THE MARYLAND
MEDICAL
ASSISTANCE PROGRAM

EPSDT Acupuncture Services
EPSDT Chiropractic Services
EPSDT Speech Language Pathology Services
EPSDT Occupational Therapy Services

Physical Therapy Services

PROVIDER MANUAL
For Medicaid Provider Types AC, 13, 16, 17, 18 and 28

This manual is a guide in understanding Maryland Medicaid's coverage of the above services and is to be used as a guide only. As a provider, it is your responsibility to adhere to established Program policies and regulations for these services.

Provider Types
AC= MD MA enrolled acupuncture
13 = MD MA enrolled chiropractor
16 = MD MA enrolled physical therapist
17 = MD MA enrolled speech language pathologist
18 = MD MA enrolled occupational therapist
28 = MD MA enrolled therapy group

Effective December 1, 2013

MARYLAND MEDICAL ASSISTANCE PROGRAM
PROVIDER MANUAL FOR
EPSDT ACUPUNTURE, CHIROPRACTIC, SPEECH LANGUAGE PATHOLOGY AND OCCUPATIONAL THERAPY PHYSICAL THERAPY SERVICES
For Medicaid Provider Types AC, 13, 16, 17, 18 and 28

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EPSDT Acupuncture Services (COMAR 10.09.23)
Physical Therapy Services (COMAR 10.09.17)
EPSDT Chiropractic Services (COMAR 10.09.23)
EPSDT Occupational Therapy Services (COMAR 10.09.23)
EPSDT Speech Language Pathology Services (COMAR 10.09.23)
(For Medicaid Provider Types AC, 13, 16, 17, 18 and 28)

EPSDT Overview

Effective November 1, 1999, Occupational Therapy, Speech Language Pathology and Physical Therapy services were "carved-out" from the HealthChoice Managed Care Organization (MCO) benefits package for recipients *who are 20 years of age and younger*. (This does not include home health and inpatient services.) The services for this Medicaid population are now considered "fee-for-service" and are billed directly to the Medicaid Program. [Note: All codes billed by pediatricians, internists, family practitioners, general practitioners, nurse practitioners, neurologists, and/or other physicians to determine whether a child has a need for Occupational Therapy, Physical Therapy or Speech Therapy services remain the responsibility of the MCO and may not be billed fee-for-service.] The MCOs continue to be responsible for the following services rendered to recipients who are 21 years of age and older: EPSDT: Acupuncture, chiropractic care, inpatient and home health services. Please contact the MCO for these services.

The Acupuncture, Chiropractic, Occupational and Speech Therapy services addressed in this manual are limited to Maryland Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) population (recipients who are 20 years of age and younger). **An exception to this age limitation is physical therapy services. All EPSDT acupuncture and chiropractic services and physical therapy services for recipients who are 21 years of age or older, inpatient and home health services remain under the MCO benefit package. Contact the MCO for their preauthorization and billing policy/procedure.**

Following is a chart outlining the payer for these services when the recipient is enrolled in an MCO:

Service	Bill the MCO	Bill Fee for Service (FFS) Medicaid
Occupational Therapy	21 + older	0-20
Physical Therapy	21 + older	0-20
Speech Language	21 + older	0-20
Acupuncture	0-20	------
Chiropractic	0-20	------
Home Health Therapy	0-99	------
Inpatient Therapy	0-99	------
DME/DMS	0-99	------

Therapy services provided by a hospital, home health agency, inpatient facility, nursing home, RTC, local lead agency, school or in accordance with an IEP/IFSP, model waiver, etc., are not specifically addressed in this manual.

Covered Services

EPSDT ACUPUNCTURE, OCCUPATIONAL THERAPY, SPEECH LANGUAGE PATHOLOGY AND CHIROPRACTIC SERVICES

Services are covered for recipients who are 20 years of age and younger when the services are:

- Necessary to correct or ameliorate defects and physical illnesses and conditions discovered in the course of an EPSDT screen;
- Provided upon the referral order of a screening provider;
- Rendered in accordance with accepted professional standards and when the condition of a participant requires the judgment, knowledge, and skills of a licensed acupuncturist, occupational therapist, licensed speech pathologist or licensed chiropractor;
- Delivered in accordance with the plan of treatment developed at the time of initial Referral;
- Limited to one initial evaluation per condition; and
- Delivered by a licensed acupuncturist, licensed chiropractor, licensed occupational therapist, or a licensed speech pathologist.

