wisconsin Medicaid update and BadgerCare

August 2002 • No. 2002-49

PHC 1898

Wisconsin Medicaid and BadgerCare Information for Providers

To:

Nursing Homes

Outpatient Hospitals

Rehabilitation Agencies

Speech and Hearing Clinics

Speech-Language Pathologists

Therapy Groups

HMOs and Other Managed Care Programs

Procedure code changes for speech and language pathology services

Effective for dates of service (DOS) on and after October 1, 2002, Wisconsin Medicaid has adopted a range of procedure codes for billing and prior authorization of speech and language pathology (SLP) services. Independent speech-language pathologists, rehabilitation agencies, speech and hearing clinics, and therapy groups are required to use these procedure codes. Also, Wisconsin Medicaid will be using a new reimbursement system for procedure codes for SLP services.

This *Wisconsin Medicaid and BadgerCare Update* describes the following new policies for SLP services:

- Units of service.
- Daily service limits.
- Maximum allowable fees.

Effective for dates of service (DOS) on and after October 1, 2002, Wisconsin Medicaid has adopted a range of procedure codes for billing and prior authorization of speech and language pathology (SLP) services. This project was initiated to expand the number of procedure codes to more accurately reflect services performed and billed. Independent speech-language pathologists, rehabilitation agencies, speech and hearing clinics, and therapy groups are required to use these procedure codes.

New policies

Unit of service

Effective for DOS on and after October 1, 2002, procedure code descriptions do not refer to amounts of time with the exception of 96105. Therefore, one unit is considered to be one complete service for the remaining procedures with the exception of 96105. All evaluations and re-evaluations are billed upon completion regardless of the number of days needed to complete. In accordance with Medicare, providers can not bill for services performed for less than 8 minutes.

Daily service limitation

The 90-minute-per-day limit is no longer applicable *except for procedure code 96105* for which one unit is defined as one hour. As noted in Attachment 1, the daily service limit

Attachment information

Attachment 1 of this *Update* lists *Current Procedural Terminology* and HCFA Common Procedure Coding System codes for speech and language pathology (SLP) services including code descriptions and further explanation of Medicaid policy.

Attachment 2 lists the Medicaid requirements for SLP services.

Attachment 3 lists the maximum allowable fees of procedure codes for SLP services.

per recipient, per procedure code for the remaining procedure codes is one.

The provider's medical records must document that the service was completed on the DOS shown on the claim. Refer to the August 1999 *Wisconsin Medicaid Update* (99-36), titled "Therapy services clinical documentation and record-keeping requirements," for more information.

Maximum fees

Effective for DOS on and after October 1, 2002, Wisconsin Medicaid maximum fees for procedure codes for SLP services are based on the national standard Medicare relative value units (RVUs) and a 5% differential for rehabilitation agencies. These rates reflect the 1.095% rate increase in maximum allowable fees for most Wisconsin Medicaid non-institutional providers effective July 1, 2002. In addition to this increase, Wisconsin Act 16, the 2001-2003 biennial budget, authorized additional targeted rate increases for selected providers. The amount of money paid to the entire Medicaid-certified SLP community will not change, but payments to individual SLP providers may change.

The resource-based value scale assigns the RVU based on the complexity of procedures. The provider's work (physical and mental intensity, time taken to perform the service, non-face-to-face work) for each procedure, practice expenses, and liability insurance are also considered when determining the RVU. These rates apply to independent speech-language pathologists, rehabilitation agencies, speech and hearing clinics, and therapy groups.

Relative value units are based on the expectation that the code's definition represents *exactly* how the service will be provided when submitted to Wisconsin Medicaid. Refer to Attachment 3 for a list of maximum allowable fees for SLP services procedure codes.

Multiple procedure codes per date of service

When appropriate, multiple procedure codes may be performed and submitted for reimbursement for a single DOS. Refer to Attachment 1 for billing limitations.

Submit the claim with the procedure codes that accurately reflect the services performed. The provider's medical records must document that the service was completed. See *Wisconsin Medicaid Update* 99-36 for more information.

