

# **PROTOCOLS FOR SPEECH THERAPY PROVIDERS**

## **Type of Services Provided**

Services provided by Speech Therapy (or Speech Pathology) providers are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI), Healthy Families Program (HFP), Healthy Kids (HK), Prenatal PLUS 2 (PP2), and In-home Supportive Services (IHSS) members. Services are provided for the purpose of identification, measurement and correction or modification of speech, voice or language disorders and conditions, and counseling related to such disorders and conditions. Speech therapy services also include speech therapy evaluation, treatment planning, treatment, and consultations.

## **Covered Speech Therapy (ST) Benefits for IHSS**

The following procedures are covered benefits:

- ST services are a covered benefit only when services are provided pursuant to a written treatment plan or written prescription of a CenCal Health physician, which is within the scope of his/her medical practice. See below for additional information on information needed on the prescription or written treatment plan
- ST services are only covered when care is rendered in the Provider's office or in an outpatient department of a hospital facility
- ST services must be performed by licensed and registered therapists or pathologists. However, licensed speech pathologists may be reimbursed for covered services performed by unlicensed speech pathologists working under their direct supervision to fulfill Required Professional Experience (RPE) for licensure
- ST services are also covered when the member is an inpatient at an acute care hospital, or at a rehabilitation hospital
- SGDs are available when complete documentation is submitted as set forth below

## **Covered ST Benefits for SBHI, SLOHI, HFP, HK and PP2**

The following procedures are covered benefits:

- ST services are a covered benefit only when services are provided pursuant to a written treatment plan or written prescription of a CenCal Health physician, which is within the scope of his/her medical practice. See below for additional information on information needed on the prescription or written treatment plan
- ST services are only covered when care is rendered in the Provider's office, at home or in an outpatient department of a hospital facility
- ST services must be performed by licensed and registered therapists or pathologists. However, licensed speech pathologists may be reimbursed for covered services performed by unlicensed speech pathologists working under their direct supervision to fulfill Required Professional Experience (RPE) for licensure

- ST services are also covered when the member is an inpatient at an acute care hospital, in a skilled nursing facility, or at a rehabilitation hospital

**Limitations for IHSS-** The maximum number of aggregate speech therapy, occupational therapy, and physical therapy visits, in an outpatient setting, is limited to 36 visits per calendar year. Additional visits may be authorized as Medically Necessary with evidence of continued significant improvement, as part of an approved treatment plan.

**Non-Covered Charges for Speech Therapy Benefits**

- Non-authorized services are not covered
- IHSS - visits beyond the limit of 36, unless additional visits are Medically Necessary and are authorized as set forth below

Speech Therapy provider will be responsible for:

- First determining the eligibility of members to receive services
- For meeting the elements of Speech Therapy services and for documenting services as indicated below
- For submitting claim forms to CenCal Health.

**Speech Therapy for Children**

The primary responsibility for speech therapy for children ages three to twenty-one is the school system. Also, remember that CCS will authorize speech therapy for those children with eligible conditions.

**Eligibility**

Speech Therapy providers must confirm that the member presenting in his/her office is eligible for services under CenCal Health and is assigned to the referring PCP for the month in which he/she is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems. Information regarding eligibility is in the Member Services Section of this Provider Manual.

In the event the member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the member will not be the responsibility of CenCal Health.

**Treatment Plan (required for all members when requesting authorization)**

The following must be present on the written treatment or prescription plan:

- Signature of the prescribing practitioner
- Name, address and telephone number of the prescribing practitioner
- Date of treatment or prescription plan
- Medical condition necessitating the service(s) (diagnosis)
- Supplemental summary of the medical condition or functional limitations
- Specific services (for example, evaluation, treatments, modalities) prescribed
- Frequency of services

- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by prescriber
- Anticipated medical outcome as a result of the therapy (therapeutic goals)
- Date of progress review (when applicable)
- Age of member
- Developmental status and rate of achievement of developmental milestones
- Mental status and ability to comprehend
- Related medical conditions

The goal of therapy should be achievement of intelligibility rather than age-specific qualities or previous condition status, such as with a stroke victim.