PLEASE NOTE: Acupuncture and chiropractic services are covered through the MCO; contact the MCO for preauthorization information if serving an MCO enrollee.

In order to participate as an EPSDT-referred services provider, the provider shall:

- Gain approval by the screening provider every six (6) months or as authorized by the Department for continued treatment of a participant. Approval must be documented by the screening provider and the therapist or chiropractor in the recipient's medical record.
- Have experience with rendering services to individuals from birth through 20 years of age.
- Submit a quarterly progress report to the recipient's primary care provider.
- Maintain medical documentation for each visit.

PLEASE NOTE: Services provided in a facility or by a group where reimbursement is covered by another segment of the Medicaid Program **are not covered**.

PHYSICAL THERAPY (Bill FSS for recipients under 21 years of age. Contact the MCO for preauthorization for recipients 21 years of age and older.)

Medically necessary physical therapy services ordered in writing by a physician, dentist, or podiatrist are covered when:

- Provided by a licensed physical therapist or by a physical therapist assistant under direct supervision by the licensed physical therapist;
- Provided in the provider's office, the recipient's home, or a domiciliary level facility;
- Diagnostic, rehabilitative, therapeutic and directly related to the written treatment order;
- Of sufficient complexity and sophistication, or the condition of the patient is such, that the services of a physical therapist are required;
- Rendered pursuant to a written treatment order that is signed and dated by the prescriber and which the order specifies: 1) part or parts to be treated; 2) type of modalities or treatments to be rendered; 3) expected results of physical therapy treatments; 4) frequency and duration of treatment;
- Treatment order is kept on file by the therapist as part of the recipient's permanent record;
- Not altered in type, amount, frequency, or duration by the therapist unless medically indicated. The physical therapist shall make necessary changes and sign the treatment order, advising the prescriber of the change and noting it in the patient's record;
- Limited to one initial evaluation per condition; and
- If pursuant to a written treatment order for treatment exceeding 30 days, reviewed monthly, thereafter, by the prescriber in communication with the therapist and the order is either rewritten or a copy of the original order is initialed and dated by the prescriber. A quarterly progress report should be submitted to the recipient's primary care physician.

Services are to be recorded in the patient's permanent record which shall include:

- The treatment order of the prescriber;
- The initial evaluation by the therapist and significant past history;
- All pertinent diagnoses and prognoses;
- Contraindications, if any; and
- Progress notes, at least once every two weeks.

The following physical therapy services are not covered:

- Services provided in a facility or by a group where reimbursement for physical therapy is covered by another segment of the Medicaid Program;
- Services performed by licensed physical therapy assistants when not under the direct supervision of a licensed physical therapist;
- Services performed by physical therapy aides; and/or
- More than one initial evaluation per condition.

Preauthorization

Contact the MCO for information regarding their billing and preauthorization procedures for acupuncture, chiropractic, and therapy services for recipients who are 21 or older, home health and inpatient services.

Preauthorization is not required under the fee-for-service system; however, it is expected that a quarterly care plan be shared with the primary care provider.

Provider Enrollment

PLEASE NOTE: UNDER THE MARYLAND MEDICAID PROGRAM, ACUPUNCTURISTS, THERAPISTS AND CHIROPRACTORS WHO ARE PART OF A PHYSICIAN'S GROUP ARE NOT CONSIDERED PHYSICIAN EXTENDERS. SERVICES RENDERED BY THESE PROVIDERS CANNOT BE BILLED UNDER THE SUPERVISING PHYSICIAN'S RENDERING NUMBER. THESE PROVIDERS MUST COMPLETE AN ENROLLMENT APPLICATION AND BE ASSIGNED A MARYLAND MEDICAID PROVIDER NUMBER THAT HAS BEEN SPECIFICALLY ASSIGNED TO THEM UNDER THEIR NAME. THE NUMBER WILL BE USED WHEN BILLING DIRECTLY TO MEDICAID.

Therapists, acupuncturists, and chiropractors ***must be*** licensed to practice their specialties in the jurisdictions where they practice. (Chiropractors must be licensed and enrolled as a physical therapist in order to bill for physical therapy services.)

Once a Maryland Medical Assistance Program provider application has been approved, the Program will enroll the provider and issue a 9 digit provider identification number. This number will permit the provider to bill the Program's computerized payment processing system for services that are covered under the fee-for-service system. Applicants enrolling as a renderer in a group practice must be associated with a Maryland Medicaid existing or new group practice of the same provider type [i.e. a PT can enroll as a renderer in a PT group practice but not in a physician group practice].

PLEASE NOTE: At this time, renderers in a therapy group provider type practice [type 28] are not required to be assigned an individual rendering Maryland Medicaid provider number. A listing of therapists and license numbers of participating members of the practice must be attached

to the therapy group [type 28] application for in-state applicants. Out-of-state applicants must submit a copy of all licenses and/or certificates of the therapists participating in the practice.

Changes to the practice must be brought to the attention of the Program.

Provider Type	Type of Practice	Specialty Codes
AC-Acupuncture	35(group) or 30 (individual or renderer in a group practice)	
18- Occupational Therapist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT –Occupational Therapy (173)
17- Speech Language Pathologist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Speech /Language Pathology (209)
13- Chiropractor	35(group) or 30(individual or renderer in a group practice)	EPSDT – Chiropractor (106)
16- Physical Therapist	35(group) or 30 (individual or renderer in a group practice)	Physical Therapy (189)
28- Therapy Group	99(other)	Must be comprised of at least two different specialties: OT (173), PT (189), SP (209)

PATIENT ELIGIBILITY (Recipient must be Medicaid eligible on the date of service. Utilize the Program's EVS system to verify eligibility.)

21years of age and older

The majority of Maryland Medicaid recipients are enrolled in an MCO. It is customary for the MCO to refer their enrollees to therapists in their own provider network for this age group. If a recipient is 21 or older and is enrolled in an MCO, preauthorization may be required by the MCO before treating the patient. Contact the recipient's MCO for their authorization/treatment procedures.

Under Medicaid's fee-for-service system, coverage for therapy services for the 21 and over age population is limited to physical therapy services unless coverable under a different Maryland Medicaid Program that is not specifically addressed in this manual (i.e. hospital services, home health services, etc.)

Under 21 years of age –EPSDT Population

Speech language pathology, occupational therapy and physical therapy services provided to recipients who are 20 years of age or younger are part of Maryland Medicaid's fee-for-service system when not provided as a home health or inpatient service. Home health and inpatient care are coverable by the MCO. Therapy providers who are enrolled as a Maryland Medicaid provider may render the prescribed therapy services and bill the Program directly on the CMS-1500 form under his/her Maryland Medicaid assigned provider identification number.

Acupuncture and chiropractic services continue as a covered benefit under the MCO system; these services must be billed to the MCO for MCO enrollees. Contact the MCO for preauthorization and/or treatment procedures for acupuncture and chiropractic services.

BILLING GUIDELINES

The following billing instructions are to be used for fee-for-service therapy services provided by the provider types addressed in this manual. Acupuncture, occupational therapy, speech therapy and chiropractic services are limited to children under the age of 21 in Medicaid's EPSDT Program. Physical therapy services are covered for all age groups; however, MCO enrollees who are 21 or older are covered through the MCO and are not considered fee-for-service. In addition, EPSDT acupuncture and chiropractic services are covered through the MCO for MCO enrollees.

The providers addressed in these guidelines cannot bill the Program using a ***physician's*** provider number. They are ***not*** considered physician extenders. They must enroll with the Program and be assigned a provider number. All fee-for-service claims are to be billed under the assigned Medicaid provider number for therapy services.

Fee for Service (FFS) Billing

Providers shall bill the Maryland Medicaid Program for reimbursement on the CMS-1500 and attach any requested documentation. Maryland Medicaid specific procedure codes are required for billing purposes. Please refer to the procedure code and fee schedule that is included in this manual.

The Program reserves the right to return to the provider, before payment, all invoices not properly signed, completed and accompanied by properly completed forms required by the Department.