Submitting claims

Providers submitting claims to Wisconsin Medicaid for SLP services should follow these procedures:

- Use the type of service and place of service codes listed in Attachment 1.
- Use the procedure codes in Attachment 1 when submitting claims for DOS on and after October 1, 2002.
- Submit claims for services with a current approved prior authorization (PA) or spell of illness (SOI) with the procedure code(s) indicated on the approved PA or SOI until September 30, 2002. For services provided on and after October 1, 2002, refer to the "prior authorization/spell of illness" section of this *Update*.
- Submit procedure codes with a quantity of 1 for DOS on and after October 1, 2002, except for procedure code 96105. For information on submitting claims, refer to

the first page of this *Update* and Attachment 1.

- Continue to submit claims to commercial health insurance and Medicare before submitting claims to Wisconsin Medicaid for recipients with other health care coverage.
- Submit claims, including claims for off-site hospital services, on the HCFA 1500 claim form. Off-site hospital services are not billable under the hospital's billing provider number.

Medicare crossover claim payments for some SLP services are subject to Wisconsin Medicaid maximum fees and Medicaid limits on Medicare Part B coinsurance payments. Refer to the Coordination of Benefits section of the All-Provider Handbook for more information.

Prior authorization/spell of illness

When to use the new coding structure for all prior authorization and spell of illness requests

Beginning September 1, 2002, for anticipated and/or grant dates on and after October 1, 2002, providers may submit requests for amendments and new PAs or SOI under the new coding structure. When appropriate, multiple procedure codes may be requested on PA requests.

Prior authorizations or SOI requests approved under the old coding structure with expiration dates on and after October 1, 2002

For current PAs or SOI requests that were previously approved under the old coding structure, with expiration dates on and after October 1, 2002, providers may do any one of the following:

- Continue to submit claims until the PA expiration date to Wisconsin Medicaid using the procedure codes on the approved PA. However, submit claims according to the new procedure code description and units for DOS that occur on and after October 1, 2002. The following table provides an example.

Procedure code approved on PA	Date of service	Actual minutes of treatment	Quantity submitted on claim
92507	08/26/02	60	2
	10/07/02	60	1
	10/08/02	30	1

- Amend the PA to use the expanded list of procedure codes.
- Request a new PA to use the expanded list of procedure codes.

How to amend a previously approved prior authorization or spell of illness

1. Write a letter to Wisconsin Medicaid requesting an amendment to the approved PA (see address below).

2. Include all of the following information in your letter:
   - ✓ The requested effective date of the amendment.
   - ✓ The number of sessions provided under the old coding system before the requested effective date of the amendment.

3. Attach both of the following to your letter:
   - ✓ A copy of the approved PA to be amended.
   - ✓ Any additional supporting clinical documentation. To explain use of the new codes, refer to Attachment 1 for additional conditions.

4. Send the letter and any attachments or additional documentation to:

   Wisconsin Medicaid
   Prior Authorization
   Ste 88
   6406 Bridge Rd
   Madison WI 53784-0088

Prior authorization requests for therapy services provided as part of the Birth to 3 Program

Effective July 1, 2002, Wisconsin Medicaid:

- Requires therapy providers to submit a PA request *only once* per child, per therapy type, per provider for therapy groups and for independent therapy providers.
- Requires rehabilitation agencies to submit a PA request *only once* per child per therapy type.
- Grants PA up to the recipient's third birthday.

The only children to whom the new B-3 process applies meet one of the following criteria:

- Receive an initial evaluation and assessment for the Birth to 3 (B-3) Program.
- Participate in the B-3 Program.

Speech and language pathology procedure codes that may be billed under the B-3 PA process are highlighted in Attachment 1. Providers must follow Wisconsin Medicaid's current PA process for all other SLP procedure codes.

