

PROVIDER BULLETIN

No. 11-46

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TO: Speech Therapy Providers

FROM: Vivianne M. Chaumont, Director 
Division of Medicaid & Long-Term Care

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RE: Medicaid Coverage of Speech Therapy

Please share this information with professional, clinical, administrative, and billing staff.

This provider bulletin replaces bulletin number 05-05 (dated 2/15/2005) and number 06-21 (dated 8/14/2006).

The following policies and coverage criteria regarding Nebraska Medicaid coverage of speech therapy services applies to all Nebraska Medicaid eligible clients.

- **Nebraska Medicaid reimburses for services that are medically necessary.** Policy regarding medical necessity can be found in the Nebraska Medicaid regulations at 471 NAC 1-002.02A.
- **Nebraska Medicaid does not pay for services that are experimental or investigational.** Policy regarding experimental or investigational services can be found at 471 NAC 1-002.02C.
- **A physician (MD or DO) order for speech therapy services is required before services are provided.** See 471 NAC 23-003. The following intervals for recertification of the physician order should be followed:
 1. The patient can receive therapy for up to 60 days from the initial physician order. If therapy is to continue past the initial 60 days, another physician order must be obtained every 30 days.
 2. The initial and subsequent physician orders must describe the need for therapy services, an estimate of how much longer the services will be needed, the diagnosis, and the anticipated goals for the client.
- **For individuals age 21 and older, Medicaid covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy, and speech therapy). Services for individuals age 20 and younger are covered when specific criteria are met (see 471 NAC 17-003.02, 471 NAC 14-003.02, and 471 NAC 23-003-02). All therapy services must be medically necessary, with an expectation that there will be a definable degree of improvement in a reasonable length of time.**
- Services billed to Nebraska 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 or audiologist can safely and effectively perform the services required. Services that do not require the performance of or supervision of a speech pathologist, audiologist, or physician are not considered reasonable or

necessary therapy services, even if they are performed or supervised by a licensed speech pathologist or audiologist.

- 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 Nebraska Medicaid if a speech generating device produces digital or synthesized speech.
- Nebraska Medicaid coverage of group speech 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.
- Nebraska Medicaid **does not** provide reimbursement for:
 1. Sensory integrative techniques to enhance sensory processing and promote adaptive response to environmental demands
 2. Therapy to facilitate communication
 3. Learning disorders or for services that are formal educational services in academic subjects
 4. Functional capacity evaluations
 5. Maintenance therapy (Nebraska Medicaid policy for maintenance therapy is found in 471 NAC 23-003.03)
 6. Procedure codes 92605 and 92606
- Nebraska Medicaid pays for face-to-face treatment time. Time starts when the pathologist is working directly with the patient and the time counted is the time the patient is treated. Nebraska Medicaid does not reimburse for travel time, time spent documenting the 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
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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.

1. A copy of the physician order for the evaluation and treatment and all recertification orders for ongoing therapy.
2. A copy of the therapy evaluation containing the following elements:
 - a. The patient's significant past medical history, including past therapy services
 - b. The patient's diagnoses that require therapy
 - c. The results achieved during prior therapy services
3. 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.
4. The time each individual session is initiated and terminated.
5. The duration of each individual modality that is reported with a time based code.
6. 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.
7. The name and credentials of the individual providing therapy.

Claim & Billing Requirements

These billing requirements pertain to claims submitted to the Nebraska Medicaid for Nebraska Medicaid clients. In addition to the claim form completion instructions in appendix 471-000-61, claims must include the following information:

1. Services for Nebraska Medicaid clients enrolled in a managed care plan must be authorized and billed through that plan (see provider Bulletin 10-33).
2. A valid medical diagnosis. Medicaid will not accept ICD-9-CM "V" codes as a valid primary diagnosis for therapy services.
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.

Claims must be billed in a manner consistent with good coding practices and the National Correct Coding Initiative.

The units of service for procedure codes 92507 and 92508 are not based on minutes. For each treatment encounter, one unit should be billed.

It is your responsibility as a Nebraska Medicaid provider to ensure that you have current regulations. This includes provider handbooks, appendix material, provider bulletins, and all updates. The Nebraska Medicaid regulations are found at http://dhhs.ne.gov/medicaid/Pages/med_regs.aspx. Provider Handbooks are found at http://dhhs.ne.gov/medicaid/Pages/med_ph.aspx. Provider Bulletins are found at http://dhhs.ne.gov/medicaid/Pages/med_pb_index.aspx. These sites should be checked regularly for updates and changes.

Please contact Nola Pollmann at (402) 471-9342 or via e-mail at nola.pollmann@nebraska.gov with questions.