

## CHAPTER 23-000 SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

23-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), a qualified professional speech pathologist or a qualified professional audiologist must be licensed by the Nebraska Department of Health and Human Services. If services are provided outside Nebraska, the speech pathologist or audiologist must:

1. Have been granted a certificate of competency by the American Speech, Language, and Hearing Association;
2. Meet the equivalent educational and work experience requirements needed for a certificate of competency;
3. Have completed the academic program requirements and be acquiring the supervised work experience needed for the certificate of competency; or
4. Where applicable, licensed by the state.

23-001.01 Registered Communication Assistants: NMAP does not enroll registered communication assistants as providers. Services provided by a registered communication assistant are billable to NMAP when all requirements of 172 NAC 23 and 172 NAC 24 are met.

23-001.02 Provider Agreement: The speech pathologist or audiologist must complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit it to the Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care, to be approved for provider enrollment.

Out of state providers who are not licensed must submit a photocopy of the certificate of clinical competency to the Department with the signed and completed Form MC-19. Out-of-state individuals who meet the academic requirements but are acquiring work experience for certification must submit a signed and completed Form MC-19 to the Department to be approved for provider enrollment. The Department will submit Form MC-19, completed by the applicant-provider, to the Nebraska Speech Pathology and Audiology Licensure Board for evaluation.

23-002 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

23-002.01 Health Maintenance Organization (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider must provide services only under arrangement with the HMO.

23-002.02 Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. The client's primary care physician (PCP) in the PCCM must refer the client for speech therapy or audiology services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

23-003 Covered Services: NMAP covers speech pathology and audiology services when the following criteria are met:

1. The services are ordered by a licensed physician;
2. The services are medically necessary;
3. The services are of such a level of complexity and sophistication or the condition of the patient is such that only a licensed speech pathologist or audiologist can safely and effectively perform the service; and
4. The speech pathology or audiology service meets at least one of the conditions listed in 471 NAC 23-003.01 or 23-003-02.

23-003.01 Services for Individuals Age 21 and Older: NMAP covers a combined total of 60 therapy sessions per fiscal year (physical therapy, occupational therapy and speech therapy). The service must be:

1. An evaluation; or
2. Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time; or
3. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
  - a. DD Adult Comprehensive Services Waiver;
  - b. DD Adult Residential Services Waiver;
  - c. DD Adult Day Services Waiver;
  - d. Community Supports Waiver; or
  - e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

23-003-02 Services for Individuals Age 20 and Younger: NMAP covers speech pathology and audiology services for individuals birth to age 20 when the following criteria are met. The service must be:

1. An evaluation; or
2. Reasonable and medically necessary for the treatment of the client's illness or injury; or
3. Restorative therapy with a medically appropriate expectation that the client's condition; or
4. Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the following waiver program:
  - a. DD Adult Comprehensive Services Waiver;
  - b. DD Adult Residential Services Waiver;
  - c. DD Adult Day Services Waiver;
  - d. Community Supports Waiver; or
  - e. Home and Community Based Services Waiver for Children with Developmental Disabilities and their Families.

23-003.03 Maintenance Therapy: NMAP does not cover maintenance therapy provided by a speech pathologist. The speech pathologist must:

1. Evaluate the client's needs;
2. Design a maintenance program;
3. Instruct the client, family members, or nursing facility staff in carrying out the program.

23-004 Non-Covered Speech Pathology and Audiology Services: NMAP does not cover, speech pathology or audiology services in the following situations:

1. Clients Age 21 and Older – therapy sessions in excess of 60 sessions per fiscal year for any combination of physical therapy, occupational therapy, and speech therapy;
2. Therapy for vocational and prevocational assessment and training;
3. Therapy for functional capacity evaluations, educational testing, drivers training, or training in non-essential self-help or recreational activities (e.g. homemaking, cooking, finance), visual perception training, or treatment of psychological conditions;
4. Therapy for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting;
5. Therapy for delays in speech development that is not due to a specific disease or brain injury; or
6. Therapy for the following conditions or diagnosis categories:
  - a. Psychosocial speech delay
  - b. Behavior problems
  - c. Attention disorders
  - d. Conceptual handicap
  - e. Learning disability

23-005 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Division of Medicaid and Long-Term Care.

23-006 Payment for Speech Pathology and Audiology Services

23-006.01 Payment for Individual Providers: NMAP pays for covered speech pathology and audiology services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
  - a. The unit value multiplied by the conversion factor;
  - b. The invoice cost (indicated as "IC" in the fee schedule);
  - c. The maximum allowable dollar amount; or
  - d. The reasonable charge for the procedure as determined by the Division of Medicaid and Long-Term Care (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

23-006.01A Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Division of Medicaid and Long-Term Care determines that the current allowable amount is -
  - a. Not appropriate for the service provided; or
  - b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

23-006.02 Hospitals: For payment as a hospital service, see 471 NAC 10-000, Hospital Services.

23-006.03 Home Health Agencies: For payment as a home health agency service, see 471 NAC 9-000, Home Health Agency Services.

23-007 Billing Requirements

23-007.01 Medicare or Other Insurance Coverage: If a client is eligible for Medicare or has other insurance which may cover speech pathology or audiology services, the provider must bill the Medicare carrier or the insurance company before submitting a claim to the Department.

23-007.02 Medical Necessity Documentation: The provider must provide the following information when submitting a claim for speech pathology services:

1. Date of illness/injury onset;
2. Date speech pathology plan established;
3. Date speech pathology started; and
4. Number of speech pathology visits from onset.

23-007.03 Utilization Review: Claims for speech pathology and audiology services are subject to utilization review by the Department to determine medical necessity and appropriateness of service.

23-007.04 Required Forms and Standard Electronic Transactions: Depending on the place of service, the provider must use the forms and transactions required by the Department as follows:

1. If the service is provided at the patient's home or the provider's office, the provider must claim payment on Form CMS-1500 (see 471-000-61) or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837). The provider must use the appropriate place of service code and CPT or HCPCS codes on Form–CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837);
2. If the service is provided in a hospital, the hospital makes payment to the physical therapist. The hospital submits claims to the Department for physical therapy services provided in the hospital facility to inpatients or outpatients on Form CMS-1450 or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837); and
3. If the service is provided by a home health agency, the agency must claim payment on Form CMS-1450, (see 471-000-57) or electronically using the standard Health Care Claim: Institutional transaction (ASC X12N 837).

The provider or the provider's authorized agent must enter the provider's usual and customary charge for each procedure code listed on or in the claim.

23-007.05 Procedure Codes: Individual providers billing on Form CMS-1500 or electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) must use the American Medical Association's Current Procedural Terminology (CPT) or HCPCS procedure codes when billing the Department. When billing on Form CMS-1500 with CPT procedure codes, NMAP defines 30 minutes of speech pathology services as "1" "unit of service".

Hospital providers billing on the appropriate institutional claim (see Claim Submission Table at 471-000-49) must use the appropriate revenue codes when billing the Department.

Home health providers billing on the appropriate institutional claim (see Claim Submission Table at 471-000-49) must use the procedure codes listed in 471-000-57.