The provider shall charge the Program their usual and customary charge to the general public for similar services. The Program will pay for covered services, based upon the lower of the following:

- The provider's customary charge to the general public, or
- The Department's fee schedule.

The Provider may <u>not</u> bill the Program for:

- Services rendered by mail or telephone,
- Completion of forms and reports,
- Broken or missed appointments, or
- Services which are provided at no charge to the general public.

To ensure payment by the Maryland Medicaid Program, check Maryland Medicaid's Eligibility Verification System (EVS) for ***every Medicaid patient*** on the date of service to ensure payment by Maryland Medicaid.

Under Medicaid's fee-for-service system, services are reimbursed on a per visit basis under the procedure code that is listed on Maryland Medicaid's established procedure code and fee schedule. The schedule will indicate the maximum units allowed for the service and the fee amount for each unit of service. The maximum units are the total number of units that can be billed on the same day of service. Maryland Medicaid will reject claims that exceed the maximum units of service.

PLEASE NOTE: Providers assigned a rendering provider number must bill the Medicaid Program with a group provider number. At this time, only therapy group (provider type 28) providers can bill without including a rendering provider number on the claim.

MCO Billing

Claims for recipients who are 21 years of age or older and enrolled in an MCO, must be submitted to the MCO for payment. Contact the MCO for information regarding their billing and preauthorization procedures.

Acupuncture and chiropractic services are a covered benefit through the MCO system for recipients who are 20 years old and younger. Contact the MCO for information regarding their billing and preauthorization procedures.

Regulations

Visit the following website to review the regulations that pertain to this manual:

www.dsd.state.md.us/comar

Select option #3; choose select by title number; select title number 10-Department of Health and Mental Hygiene. Select Subtitle 09-Medical Care Programs; Select regulations 10.09.23 - EPSDT: Referred Services.

To review the regulation for acupuncture, chiropractic, occupational therapy, or speech language pathology services, select 10.09.23, Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Services.

To review the regulation for physical therapy services, select 10.09.17, Physical Therapy Services.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that standard electronic health transactions be used by health plans, including private, commercial, Medical Assistance (Medicaid) and Medicare, healthcare clearinghouses, and health care providers.

More information on HIPAA may be obtained from:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/index.

NPI

Effective July 30, 2007, all health care providers that perform medical services must have a National Provider Identifier (NPI). The NPI is a unique, 10-digit, numeric identifier that does not expire or change. NPI's are assigned to improve the efficiency and effectiveness of the electronic transmission of health information. Implementation of the NPI impacts all practice, office, or institutional functions, including billing, reporting, and payment.

The NPI is administered by the Centers of Medicare and Medicaid Services (CMS) and is required by HIPAA. Providers must use the legacy MA number as well as the NPI number when billing on paper.

Apply for an NPI by using the web-based application process via the National Plan and Provider Enumeration System (NPPES) at www.nppes.cms.hhs.gov/NPPESWelcome.com

Use the NPI as the primary identifier and the MA provider legacy number as the secondary identifier on all paper and electronic claims

Medicare

The Program will authorize payment on Medicare claims if:

- The provider accepts Medicare assignments;
- Medicare makes direct payment to the provider;
- Medicare has determined that services were medically justified;
- The services are covered by the Program; and
- Initial billing is made directly to Medicare according to Medicare guidelines.

Recovery and Reimbursement

If the recipient has insurance or other coverage, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the recipient for the services in these guidelines, the provider should seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by the Medicaid Program, the provider should submit a claim to the Program. A copy of the insurance carrier's notice or remittance advice should be kept on file and available upon request by the Program. In this instance, the CMS 1500 must reflect the letter K (services not covered) in box 11 of the claim form. Contact Medicaid's Provider Relations Office if you have questions about completing the claim form.

Medical Assistance Payments

You must accept payment from Medical Assistance as ***payment in full*** for a covered service.

You ***cannot*** bill a Medical Assistance recipient under the following circumstances:

- For a covered service for which you have billed Medical Assistance;
- When you bill Medical Assistance for a covered service and Medical Assistance denies your claims because of billing errors you made, such as: wrong procedure codes, lack of preauthorization, invalid consent forms, unattached necessary documentation, incorrectly completed forms, filing after the time limitations, or other provider errors;
- When Medical Assistance denies your claim because Medicare or another third party has paid up to or exceeded what Medical Assistance would have paid;
- For the difference in your charges and the amount Medical Assistance has paid;
- For transferring the recipient's medical records to another health care provider; and/or
- When services were determined to not be medically necessary.