For additional information, refer to the June 2002 *Update* titled, "Elimination of need for renewal requests for therapy services provided as part of the Birth to 3 Program." Included in the June 2002 *Update* is a Prior Authorization/ Birth to 3 Program form to use with the new process.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT 1
Medicaid procedure codes for speech and language pathology services effective October 1, 2002

Allowable types and places of service for specific providers	
Independent Therapists, Therapy Groups, and Therapy Clinics Type of service (TOS) = 1	Allowable places of service (POS)* = 0, 1, 2, 3, 4, 7, 8
Rehabilitation Agencies TOS = 9	Allowable POS* = 0, 3, 4, 7, 8

Procedure code	Description	Daily service limit**	Billing limitations	Additional conditions
31575	Laryngoscopy, flexible fiberoptic; diagnostic	1		Use this code if speech-language pathologist actually inserts laryngoscope. Do not use this code if speech-language pathologist is providing an analysis and does not insert the laryngoscope. Instead use code 92506 or G0195, as appropriate. For treatment, use 92507 or 92526, as appropriate. This service is to be performed according to the American Speech-Language-Hearing Association (ASHA) Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	1		Use this code if speech-language pathologist actually inserts laryngoscope. Do not use this code if speech-language pathologist is providing an analysis and does not insert the laryngoscope. Instead use code 92506 or G0195 as appropriate. This service is to be performed according to the ASHA Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.

*Place of service
0 = Other
1 = Inpatient Hospital
2 = Outpatient Hospital
3 = Doctor Office
4 = Home
7 = Nursing Home/Extended Care
8 = Skilled Nursing Facility

**In accordance with Medicare, providers can not bill for services performed for less than 8 minutes.

Procedure code	Description	Daily service limit*	Billing limitations	Additional conditions
92506**	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	1	Cannot use on the same date of service (DOS) as 96105 or 92510.	This code is also used for re-evaluation.
92507**	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual	1	Cannot use on the same DOS as 92510.	Therapy addressing communication/cognitive impairment should use this code. If treatment focus is aural rehabilitation as a result of cochlear implant, use code 92510.
92508**	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); group, two or more individuals***	1		Group is limited to two to four individuals.
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	1	Cannot use on the same DOS as 92506 or 92507.	Prior authorization is always required. Use this procedure code for evaluation and treatment.
92511	Nasopharyngoscopy with endoscope (separate procedure)	1		Use this code if speech-language pathologist actually inserts endoscope. Do not use this code if speech-language pathologist is providing an analysis and does not insert the scope. Instead use code 92506 or G0195 as appropriate. Use this code for evaluation of dysphagia or assessment of velopharyngeal insufficiency or incompetence. This service is to be performed according to the American Speech-Language Hearing Association (ASHA) Code of Ethics and ASHA Training Guidelines for Laryngeal Videoendoscopy/Stroboscopy.
92512	Nasal function studies (eg, rhinomanometry)	1		Use this code if completing aerodynamic studies, oral pressure/nasal airflow, flow/flow studies, or pressure/pressure studies.
92520	Laryngeal function studies	1		Use this code for laryngeal air flow studies, subglottic air pressure studies, acoustic analysis, EGG (electroglottography) laryngeal resistance.

*In accordance with Medicare, providers can not bill for services performed for less than 8 minutes.
**Procedure code may be billed under the Birth to 3 prior authorization process.
***Wisconsin Mediciad limits group to 2 to 4 individuals.

Procedure code	Description	Daily service limit*	Billing limitations	Additional conditions
92526**	Treatment of swallowing dysfunction and/or oral function for feeding	1		The recipient must have an identified physiological swallowing and/or feeding problem. This is to be documented using professional standards of practice such as identifying oral phase, esophageal phase or pharyngeal phase dysphagia, baseline of current swallowing and feeding skills not limited to signs of aspiration, an oral mechanism exam, report of how nutrition is met, current diet restrictions, compensation strategies used, and level of assistance needed.
92599	Unlisted otorhinolaryngological service or procedure	1		Prior authorization is always required. Use this code when no other *current procedural terminology* code description appropriately describes the evaluation or treatment.
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	1.5***	Cannot use on the same DOS as 92506, G0197, G0199, or G0200.	
G0193	Endoscopic study of swallowing function (also fiberoptic endoscopic evaluation of swallowing (FEES)	1		
G0194	Sensory testing during endoscopic study of swallowing referred to as fiberoptic endoscopic evaluation of swallowing with sensory testing (FEEST)	1	Only allowable when used in conjunction with G0193.	
G0195**	Clinical evaluation of swallowing function (not involving interpretation of dynamic radiological studies or endoscopic study of swallowing)	1		