### **Documentation of Services**

The Speech Therapy provider shall document services by completing a claim form and submitting the form to CenCal Health. Speech Therapy providers shall also provide documentation to the member's PCP.

### **Authorizations**

Speech Therapy providers are required to obtain a prescription from the member's PCP, or any qualified physician, for Speech Therapy services provided to all members. Referral Authorization Forms (RAFs) are not required for services under any program. Additionally, all speech therapy services require a Treatment Authorization Request (TAR) or an Authorization Request (AR) to be approved by CenCal Health. Please refer to the TAR/AR Sections of this Provider Manual for more information.

### **Specific Authorization of Speech Generating Devices**

Information regarding Speech Generating Devices (SGDs), including Authorization requirements, is set forth below in this document.

### **Billing for Covered Services**

Speech Therapy providers bill CenCal Health for the Speech Therapy services he or she has provided to the eligible member. In the event the member has other coverage, or third-party liability is involved, the Speech Therapy provider shall follow the terms and conditions of his/her Agreement with CenCal Health, or as indicated in "Other Health Coverage" in the Claims Section of this Provider Manual.

Speech Therapy Services:

- Speech Therapy providers shall bill using Provider's valid billing number
- The ICD-9-CM diagnosis code(s) of the member's condition must be on the claim
- If member's condition is related to employment, then CMS-1500 box 10a must be checked "YES";
- For IHSS only- If member's condition is related to an auto accident, then CMS-1500 box 10b must be checked "YES"

- For IHSS only- For SGDs, Provider must include the appropriate and required modifiers on the claim, and any required invoice must be attached.

**Co-insurance**

Co-insurance for Speech Therapy services for the following members should be collected at the time the service is rendered:

IHSS members:	\$15 Co-insurance when therapy services are provided in a medical office, home or outpatient setting and when ordered by the member’s PCP. 40% Co-insurance for SGDs. Calculated based on a percentage of the Contract Rate.
HFP/HK members:	\$5 Co-insurance when provided in the home or other outpatient setting
PP2 members:	no Copayment

**Procedures Codes**

**SBHI & SLOHI**- Allied Health Providers who have rendered Covered Services to eligible SBHI and SLOHI Members shall submit Claim forms within one (1) year of the date of service, in accordance with the provisions of Section 4.6 of the Agreement. However, Claims submitted after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable.

Speech Therapy Provider shall bill for services using procedure codes referenced in Title 22, CCR, S51507.1, Occupational Therapy, or as indicated in the EDS Medi-Cal Provider Manual.

**HF/HK/PP2 and IHSS**- Allied Health Provider should submit Claims within one hundred and eighty (180) Days of the date of service.

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Billing Codes. Allied Health Provider shall bill for services for HF/HK/PP2 and IHSS Members within the acceptable range of CPT and/or HCPCS billing codes as established in the most recently published American Medical Association’s (AMA) CPT guide and/or the HCPCS guide as published by the federal Department of Health and Human Services (HHS).

**IHSS Reimbursement for Speech Therapy Services**

Speech Therapy provider shall be reimbursed for covered services rendered to members as follows:

The lessor of (a) allowable billed charges, less applicable member per visit co-insurance **or** (b) Contract Rate, less applicable member per visit co-insurance; subject to submission of complete claims.

The Contract Rate for the range of CPT codes shall be 100% of the applicable Medicare Fee Schedule for CPT codes with an established Medicare rate. For CPT

codes without an established Medicare rate, the Contract Rate shall be 100% of CenCal Health's fee schedule. In the event member Copayment exceeds allowable billed charges or Contract Rate, Provider will be reimbursed \$0.00.

### **SBHI & SLOHI Reimbursement for Speech Therapy Services**

Speech Therapy Provider and its Subcontractors agree and understand that they will accept the State Medi-Cal rate in effect at the time of service, or CenCal Health's rate in effect at the time of service, whichever is higher.

Speech Therapy Provider may request rate information for specified reimbursement codes for its specialty by contacting the Provider Services Department or a Claims Representative, or by accessing the Procedure Pricer on CenCal Health's website [www.cencalhealth.org](http://www.cencalhealth.org) for CenCal Health rates and on the Medi-Cal website for Medi-Cal rates.

