Speech-Language Pathology

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. SPEECH-LANGUAGE PATHOLOGISTS ELIGIBLE TO PARTICIPATE

For Medicaid payment purposes, a qualified speech-language pathologist is licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed speech-language pathologists in an independent group practice are eligible to enroll. Speech-language pathologists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

Speech-language pathologists who provided services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

B. COVERAGE OF SPEECH-LANGUAGE PATHOLOGY (SLP) SERVICES

Total Medicaid payment for combined services provided by an independently practicing speech-language pathologist and physical therapist shall not exceed the therapy cap as disclosed by the Centers of Medicare and Medicaid Services (CMS). Click here to view the current cap information.

For Medicaid purposes, speech-language pathology services are those services furnished a patient that meet all of the following conditions:

- The services are directly and specifically related to an active written treatment regimen that is:
  - Designed by the physician after any needed consultation with the qualified speech-language pathologist, and
  - Included in the final treatment plan.
- The services are of such a level of complexity and sophistication or the condition of the patient is such that the judgment, knowledge, and skills of a qualified speech-language pathologist are required.
- The services are in fact performed by or under the supervision of a qualified speech-language pathologist, meaning that the qualified speech-language pathologist:
  - Provides authoritative procedural guidance for the rendering of the services with initial direction and periodic inspection of the actual act, and
  - Is on the premises if the person performing the service does not meet the assistant-level qualifications.

- The services either:
  - Are provided with the expectation that the patient will improve significantly in a reasonable and generally predictable period of time, based on the physician's assessment of the patient's restorative potential after any needed consultation with a qualified speech-language pathologist, or
  - Are necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state.
- The services are considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition.
- The services are reasonable and necessary to the treatment of the patient's condition.

Services related to activities for the general good and welfare of patients, such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute speech-language pathology for Medicaid purposes.

Services that exceed the cap listed above may be provided if the therapist provides documentation that services were medically reasonable and necessary. The need for medically necessary and reasonable services must be documented in the medical record. Submit the documentation of the medical necessity of the services up to the limit of $3,700 for speech-language pathology and physical therapy combined. If the services are not determined to be medically necessary and reasonable, the services are not covered.

C. INTERPRETER SERVICES

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing agency
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

1. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

2. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

D. BASIS OF PAYMENT

The basis of payment for the services of an independently practicing speech-language pathologist is based on a fee schedule.

Click here to view the fee schedule for Speech-Language Pathology.

E. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. Surgical procedures not covered by Medicare may be identified as payable by Medicaid. Reimbursement rates are established by the Medicaid program for those surgical procedures. The five-digit procedure code must be followed by an EP modifier if the service is the result of an EPSDT (Early and Periodic Screening, Diagnosis and Treatment) physical.

It is your responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Speech-Language Pathology are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading your Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf.