SPEECH-LANGUAGE SERVICES

ND Medicaid covers speech-language services provided to a member by a speech-language pathologist, a speech language pathology licensed assistant, or a speech language pathology paraprofessional under the supervision of a licensed, qualified, and enrolled speech language pathologist.

COVERED SERVICES

Speech-language services includes those services necessary for the evaluation and treatment of speech, hearing, and language disorders that result in communication disabilities and for the evaluation and treatment of swallowing disorders (dysphagia) regardless of the presence of a communication disability.

Speech-language services require referral for evaluation and treatment from a physician or practitioner of the healing arts within their scope of practice according to state law.

Speech-language services must be of a level of complexity and sophistication, or the condition of the member must be of a nature that requires the judgment, knowledge, and skills of a qualified speech-language pathologist.

Speech-language services provided on an ongoing basis
to maximize the member's functional level is covered for members who have:

- experienced trauma;
- a chronic condition; or
- a condition due to congenital abnormality, deprivation, or disease

that interrupts or delays the sequence and rate of normal growth, development, and maturation.

Speech-language services provided to a resident staying at a nursing facility, swing bed, hospital, or ICF/IID are not separately billable. ND Medicaid pays for speech-language services through the rate established for these facilities.

ND Medicaid covers the following speech-language CPT® codes:

92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

92521	Evaluation of speech fluency
92522	Evaluation of speech sound production
92523	Evaluation of speech sound production with evaluation of language comprehension and expression
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing and/or oral feeding function
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92606	Therapeutic services for use of non-speech-generating device«, including programming and modification»
92607	Evaluation for prescription of speech-generating augmentative and alternative communication device, face-to-face with the patient, first hour
92609	Therapeutic services for use of speech-generating device«, including programming and modification»
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic «evaluation of swallowing function «by cine or video recording
96105	Assessment aphasia with interpretation and report per hour
96110	Developmental screening with scoring and documentation, per standardized instrument
96112	Developmental test administration by physician or other qualified health care professional, with interpretation and report; first hour
96113	Each additional 30 minutes. Use in conjunction with 96112.
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Each additional 15 minutes. Use in conjunction with 97129.

PLAN OF CARE

Speech-language services must be provided in accordance with a documented plan of care that is dated and signed by the speech-language therapist responsible for oversight of the plan.

The initial plan of care shall contain, at minimum:

- Diagnoses;
- A description of the member's functional status;
- The objectives of the speech-language service;
- Short-term treatment goals;
- Long-term treatment goals; and
- Type, amount, duration, and frequency of therapy services

The plan of care shall be consistent with the related evaluation which is considered part of the plan. The plan should provide for treatment in the most efficient and effective manner and anticipate progress toward achieving the treatment goals within a relatively short amount of time, generally not to exceed 90 days. Long-term treatment goals should be developed for the entire episode of care in the current setting. When the episode is anticipated to be long enough to require more than one certification, the long-term goals may be specific to the part of the episode that is being certified. Goals should be measurable and pertain to identified functional impairments. Therapists typically also establish short-term goals, such as goals for a week or month of therapy, to help track progress toward the goal for the episode of care.

The speech-language therapist must update the plan of care within 90 days of the initial evaluation or first therapeutic encounter; and each 90-day interval throughout the course of treatment. With each 90-day interval, the plan of care must be certified (signed and dated) by the physician or other licensed practitioner of the healing arts who has knowledge of the need for and supports ongoing therapy services for the member.

Updates to the plan of care must include:

- Prior short-term goals;
- Prior long-term goals;
- Explanation of progress toward goal attainment, since initial or previous plan of care update;
- New, modified, or carried-over short-term goals; and
- New, modified, or carried-over long-term goals.

GROUP THERAPY

Group therapy supplements, not replaces, individual therapy. Group therapy may not represent the entire care plan for any individual.

Medical documentation must include the following.

- Justification for group (vs. individual) treatment for each treatment session;
- Specific goals targeted and how the group activity supported them;
- How activities used skilled interventions that were reasonable and medically necessary supported the member's established care plan;
- Member's response to activities and related data;
- Percentage of treatment that group therapy represents; and
- Continued need for the continuation of group therapy.

LIMITATIONS

Speech therapy evaluations are limited to one per calendar year. Speech-language services are limited to 30 visits per calendar year for members age 21 and over.

SERVICE AUTHORIZATIONS

With the exception of CPT® codes 92597, 92607, and 92610, members are limited to one evaluation per year which does not require a service authorization. **This is not a per code per year limit**. It refers to all evaluation codes except those listed in this section.

Service authorizations are also required for therapy visits that exceed the limit of 30 visits per calendar year for members ages 21 and over.

ND Medicaid will not cover services exceeding the limit provided without a service authorization.

Service Authorization Requirements

The speech language pathologist must submit a service authorization prior to the member's receipt of services requiring authorization. Therapists must:

- Complete and submit a Service Limits Service Authorization Request (SFN 481) to ND Medicaid along with a copy of the current plan of care and relevant progress notes.
    - SFN 481 is available at https://www.nd.gov/eforms/.

Upon receipt of the complete service authorization request, including the current plan of care and progress notes, ND Medicaid will evaluate the request for additional services for the following:

- Medical necessity;
- Progress toward goal attainment;

- Type, amount, duration, and frequency of continued therapy services; and
- Reasonableness of new, modified, or carried-over goals.

«Generally, service authorizations for new evaluations or reevaluations will not be approved when a member has missed appointments or fails to follow through with the recommended plan of care.»

To be eligible for retroactive authorization consideration, all requirements for service authorization must be met, and ND Medicaid must receive the retroactive authorization request no later than 90 days from the date the service. The speech-language pathologist must demonstrate good cause for the failure to secure the required prior service authorization request. Retroactive authorization requests are reviewed internally and decided upon on a case-by-case basis.

NONCOVERED SERVICES

- Speech-language services provided without an order from a physician or licensed practitioner of the healing arts;
- Services that are not part of the member's plan of care, or are specified in a plan of care but are not reviewed and revised as medically necessary;
- Services that are not designed to improve or maintain the functional status of a member with a speech-language disorder;
- Duplicate therapy is allowed when delivered 1) collaboratively pursuant to an existing Plan of Care or therapy series or 2) by a school district as specified in the member's Individualized Education Plan (IEP). Therapy received outside of an IEP cannot duplicate therapy received through the member's IEP.
- Maintenance therapy.

DOCUMENTATION REQUIREMENTS

See the Documentation Guidelines for Medicaid Services found in the Provider Information policy.

DEFINITIONS

Duplicate therapy – means therapy and/or treatment provided by more than one provider of the same type for the same diagnosis.

Group Therapy – provision of treatment at the same time, to two or more individuals performing the same or similar activities.

BILLING GUIDELINES

Practitioners: When billing for one code that is billed in units (i.e. 15 minutes) throughout a day, report the total amount of units on one claim line.