

**PROVIDER BULLETIN****No. 06- 21**

August 14, 2006

TO: Speech Therapy Providers

FROM: Mary Steiner, 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 and coverage criteria regarding Medicaid coverage of speech therapy services applies to all Medicaid eligible clients. (The term “Medicaid eligible client” includes – Medicaid eligible children and adults, Medicaid clients who are eligible for waiver services and Medicaid eligible clients enrolled in the Nebraska Medicaid managed care program - Nebraska Health Connection.)

- **Medicaid provides coverage for services that are medically necessary.** Medicaid policy regarding medical necessity can be found in the Nebraska Medicaid provider handbook for Speech Therapy Services, 471 NAC - Chapter 1, section 1-002.02A.
- **Medicaid does not pay for services that are experimental or investigational.** Medicaid policy regarding experimental or investigational services can be found in 471 NAC in Chapter 1, section 1-002.02C.
- A physician order for therapy services is required before services are provided. It is suggested that the following interval for recertification of the physician order be followed:

The patient can receive therapy for up to 60 days before recertification is obtained. If therapy is to continue past the initial 60 days, recertification must be obtained every 30 days after the initial 60-day therapy period.

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.

- Services billed to Medicaid must be of such a level of complexity and sophistication or the condition of the patient must be such that only a licensed speech pathologist can safely and effectively perform the services required.

Services that do not require the performance of or supervision of a licensed speech pathologist or physician are not considered reasonable or necessary therapy services, even if they are performed or supervised by a therapist.

- Services are billable to Medicaid when they are reasonable and necessary to the treatment of the individual's illness and there is an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time.

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.

- Procedure codes 92607, 92608 and 92609 are billable to Medicaid if the speech-generating device produces digital or synthesized speech.
- Medicaid coverage of group therapy is determined 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 and the number of persons in the group.
- Medicaid **does not** provide coverage for:
 1. Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands.
 2. Facilitated communication.
 3. Learning disorders or for services that are formal educational services in academic subjects.
 4. Maintenance therapy. Medicaid policy for maintenance therapy is found in the Medicaid provider handbook 471 NAC 23-003.03.
 5. Procedure codes 92605 and 92606. (See codes 92506 and 92507.)
- Medicaid pays for face-to-face treatment time. Time starts when the therapist is working directly with the patient and the time counted is the time the patient is treated. Medicaid does not reimburse for therapist travel time, time spent documenting treatment provided, or time spent in consultation regarding the client. This non-face-to-face time is considered part of the provider's overhead cost and is not reimbursable.

PATIENT FILE DOCUMENTATION REQUIREMENTS:

The following documentation must be maintained in the patient's file and be available to the Department 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 and all recertification orders for ongoing 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.
 - A plan of care regarding 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.

CLAIM/BILLING REQUIREMENTS:

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.)

In addition to the claim form completion instructions in appendix 471-000-61, claims must contain the following information:

1. A valid medical diagnosis. Medicaid will not accept ICD-9-CM "V" codes as a valid primary diagnosis for therapy services.
 2. The date of the physician referral and/or the date of the most recent recertification of the physician referral.
 3. The date of the most recent therapy evaluation for the treatment being provided.
- 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.

- The following time intervals apply when billing service units per modality.

Unit(s) Of service	Time interval/duration of a single modality per date of service
1	Equal to 8 minutes and less than 38 minutes
2	Equal to 38 minutes and less than 68 minutes
3	Equal to 68 minutes and less than 98 minutes
4	Equal to 98 minutes and less than 128

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.

Medicaid Speech Pathology policy referenced in this provider bulletin and Chapter 23-000 Speech Pathology and Audiology policy can be printed from web address - www.hhs.state.ne.us/reg/t471.htm.

Please contact Marsha Rekart at e-mail address marsha.rekart@hss.ne.gov or 402-471-9395 with any questions regarding this memo.