You ***can*** bill the recipient under the following circumstances:

- If the service provided is not covered by Medical Assistance and you have notified the recipient prior to providing the service that the service is not covered; or
- If the recipient is not eligible for Medical Assistance on the date you provided the service.

Fraud and Abuse

It is illegal to submit reimbursement requests for:

- Amounts greater than your usual and customary charge for the service. If you have more than one charge for a service, the amount billed to the Maryland Medical Assistance Program should be the lowest amount billed to any person, insurer, health alliance or other payer;
- Services which are either not provided or not provided in the manner described on the request for reimbursement. In other words, you must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service;
- Any procedures other than the ones you actually provide;
- Multiple, individually described or coded procedures if there is a comprehensive procedure which could be used to describe the group of services provided;
- Unnecessary, inappropriate, non-covered or harmful services, whether or not you actually provided the service; or
- Services for which you have received full payment by another insurer or party.

You are required to refund all overpayments received from the Medical Assistance Program within 30 days. Providers must not rely on Department requests for any repayment of such overpayments. Retention of any overpayments is also illegal.

The Medical Assistance Program will give reasonable written notice of its intention to impose any of the previously noted sanctions against a provider. The notice will state the effective date and the reasons for the action and will advise the provider of any right to appeal.

If the U.S. Department of Health and Human Services suspends or removes a provider from Medicare enrollment, the Medical Assistance Program will take similar action against the provider.

A provider who is suspended or removed from the Medical Assistance Program or who voluntarily withdraws from the Program must inform recipients ***before*** rendering services that he/she is no longer a Medical Assistance provider and the recipient is therefore financially responsible for the services.

Sanctions against Providers – Specific

In addition to penalties arising from any criminal prosecution, which may be brought *against a provider,* Medical Assistance may impose administrative sanctions on a provider, should the provider defraud or abuse the Program.

Administrative sanctions include termination from the Medical Assistance Program, suspension from the Program, or required participation in provider education. Examples of instances in which Medical Assistance may take administrative action are when a provider:

- Refuses to allow authorized auditors or investigators reasonably immediate access to records substantiating the provider's Medical Assistance billings; or
- Is not in compliance with the following:
  - Maryland Statutes;
  - Federal and State rules and regulations;
  - Medical Assistance policy handbooks;
  - The Medical Assistance provider agreement;
  - Maryland Administrative Code;
- Provides services in excess of recipient's needs;
- Provides services harmful to the recipient; or,
- Provides services insufficient to meet the recipient's needs.
- Fails to provide necessary access to medical care for recipients who are bound to the provider through MCOs or HMOs or "lock-in" programs, including
  - Not providing necessary preventive care and treatment in a reasonably timely manner,
  - Failing to provide reasonable accessible and adequate 24-hour coverage for evaluation of emergency complaints,
  - Discouraging a recipient from seeking medically necessary care,
  - Failing to provide a timely referral to an accessible provider for medically necessary care and/or ancillary services, or
  - Making a misleading statement of a material fact as to the recipient's medical condition or need for referred or emergency care, whether to the Program or to another provider;
- Provides misleading or false information to the Medical Assistance Program, or to its authorized representatives or delegates;
- Demands, bills or accepts payments from recipients or others for services covered by Medical Assistance;
- Has been indicted for, convicted of, or pled guilty to Program related offenses, or is suspended or terminated from the Medicare Program; or,
- Does not have all required professional licensure and certifications necessary for the services he/she is performing.

Appeal Procedure

Appeals related to Medical Assistance are conducted under the authorization of COMAR 10.09.36.09 and in accordance with COMAR 10.01.03 and 28.02.01. To initiate an appeal, the appeal must be filed within 30 days of receipt of a notice of administrative decisions in accordance with COMAR 10.01.03.06.

