SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

CSHCN SERVICES PROGRAM PROVIDER MANUAL

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SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

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37.1 Enrollment

To enroll in the Children with Special Health Care Needs (CSHCN) Services Program, speech-language pathology (SLP) providers must be actively enrolled in Texas Medicaid, have completed the CSHCN Services Program enrollment process, have a valid Provider Agreement with the CSHCN Services Program, and comply with all applicable state laws and requirements. Out-of-state SLP providers must meet all these conditions, and be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

37.2 Benefits, Limitations, and Authorization Requirements

SLP services are benefits of the CSHCN Services Program for clients with acute or chronic medical conditions when documentation from the prescribing physician and the treating therapist shows there is or will be progress made towards goals.

Note: *An advanced practice registered nurse (APRN) or physician assistant (PA) may sign and date all documentation related to the provision of SLP services on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number are required.*

Speech therapy services must be rendered in accordance with the State Board of Examiners for Speech-Language Pathology and Audiology or performed by a physician within their scope of practice.

The CSHCN Services Program may reimburse licensed speech-language pathologists, physicians, home health agencies, hospitals, and outpatient facilities based on the procedure codes listed in this chapter.

Note: *Therapy services provided by a licensed intern or assistant must be billed by the licensed supervising provider.*

Therapy goals for acute or chronic medical conditions include, but are not limited to:

- Improving function

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- Maintaining function
- Slowing the deterioration of function

Speech therapy evaluations and treatments must be ordered or prescribed by the client's physician, APRN, or PA and based on medical necessity.

A client may receive any combination of physical, occupational, or speech therapy in the office, home, or outpatient setting, up to the limits outlined in this chapter for each type of therapy.

Therapy evaluations and re-evaluations are a benefit once per 180 days, any provider. Speech therapy re-evaluations are a benefit when documentation supports one of the following:

- A change in the client's status
- A request for extension of services
- A change of provider

Additional therapy evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client's medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
- The date that the client ended therapy (effective date of change) with the previous provider
- The names of the previous and new providers
- An explanation of why providers were changed

All documentation, including the medical necessity and comprehensive treatment plan related to the therapy services prior authorized and provided, must be maintained in the client's medical record and made available upon request.

Each therapy discipline provided must be of the level of complexity that requires the judgment, knowledge, and skill of a licensed speech-language pathologist, or physician within their scope of practice, to perform or directly supervise.

The documentation maintained in the client's medical record must identify the therapy provider's name and credentials, and must include all of the following:

- Date of service
- Start time of the therapy
- Stop time of the therapy
- Total minutes of the therapy
- Specific therapy performed
- Client's response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

37.2.1 Speech Therapy Limitations

Providers should use the following procedure codes for speech therapy services:

Procedure Codes							
92507	92521	92522	92523	92524	92526	92610	S9152

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Only one of the following encounter-based speech therapy treatment codes is payable per date of service any provider:

Procedure Codes	
92507	92526

An encounter for speech therapy individual treatment is defined as face-to-face time with the patient and/or caregiver for a length of time compliant with nationally recognized professional speech-language pathology standards for a typical session.

Speech therapy treatment procedure codes should be billed with the GN modifier.

The following modifiers must be used to indicate when treatment services have been rendered by a licensed therapist or physician, or by a licensed therapy assistant under supervision of a licensed therapist:

Modifier	Modifier Description
U5	Services delivered by a licensed therapist or physician
UB	Services delivered by a licensed therapy assistant under supervision of a licensed therapist

Note: *These modifiers are not required for evaluation and re-evaluation procedure codes because those services may not be rendered by licensed therapy assistants.*

SLP evaluations and re-evaluations (procedure codes 92521, 92522, 92523, 92524, 92610, and S9152) are untimed and do not require a modifier.

Re-evaluations of oral and pharyngeal swallowing functions (procedure code 92610) require the U2 modifier.

If an initial evaluation and a re-evaluation from the same therapy discipline are billed for the same date of service by any provider, the re-evaluation will be denied.

If a therapy evaluation or re-evaluation procedure code and therapy treatment procedure code(s) from the same discipline are billed for the same date of service by any provider, the evaluation or re-evaluation will be denied.

An evaluation or re-evaluation performed on the same day as therapy treatment from a different therapy type must be performed at distinctly separate times to be considered for reimbursement.

Outpatient speech therapy treatments will deny if billed on the same date of service by any provider as procedure code G0153.

37.2.2 Authorization Requirements

Speech therapy evaluations and re-evaluations do not require prior authorization.

All other speech therapy services require prior authorization. Only one encounter-based speech therapy treatment procedure code is payable per day per provider. Additional services may be considered with documentation of medical necessity supporting the rationale for exceeding the daily limitation.

Note: *If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day.*

Prior authorization for therapy services will be considered when all of the following are met:

- The client has acute or chronic medical conditions resulting in a significant decrease in functional ability that will benefit from therapy services in an office, home, or outpatient setting.
- Documentation must support treatment goals and outcomes for the specific therapy disciplines requested.

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- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider's scope of practice as defined by state law.

37.2.2.1 Paper and Electronic Prior Authorization Documentation

To complete the prior authorization process by paper, the provider must complete and submit the prior authorization request and required documentation through fax or mail.

A copy of the prior authorization request and all submitted documentation must be maintained in the client's medical record at the therapy provider's place of business.

Note: *All prior authorization requests must be submitted with the ordering practitioner's signature.*

To complete the prior authorization process electronically, the provider must complete and submit the prior authorization request and required documentation through any approved method, and must maintain a copy of the prior authorization request and all submitted documentation in the client's medical record at the therapy provider's place of business.