*In accordance with Medicare, providers can not bill for services performed for less than 8 minutes.
**Procedure code may be billed under the Birth to 3 prior authorization process.
***96105: The procedure code description defines this code as one hour. One unit of this code = 1 hour. A maximum of 90 minutes or 1.5 units is allowable. If less or more than 1 hour is used, bill in decimals to the nearest quarter hour. For example, 45 minutes = .75 and 30 minutes = .5.

Procedure code	Description	Daily service limit*	Billing limitations	Additional conditions
G0196	Evaluation of swallowing involving swallowing of radio-opaque materials	1		Accompanying a recipient to a swallow study is not reimbursable. This code involves the participation and interpretation of results from the dynamic observation of the patient swallowing materials of various consistencies. It is observed fluoroscopically and typically recorded on video. The evaluation involves using the information to assess the patient's swallowing function and developing a treatment plan for the patient.
G0197**	Evaluation of patient for prescription of speech generating devices	1	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient to specify the speech-generating device recommended to meet the patient's needs and capacity. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead use code 92506.
G0198**	Patient adaptation and training for use of speech generating devices	1		This code describes the face-to-face services delivered to the patient to adapt the device to the patient and train him or her in its use. Therapy with a focus on picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead use code 92507.
G0199**	Re-evaluation of patient using speech generating devices	1	Cannot use on the same DOS as 96105.	This code describes the services to re-evaluate a patient who had previously been evaluated for a speech-generating device, and is either currently using a device or did not have a device recommended. Re-evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for his code. Instead use code 92506.

*In accordance with Medicare, providers can not bill for services performed for less than 8 minutes.

**Procedure code may be billed under the Birth to 3 prior authorization process.

Procedure code	Description	Daily service limit*	Billing limitations	Additional conditions
G0200**	Evaluation of patient for prescription of voice prosthetic	1	Cannot use on the same DOS as 96105.	This code describes the services to evaluate a patient for the use of a voice prosthetic device, e.g., electrolarynx, tracheostomy speaking valve, etc. Evaluation of picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead use code 92506.
G0201**	Modification or training in use of voice prosthetic	1		Examples of voice prosthetic devices include, but are not limited to, electrolarynx and tracheostomy-speaking valves. Therapy to address picture communication books, manual picture boards, sign language, the Picture Exchange Communication System, picture cards, gestures, etc., are not included in the reimbursement for this code. Instead use code 92507.

*In accordance with Medicare, providers can not bill for services performed for less than 8 minutes.
**Procedure code may be billed under the Birth to 3 prior authorization process.

ATTACHMENT 2
Reminder of Medicaid requirements for speech and language pathology services

The following requirements apply to all speech and language pathology services:

- Services must be medically necessary as defined in HFS 101.03(96m), Wis. Admin. Code.
- All speech and language therapy services require a physician's order or prescription as listed in HFS 107.02(2m)(a)(8), Wis. Admin. Code.
- All documentation must be signed or co-signed by a Medicaid-certified speech-language pathologist. Evaluations must be performed by a Medicaid-certified speech-language pathologist. Therapy may be provided by a certified speech-language pathologist or under the direct, immediate, on-premise supervision of a certified speech-language pathologist. "Direct, immediate, on-premise supervision" is defined as face-to-face contact between the supervisor and person being supervised, as necessary, with the supervisor being physically present in the same building when the service is being performed. Refer to the November 2000 *Wisconsin Medicaid and BadgerCare Update* (2000-55), titled "Medicaid requirements for speech-language pathology providers and non-billing performing providers," for more information.
- Services performed by speech-language pathology students are coverable in accordance with HFS 107.01(2) and HFS 107.18(1)(a), Wis. Admin. Code. Refer to *Update* 2000-55 for more information.
- All evaluations and re-evaluations are billed upon completion regardless of the number of days needed to complete.
- All co-treatment requires prior authorization. Each provider involved in co-treatment must complete a separate PA request that identifies the other co-treatment provider and document the medical necessity of co-treatment. Requests for co-treatment must include documentation justifying why individual treatment from a therapist does not provide maximum benefit to the recipient and why two different therapists treating simultaneously are required.
- All therapy services must be conducted face-to-face.

