Speech Therapy Services

Overview/Reminders for 2017

General Information

- Speech Therapy is a review area that starts over every calendar year.
  - A calendar year is between January 1st and December 31st.
  - Prior authorizations cannot be extended into the next year. A new request must be made.
    - A copy for correction would not need to be submitted, they will not work in this instance.
- 1 unit = 1 visit
- Units can only be added when the case was reviewed and approved for the requested amount and failed to reflect unit amount in the approval.
  - If the member needs more units/visits, a new request needs to be made.

General Information - continued

- If the member has remaining units but the prior authorization has expired, a modification form can be submitted to extend the prior authorization up to an additional 90 days.
- Code 92506 does not require prior authorization unless service limitations have been exceeded.
  - 1 per 6 months (Calendar year)
- Services are available to members up to 21 years of age. Services provided on or after the 21st birthday are limited.

Provider Enrollment

- Please be sure that the Speech therapist performing the service(s) is enrolled as a participating provider with WV Medicaid.
- It may result in billing issues if the Speech therapist performing the service(s) is not enrolled under your organization as a participating provider with WV Medicaid.
- If there are issues or concerns regarding billing and claims, please call Molina at 888-483-0793 to receive further instructions to ensure claims will pay under the prior authorization.

Outpatient Setting

- Speech therapy services may be provided in an outpatient setting by Medicaid enrolled speech language pathologists.
- Acute care and critical access hospitals are not eligible for direct reimbursement for outpatient therapy services.

Duplication of Services

Birth-to-Three

- Birth-to-Three must coordinate the treatment plan of care between the providing therapists and the program providers.
  - This is to avoid duplication of speech therapy services.

Intellectual and Developmental Disabilities Waiver

- If a patient is part of the I/DD Waiver program and has a qualifying diagnosis for I/DD Waiver and has not exhausted their budget, waiver benefits must be utilized first.
- Once the budget has been exhausted; authorization may be submitted through the KEPRO C3 Portal with documentation of exhausted benefits.

What Documentation is needed for review?

- Initial evaluation
- Current progress notes
- Long term goals
- Short term goals with baseline data
  - It is important to paint a picture of where the member is starting from and where they are going. We need to clearly see that the individual is showing benefit from speech therapy services.
    - Examples:
      - Short term goal 1: Johnny will produce the K phoneme in the initial position of words correctly with 90% accuracy.
      - Baseline data: Johnny currently produces initial K with 25% accuracy. Accuracy increases when visual and verbal cues are provided.
      - Short term goal 2: Johnny will produce F in the initial position of syllable correctly with 90% accuracy.
      - Baseline data: Johnny is currently unable to produce the initial F phoneme at the syllable level. He can produce F in an isolation with 100% accuracy.
        - » This format is not required.

What Documentation is needed for review?

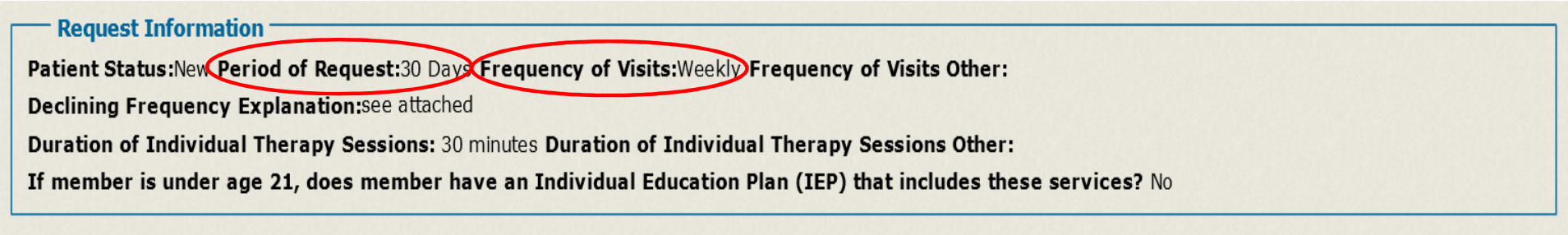
- Order
  - Diagnosis code (whether description or code) is needed on the order.
  - Order must be dated within one year, and cover the requested range of therapy.
  - Must be signed by the ORP (MD, DO, CNS, PA, or APRN).
- Audiological Evaluation
  - Must be performed by a certified audiologist.
  - Audiological evaluation is only good for one year if deficits are found.
  - If no deficits are found, the audiological evaluation does not need to be repeated and will be acceptable unless concerns arise from guardians, school, therapist, etc.
- Individual Education Plan (IEP)
  - When applicable.
  - When school is not in session, continuation of speech therapy services, if necessary, is to be coordinated with a speech therapist in private practice. The written IEP established by the school system must include the continuation of the treatment plan by the private practitioner.

