use.
3. Documentation supporting audiologic recommendations:
 - a. Audiogram – air and bone thresholds, speech thresholds, word recognition scores for each ear or reason why this data was not obtained and report of substitute data (e.g., sound field, informal tests) – internal consistency of data needed;
 - b. History of previous appliance use and status of current aid(s), if applicable;
 - c. When evidence of middle ear dysfunction exists (e.g., abnormal tympanometry or audiometric conductive loss), audiologist must give rationale for recommending hearing aid use prior to documentation of normal middle ear function (e.g., previous diagnosis of inoperable otosclerosis); and
 - d. Audiologist's documentation of need for amplification, this may include interpretation of audiometric data relative to member's communication needs, formal hearing aid evaluation, real ear measurements, sound field, etc.
4. 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 (837P) Professional or the CMS-1500 claim form. For further billing instructions, please refer to [Billing Policy, chapter 4](#).

1. Claims for hearing aid purchases must include:
 - a. The prescribing audiologist's NPI
 - b. Correct model number
 - c. Correct modifiers – NU, LT, RT

- d. ICD-9 diagnosis code(s)
- e. Monaural aid = 1 unit
- f. Binaural aids = 1 unit, effective July 15, 2009. (When billing binaural hearing aids with dates of service prior to 7-15-09, bill binaural hearing aid as 2 units.)

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

Binaural Hearing Aids	
Billing Examples	Billing Instructions
Member's binaural hearing aid consists of matching hearing aid models	Bill the binaural set using the appropriate binaural code, 1 unit , and other required modifiers (NU) and billing information
Member's binaural hearing aid consists of two different hearing aid models dispensed on the same day	Bill each hearing aid model with appropriate monaural procedure code, 1 unit , and other required modifiers (LT, RT, NU) and billing information
Member's binaural hearing aid consists of two different hearing aids dispensed on different dates of services. Authorization is required for the second aid (and dispensing fee) if the dates of service are more than 6 months apart.	Bill each aid with appropriate monaural code, 1 unit , and required modifiers (LT, RT, NU). Second claim will deny due to exhaustion of member's benefits. Contact the Provider Contact Center for assistance if date of service is fewer than six months from the provision of the first hearing aid. Authorization is required for the second aid (and dispensing fee) if the dates of service are more than 6 months apart.

2. Dispensing fee claims:
 - a. Bill the usual and customary charge.
 - b. Claims may not be submitted before the hearing aid(s) is dispensed.
 - c. Use the appropriate HCPCS code.
 - d. Bill dispensing fee procedure code for the type of hearing aid dispensed: monaural or binaural. Always bill the binaural dispensing fee when binaural hearing aid(s) are dispensed, whether the binaural unit consists of matching hearing aids or not.
 - i. Monaural = 1 unit
 - ii. Binaural = 1 unit
 - e. Dispensing fees require authorization whenever the hearing aid requires authorization.
 - f. The dispensing fee is a professional service. Do NOT bill the dispensing fee with modifier NU.
3. Replacement claim for unsatisfactory hearing Aid(s)
 - a. If the provider has billed for an unsatisfactory hearing aid, the provider must submit a replacement claim for both the replacement hearing aid and all but one-half of the dispensing fee. Both the replacement hearing aid and dispensing fee require authorization.
 - b. If the provider has not billed for the unsatisfactory aid and dispensing fee and it is the first hearing aid claim in five years, the new aid may be provided immediately without requesting authorization.
4. Claims for hearing aid repairs must include the:
 - a. Correct model number.
 - b. Correct modifiers – RA, RB, LT, RT, and 22
 - c. Claims with DOS 12-31-08 and earlier, use modifier RP

- d. Claims with DOS 1-1-09 and later, use modifier RB
 - e. Hearing aid purchase warranty expiration date entered in the comment section of the claim form using **mm/dd/yy** format.
 - f. Hearing aid volume purchase contract number in the comment section of the claim form for all contract hearing aids.
 - g. Repair invoice for repairs of non-contract hearing aids.
5. Use **Code V5014** for billing:
- a. Battery door replacement
 - b. Re-casing and/or re-plating (hearing aid is sent to manufacturer). However, if re-casing/re-plating is done in conjunction with other repairs, use the appropriate hearing aid code, model number, and appropriate modifiers, and submit the repair invoice with the claim.
 - c. Shell modification (service performed by dispenser/audiologist in office – minor repairs to shell).

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

Use the appropriate HCPCS codes to bill these services.

Hearing aid batteries: Bill hearing aid batteries in quantities of one unit per battery.

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.

Hearing Aid Services Codes

Hearing Aid Services Codes		
Code	Description	Service Thresholds
L8690	Auditory osseointegrated device, includes all internal and external components – use for Baha [®] system	Always require authorization Repairs over \$400.00 require authorization
L8691	Auditory osseointegrated device, external sound processor, replacement – use for Baha [®]	
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment – use for Baha [®]	
V5070	Hearing aid in glasses, air conductive	
V5080	Hearing aid in glasses, bone conductive	
V5150	Hearing aid in glasses, binaural	
V5190	CROS, in glasses	
V5230	BiCROS, in glasses	
V5274	Assistive listening device, not otherwise specified (for use for FM systems and vibrotactile devices)	
V5090	Dispensing fee, unspecified hearing aid - use when dispensing FM system and vibrotactile device	
V5100	Pocket Talker	
V5110	Pocket Talker dispensing fee	
V5273	Assistive listening device, for use with cochlear implant	
V5030	Monaural, body worn, air conductive	1 monaural or binaural

V5040	Monaural, body worn, bone conductive	hearing aid per 5 calendar years
V5050	Monaural, ITE	
V5060	Monaural, BTE	
V5120	Binaural, on-the-body	
V5130	Binaural, ITE	
V5140	Binaural, BTE	
V5170	CROS, ITE	
V5180	CROS, BTE	
V5210	BiCROS, ITE	
V5220	BiCROS, BTE	
V5246	Monaural ITE, digitally programmable analog	
V5247	Monaural BTE, digitally programmable analog	
V5252	Binaural ITE, digitally programmable	
V5253	Binaural BTE, digitally programmable	
V5256	Monaural ITE, digital	
V5257	Monaural BTE, digital	
V5260	Binaural ITE, digital	
V5261	Binaural BTE, digital	
V5160	Dispensing fee, binaural	1 dispensing fee per 5 calendar years
V5200	Dispensing fee, CROS	
V5240	Dispensing fee, BiCROS	
V5241	Dispensing fee, monaural hearing aid, any type	
V5266	Battery for use in hearing device	Limit, 90 day supply
V5267	Hearing aid supplies and accessories (e.g., chest harness, telecoils)	If recommended hearing aid requires authorization, parts and accessories also require authorization.
V5264	Ear mold/insert, not disposable, any type	
V5275	Ear impressions, each	
V5299	Miscellaneous hearing aid servicing (e.g., removal of ear wax, cleaning)	
V5011	Hearing aid checks	To be used to bill reprogramming; may not be billed during trial period.
V5014	Repair/modification of a hearing aid	To be used only for billing battery doors, recase/remake and shell modification

[Hearing Aid Contract Vendors, Models, Prices, and Codes](#)

Legal References

[MS 256B.0625](#), subd. 8; subd. 8a; subd. 8c; subd. 31a

[MS 256D.03](#), subd. 4

MN Rules [4658.0525](#)

MN Rules [9505.0175](#)

MN Rules [9505.0210](#)

MN Rules [9505.0220](#)

MN Rules [9505.0385](#)

MN Rules [9505.0386](#)

MN Rules [9505.0390](#)

MN Rules [9505.0391](#)

MN Rules [9505.0392](#)

MN Rules [9505.0410](#)

MN Rules [9505.0411](#)

MN Rules [9505.0287](#) (Hearing Aid Services)

[MS 256B.0625](#), subd. 311 (Augmentative Communication Devices)

[42 CFR 440.110](#)

[42 CFR 483.45](#)

[42 CFR sub. H, 485.701 – 485.729](#)

[42 CFR sub. D, 486.150 – 486.163](#)