



## PROVIDER BULLETIN

No. 05- 05

February 15, 2005

TO: Speech Therapy Providers

FROM: Mary Steiner, Interim Administrator, Medicaid Division

BY: Marsha Rekart, Program Specialist

RE: Medicaid coverage of speech therapy

**Please share this information with your speech therapy staff and billing department staff.** The following policies apply to therapy services provided to Medicaid eligible clients, children and adults, including clients enrolled in the Nebraska Medicaid managed care program, Nebraska Health Connection, and to clients eligible for waiver services.

- **Medicaid provides coverage for services that are medically necessary.** The following medical necessity policy must be applied to all services. Medical necessity policy 471 NAC 1-002.02A states:

NMAP (Nebraska Medical Assistance Program) applies the following definition of medical necessity:

Health care services and supplies which are medically appropriate and –

1. Necessary to meet the basic health needs of the client;
2. Rendered in the most cost-effective manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the client or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies which do not meet the definition of medical necessity set out above are not covered.

- Medicaid does not pay for services that are experimental or investigational. Policy 471 NAC 1-002.02C states:

NMAP does not cover medical services which are considered investigational and/or experimental or which are not generally employed by the medical profession.

The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

- The physician order for therapy services is required before services are provided. It is suggested that Medicare guidelines regarding recertification of the physician order for therapy services be followed. The recertification statement should indicate the continuing need for therapy services, an estimate of how much longer the services will be needed, the diagnosis, and anticipated goals for the client.
- The service must be of such a level of complexity and sophistication or the condition of the patient must be such that only a qualified speech pathologist can safely and effectively perform the services required. Services that do not require the performance of or supervision of a therapist or physician are not considered reasonable or necessary therapy services, even if they are performed or supervised by a therapist.
- The service must be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, the therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.
- Medicaid does not provide coverage for maintenance therapy. If a client is not making significant progress the therapist should:
  - evaluate the clients maintenance therapy needs,

- design a maintenance therapy program; and
- instruct the client, family members, or nursing facility staff on the needs of the client so they can carry out the program.

Policy for maintenance therapy is found in 471 NAC 23-003.03.

- Medicaid does not reimburse for therapist travel time, time spent documenting treatment provided, or time spent in consultation regarding the client.

**DOCUMENTATION REQUIREMENTS – EFFECTIVE MARCH 1, 2005.**

The following documentation must be maintained in the patient's file and be available upon request, or submitted with the claim when indicated in the billing requirements below. Documentation must include:

1. A copy of the physician order for the therapy evaluation and treatment.
2. A copy of the therapy evaluation containing the following elements:
  - The patient's significant past medical history, including past therapy services.
  - The patient's diagnoses that require therapy.
  - The results achieved during prior therapy services.
  - The type, amount and frequency of therapy to be provided, anticipated duration of therapy and anticipated goals. The goals must be specific and measurable.
3. The time each individual therapy session is initiated and terminated.
4. The duration of each individual modality that is reported with a time based code.
5. The patient's response to therapy, progress, or reason for lack of progress should be documented. Progress should directly relate to measurable goals established in the plan of care.
6. The name and credentials of the individual providing therapy.

**BILLING REQUIREMENTS – EFFECTIVE MARCH 1, 2005.**

These billing requirements pertain to claims submitted to the Department of Health and Human Services Medicaid Claims Processing for clients covered by Medicaid and the Medicaid managed care plan Primary Care +. (For clients enrolled in the Medicaid managed care plan Share Advantage, please contact Share Advantage regarding billing requirements.)

Claims submitted to the Department for payment must contain the following:

1. A valid medical diagnosis. Medicaid will not accept ICD-9-CM “V” codes as a valid primary diagnosis for therapy services.
  2. The name and license number of the referring physician.
  3. The date of the physician referral and/or the date of the most recent recertification of the physician referral.
  4. The date of the most recent therapy evaluation for the treatment being provided.
- If submitting a claim for code 92508 information must be provided regarding the make-up of the group. Examples, family members, nursing facility residents, group home residents. The name(s) of the group members are not required.
  - Procedure codes 92605 and 92606 are not a covered service. See codes 92506 and 92507.
  - Procedure codes 92607, 92608 and 92609 are covered if speech-generating device produces digital or synthesized speech.
  - Speech therapy codes 92506, 92507, and 92508 are billed in 30 minute units. Documentation must be submitted with the claim if 2 or more units per date of service are billed.
  - If treatment time on a single modality is less than 8 minutes the procedure code must be billed with a 52 modifier (reduced services). The unit of service would be “1”
  - The following time intervals apply when billing service units per modality.
    - 1 unit of service is billed – if the duration of a single modality is equal to 8 minutes and less than 38 minutes.
    - 2 units – equal to 38 minutes and less than 68 minutes
    - 3 units – equal to 68 minutes and less than 98 minutes
    - 4 units – equal to 98 minutes and less than 128 minutes

**Treatment is billed based on the time spent on each single modality, not total time of the treatment session for multiple modalities.** For example, if 35 minutes of 92507 and 35 minutes of 92508 were provided, 70 minutes total time, both codes would be billed as “1” unit of service.

- Group therapy will be considered on a case by case basis. Therapy documentation must be submitted with the claim and include information that identifies the specific treatment techniques, the purpose and treatment goals for the individual within the group, the number of persons in the group and make-up of the group.
- Concurrent care (e.g. speech therapist and occupational therapist providing treatment in a joint session) is billable by only one of the therapists.

Please contact Marsha Rekart at e-mail address [marsha.rekart@hhss.ne.gov](mailto:marsha.rekart@hhss.ne.gov) or 402-471-9395 with any questions regarding this memo.