### **Speech Generating Devices (SGDs)**

SGDs are electronic voice producing systems that correct expressive communication disabilities that preclude effective communication. Effective communication is defined as the member's most appropriate form of communication, allowing meaningful participation in daily activities. The HCPCS codes for SGDs require prior authorization. Prior authorization must be obtained for both purchase and rental of an SGD. If SGD is billed "By Report", a copy of the relevant page(s) of the manufacturer's catalog must be attached in order to receive reimbursement. The rental of an SGD will only be allowed if the member's SGD is being repaired or modified, or if the member is undergoing a limited trial period to determine appropriateness and ability to use the SGD. Purchase of an SGD must be billed with modifier NU and the rental of an SGD must be billed with modifier RR. A repair of an SGD should be billed with the appropriate SGD HCPCS code for the part repaired followed with modifier RP.

#### Authorization of the SGD

An Authorization Request requires all of the following documentation:

- Recipient Assessment
  - medical diagnosis and significant medical history,
  - visual, hearing, tactile and receptive communication impairments or disabilities, and their impact on the recipient's expressive communication, including speech and language skills and prognosis,
  - current communication abilities, behaviors and skills, and the limitations that interfere with meaningful participation in current and projected daily activities,
  - motor status, optimal positioning, and access methods and options, if any, for integration of mobility with the SGD,
  - current communication needs and projected communication needs within the next two years,
  - communication environments and constraints that impact SGD selection and features,

- any previous treatments of communication problems, responses to treatment, and any previous use of communication devices,
- Summary of Requested SGD
  - vocabulary requirements,
  - representational systems,
  - display organization and features,
  - rate of enhancement techniques,
  - message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory visual output, programmability, input modes and their appropriateness for use by the specific recipient,
  - portability and durability, and adaptability to meet anticipated needs,
  - identity, significant characteristics and features,
  - manufacturer’s catalog pages, including cost (for “By Report” SGDs),
  - any trial period when the recipient used the recommended device(s) in an appropriate home and community-based setting that demonstrated the recipient is able and willing to use the device effectively,
  - an explanation of why the requested device(s) and services are the most effective and least costly alternative available to treat the recipient’s communication limitations,
  - whether rental or purchase of the device is the most cost-effective option,
  - vendors,
  - warranty and maintenance provisions available for the device(s) and services, if any,
- Treatment Plan
  - the expected amount of time the device will be needed, and the amount, duration and scope of any related services requested to enable the recipient to effectively use the device to meet basic communication needs,
  - short-term communication goals,
  - long-term communication goals,
  - criteria to be used to measure the recipient’s progress toward meeting both short-term and long-term goals,
  - identification of the services and providers (and their expertise and experience in rendering these services)

**Benefit Limitation for SGDs**

SGD rental is limited to approval only when the member is undergoing a trial period to determine appropriateness and ability to use an SGD or if the member’s SGD is being repaired or modified.

**Procedure Codes for SGDs**

E2500 *	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time
E2502 *	Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but

	less than or equal to 20 minutes recording time
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508 *	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with device
E2510 *	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E1902 *	Communication board, non-electronic AAC device
E2511 *	Speech generating software program, for personal computer or personal assistant
E2512 *	Accessory for speech generating device, mounting system
E2599 *	Accessory for speech generating device, not otherwise classified

\* = Billing is subject to prior authorization requirements under CenCal Health's DME benefit

### **IHSS Reimbursement for SGDs**

- Provider will be reimbursed for SGDs according to the Medicare DMEPOS fee schedule or at "by report" pricing if no Medicare rate is listed, less the applicable member co-insurance as indicated above.
- In the event member co-insurance exceeds allowable billed charges or Contract Rate, Provider will be reimbursed \$0.00

### **CMS Correct Coding Initiative (CCI) edits**

Speech Therapists may submit claims for procedures in which CMS Correct Coding Initiative (CCI) edits will apply. These edits and the listed corresponding CPT groupings are considered mutually exclusive procedures which cannot reasonably be performed by the same provider, on the same member on the same date of service. A listing of applicable codes is as follows:

<b>Primary Procedure (CPT)</b>	<b>Mutually exclusive procedures (no reimbursement)</b>
<b>92506</b>	
<b>92507</b>	92506
<b>92508</b>	92507