To avoid unnecessary denials, the physician, APRN or PA must provide correct and complete information, including documentation of medical necessity for the service(s) requested. The ordering practitioner must maintain documentation of medical necessity in the client's medical record. The requesting therapy provider may be asked for additional information to clarify or complete a request.

37.2.2.2 Initial Prior Authorization Request for Therapy Services

The initial request for prior authorization must be approved before the initiation of therapy treatment services. Requests received after therapy treatments start will be denied for dates of service that occurred before the date the request was approved.

Initial prior authorization may be given for a service period not to exceed 180 days. Requests for extensions of ongoing treatment services may be granted up to an additional 180 days for chronic conditions with documentation of medical necessity. Prior authorizations may be approved for a time period less than the established maximum.

37.2.2.2.1 Supporting Documentation

Documentation supporting the medical need for SLP services include all of the following:

- A completed CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form. The request form must be signed and dated by the ordering physician, APRN, or PA and therapy providers.

  Note: *A request form that is missing required information is considered incomplete.*

- A current evaluation for each therapy service requested and comprehensive treatment plan with the following:
  - Date of the evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Short- and long-term treatment goals for the therapy discipline, and associated disciplines, requested related to the client's individual needs
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services

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- Prognosis for improvement
- Requested dates of service
- Date and signature of the licensed therapist

Note: *A therapy evaluation is current when performed within 60 rolling days before the initiation of therapy treatment services. The ordering practitioner must sign and date the treatment plan and request form on or after the date the evaluation was performed.*

37.2.2.3 Prior Authorization Request for Extension of Therapy Services

A prior authorization request for extension of ongoing treatment services must be received and approved no earlier than 30 days before the current authorization expires. Prior authorization requests received after the current authorization expires will be denied for dates of service that occurred before the date the submitted request was approved.

Prior authorization requests for extensions of services may be considered in increments up to 180 days for chronic conditions with documentation supporting medical necessity.

37.2.2.3.1 Supporting Documentation

Documentation supporting medical necessity of the extension of services must include all of the following:

- A new CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form. The request form must be signed and dated by the ordering physician, APRN, or PA and therapy provider(s).

  Note: *A request form that is missing required information is considered incomplete.*

- A current therapy evaluation or re-evaluation for each therapy discipline requested and an updated treatment plan containing the following:
  - Date of the evaluation or re-evaluation
  - Diagnosis(es)
  - Client's medical history and background
  - Client's current and prior functional level, to include current standardized assessment scores or criterion-referenced scores as appropriate for the client's condition
  - Date of onset of the illness, injury, or exacerbation requiring the therapy services
  - Prior and new short- and long-term treatment goals documenting the client's progress towards prior treatment goals
  - A description of the specific treatment modalities being prescribed and the recommended amount, frequency and duration of services
  - Prognosis for improvement
  - Requested dates of service
  - Date and signature of the licensed therapist

  Note: *A therapy evaluation or re-evaluation is current when performed within 60 days before the request for extension of ongoing services. The ordering practitioner must sign and date the updated treatment plan and request form on or after the date that the evaluation or re-evaluation was performed.*

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37.2.2.3.2 Discontinuation of Therapy or Change of Provider

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider the new provider must submit evidence of the following, including all documentation required for an initial request for therapy services:

- A change of provider letter signed and dated by the client, parent, or guardian documenting:
  - The date the client ended therapy with the previous provider (effective date of change)
  - The names of the previous and new providers
  - An explanation why providers were changed

A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond limitations.

Refer to: Section 4.3, "Authorizations" in Chapter 4, "Prior Authorizations and Authorizations" for detailed information about authorization requirements.

Chapter 10, "Augmentative Communication Devices (ACDs)."

CSHCN Services Program Prior Authorization Request for Initial Outpatient Therapy (TP1) Form

CSHCN Services Program Prior Authorization Request for Extension of Outpatient Therapy (TP2) Form

Note: *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

37.2.3 Services That Are Not a Benefit

The following speech therapy services are not a benefit of the CSHCN Services Program:

- Group therapy for SLP services (procedure code 92508)
- Services provided by unlicensed SLP aides, orderlies, students, or technicians
- Separate reimbursement for VitalStim therapy for dysphagia
- Unattended electrical stimulation
- Treatment solely for the instruction of other agency or professional personnel in the client's physical, occupational, or speech therapy program
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- Emotional support, adjustment to extended hospitalization or disability and behavioral readjustment
- Services and procedures that are investigational or experimental

37.3 Coordination with the Public School System

Clients may receive therapy services from both the CSHCN Services Program and school districts only when the therapy provided by the CSHCN Services Program addresses different client needs. If the client is of school age, therapy provided through the CSHCN Services Program is not intended to duplicate, replace, or supplement services that are the legal responsibility of other entities or institutions.

The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client's ability to progress.

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37.4 Claims Information

Claims for SLP treatment services must include modifier GN. Outpatient therapy services provided by outpatient facilities and SLP providers must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Note: *NCCI guidelines do not apply to therapy procedure codes if a valid prior authorization number is submitted on the claim.*

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

37.5 Reimbursement

The CSHCN Services Program may reimburse therapy providers at the lesser of the billed amount or the amount allowed by Texas Medicaid. Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

Outpatient hospital services are reimbursed at 72 percent of the billed amount multiplied by the hospital's Medicaid interim rate.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

37.6 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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