What Documentation is needed for review?

- Parent waiver letter
  - Parents have the freedom to choose services from Medicaid providers outside the school system. However, West Virginia cannot cover this duplication of services, that is, pay claims for the same services provided in the school system and also outside the school system by private practitioners for the same Medicaid member. Therefore, the parent/guardian must notify the school district to not seek Medicaid reimbursement for the relevant services. Please refer to Chapter 538, School-Based Health Services for additional information.
    - Please note, school age is considered between ages 3-21.
    - If member is not enrolled in school, please document that in the prior authorization request (no letter from guardian is needed).
  - County of school needs to be listed.
  - Current school year.

Tips for Submission

- Please be sure that the frequency/duration of visits reflects with office notes.
  - We calculate the visits from the information below.
    - Example: 30 days = 4 weeks x 1 time a week= 4 visits.
  - Cases will be pended for clarification if office notes do not match what is submitted.



Request Information

Patient Status: New **Period of Request:** 30 Days **Frequency of Visits:** Weekly **Frequency of Visits Other:**

Declining Frequency Explanation: see attached

Duration of Individual Therapy Sessions: 30 minutes **Duration of Individual Therapy Sessions Other:**

If member is under age 21, does member have an Individual Education Plan (IEP) that includes these services? No

Tips for Submission-cont.

- Please remember that with each new request all documentation must be sent or attached to the prior authorization request.
  - KEPRO will not go back to the previous case to pull any missing information.
  - This can cause a delay in review and a delay in treatment for the member.
- When submitting either DDE or by fax, the referring provider must be a MD, DO, APRN, CNS, or PA that is enrolled with WV Medicaid.

KEPRO
INTELLIGENT VALUE

Speech Generating Systems and Devices

Overview/Reminders 2017

Provider Enrollment

- Per BMS policy, the ORP must be an active WV Medicaid provider.
- Tracking member utilization and obtaining prior authorization, when required, is the responsibility of the ORP.
- Enrollment with the KEPRO C3 Provider Portal is required to request prior authorizations.
- Authorization requests submitted by an ORP that is not enrolled with WV Medicaid or the KEPRO Provider Portal will be returned until the enrollment process has been completed.

General Information
Chapter 530.1.4 BMS Provider Manual

- Speech generating device and accessories (e.g., operating system, Word core software, battery charger, mounting plate, built-in stand, vocabulary software, USB cable, one battery pack and a standard one year warranty) are included with the initial placement of the device and is not reimbursed separately.
- Accessories not included in initial placement (e.g., cables, additional battery packs, carrying case, and picture communication symbols (PCS) may be billed separately.
- These services are covered for all ages and must be provided under the direction of an enrolled Speech-Language Pathologist trained in augmentative communication(AC)/speech generating devices and services.
- Repair and/or modification to the augmentative communication(AC)/speech generating device requires prior authorization.

General Information-continued

- Artificial larynxes including an initial battery, tracheostomy speaking valves, and voice amplifier are covered for all ages. Prior authorization is required when service limits are exceeded.
- Speech therapy and audiology services may be provided in an outpatient setting by Medicaid enrolled speech language pathologists and audiologists.
- Acute care and critical access hospitals are not eligible for direct reimbursement for outpatient therapy services.
- When billing for speech generating devices, all discounts given to dispensers must also be reflected on the cost invoice submitted to the UMC (KEPRO).

KEPRO Contact Information

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GENERAL KEPRO INFORMATION: WWW.WVASO.KEPRO.COM
FAX #: 866-209-9632 (REGISTRATION AND TECHNICAL SUPPORT ONLY)
WEBSITE FOR SUBMITTING AUTHORIZATIONS: HTTPS://PROVIDERPORTAL.KEPRO.COM
WEBSITE FOR ORG MANAGERS TO ADD/MODIFY USERS: HTTPS://C3WV.KEPRO.COM

Questions?