Procedure Codes and Fee Schedules

EPSDT Acupuncture Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number Units	Maximum Payment
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient	N	1	$25.32
97811	Acupuncture without electrical stimulation, each additional 15-minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	N	1	$19.20
97813	Acupuncture with electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient	N	1	$26.74
97814	Acupuncture with electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	N	1	$21.52

EPSDT Chiropractic Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number Units	Maximum Payment
98940	Chiropractic Manipulative Treatment Spinal, 1 to 2 regions	N	1	$18.12
98941	Chiropractic Manipulative Treatment Spinal, 3 to 4 regions	N	1	$24.98
98942	Chiropractic Manipulative Treatment Spinal, 5 regions	N	1	$32.69
98943	Chiropractic Manipulative Treatment Extra spinal, 1 or more regions	N	1	$16.40

Procedure Codes and Fee Schedules

Physical Therapy

Procedure Code	Description	Requires Pre-Auth	Maximum Number Units	Maximum Payment
97001	Physical Therapy Evaluations	N	1	$72.06
97002	Physical Therapy Re-Evaluations	N	1	$28.36
97010	Application of modality to 1 or more Areas; hot or cold packs (supervised)	N	10	$3.63
97012	Mechanical Traction (supervised)	N	10	$10.65
97014	Electrical Stimulation (unattended)	N	1	$10.15
97016	Vasopneumatic Device	N	2	$11.04
97018	Paraffin Bath	N	10	$5.79
97022	Whirlpool	N	10	$12.55
97024	Diathermy (e.g. microwave)	N	10	$3.93
97026	Infrared	N	10	$3.63
97028	Ultraviolet Light	N	10	$4.83
97032	Attended Electrical Stimulation, each 15 minutes	N	4	$11.84
97033	Iontophoresis , each 15 minutes	N	4	$17.48
97034	Contrast Bath, each 15-minutes	N	4	$10.41
97035	Ultrasound, each 15-minutes	N	4	$8.67
97036	Hubbard Tanks, each 15-minutes	N	4	$18.64
97110	Therapeutic Procedure, each 15-minutes	N	4	$29.03
97112	Neuromuscular Reeducation	N	4	$21.39
97113	Aquatic Therapy	N	4	$24.97
97116	Gait Training	N	4	$17.89
97124	Therapeutic Massage	N	4	$16.47
97140	Manual Therapy Techniques, each 15 minutes	N	4	$19.04
97597	Selective Debridement (for wounds ≤ 20 sq. cm.)	N	1	$41.98
97598	Selective Debridement (for each additional 20 sq. cm wound)	N	1	$25.68
97605	Negative pressure would therapy	N	1	$25.11
97606	Total wound surface area ≥ 50 sq.cm.	N	1	$27.10
97750	Physical performance test or measurement , each 15 minutes	N	3	$21.37

Procedure Codes and Fee Schedule Lists

Physical Therapy (Continued)

97755	Assistive Technology Assessment , each 15 minutes	N	2	$24.41
97760	Orthotics Management & Training , each 15 minutes	N	4	$32.76
97761	Prosthetic Training , each 15 minutes	N	4	$28.32
97762	Checkout for Prosthetic Use , each 15 minutes	N	2	$42.29

EPSDT Occupational Therapy

Procedure Code	Description	Requires Pre-Auth	Maximum Number Units	Maximum Payment
97003	Occupational Therapy Evaluation	N	1	$ 76.65
97004	Occupational Therapy Re-Evaluation	N	1	$ 34.08
97530	Therapeutic Activities, each 15 minutes	N	4	$ 30.56

EPSDT Speech Language Pathology

Procedure Code	Description	Requires Pre-Auth	Maximum Number Units	Maximum Payment
92506	Initial Evaluation	N	1	$ 154.17
92507	Individual	N	1	$ 63.99
92508	Group	N	1	$ 30.47

PLEASE NOTE: Services are reimbursed up to the maximum units as indicated on this schedule. Providers enrolled as a Therapy Group (Type 28) may bill per visit charge for each ***enrolled*** discipline participating in the group. Please refer for the fee schedule for maximum reimbursement.

Claims must reflect the above referenced procedure codes for proper reimbursement. These codes are specific to services outlined in the Provider Manual for EPSDT Acupuncture, Chiropractic, Speech, and Occupational Therapies, as well as Physical Therapy Services, and they are specific to the Maryland Medicaid fee-for-service system of payment.