Non-covered services

- Examples of services not covered, as listed in HFS 107, Wis. Admin. Code, include, but are not limited to:
  - ✓ Charges for telephone calls.
  - ✓ Charges for missed appointments.
  - ✓ Services provided that are considered experimental in nature.
  - ✓ Consultation between or among providers.
  - ✓ Consultation with caregivers.
  - ✓ Separate charges for the time involved in completing necessary forms, claims, or reports.

Documentation requirements

- Daily documentation must be kept consistent with HFS 106, Wis. Admin. Code. Refer to the August 1999 *Wisconsin Medicaid Update* for further information.
- Documentation of coordination between the fee-for-service provider and caregivers and other provider disciplines is required.

ATTACHMENT 3
Speech and language pathology maximum allowable fees effective October 1, 2002

Procedure code	Procedure description	Recipient* copayment	Maximum allowable fee	
			Independents	Rehab agencies
31575	Laryngoscopy, flexible fiberoptic; diagnosis	$3.00	$70.96	$74.51
31579	Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy	$3.00	$113.92	$119.62
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status	$3.00	$57.19	$60.04
92507	Treatment of speech, language, voice communication, and/or auditory processing disorder (includes aural rehabilitation); individual	$2.00	$45.18	$47.44
92508	group, two or more individuals**	$2.00	$26.68	$28.01
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	$3.00	$75.95	$79.75
92511	Nasopharyngoscopy with endoscope (separate procedure)	$2.00	$46.65	$48.99
92512	Nasal function studies (eg, rhinomanometry)	$2.00	$36.02	$37.82
92520	Laryngeal function studies	$2.00	$29.29	$30.76
92526	Treatment of swallowing dysfunction and/or oral function for feeding	$2.00	$46.03	$48.34
92599	Unlisted otorhinolaryngological service or procedure	$3.00	Manually priced	
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	$2.00	$41.23	$43.29
G0193	Endoscopic study of swallowing function (also fiberoptic endoscopic evaluation of swallowing (FEES)	$3.00	Manually priced	
G0194	Sensory testing during endoscopic study of swallowing referred to as fiberoptic endoscopic evaluation of swallowing with sensory testing (FEEST)	$3.00	Manually priced	
G0195	Clinical evaluation of swallowing function	$3.00	$68.10	$71.51
G0196	Evaluation of swallowing involving swallowing of radio-opaque materials	$3.00	Manually priced	
G0197	Evaluation of patient for prescription of speech generating devices	$3.00	$71.95	$75.55
G0198	Patient adaptation and training for use of speech generating devices	$2.00	$44.92	$47.17

*Federal law permits states to charge Medicaid recipients copayments for certain services. Providers are required to request the copayment amount from recipients; however, they may not deny services to a recipient who fails to make a copayment. For a list of exemptions, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook. Co-payment may only be charged for either the first 30 hours or $1,500 of services for each type of therapy, per calendar year.

**Wisconsin Medicaid limits group to 2 to 4 individuals.

Procedure code	Procedure description	Recipient* copayment	Maximum allowable fee	
			Independents	Rehab agencies
G0199	Re-evaluation of patient using speech generating devices	$3.00	$59.89	$62.89
G0200	Evaluation of patient for prescription of voice prosthetic	$3.00	$71.61	$75.19
G0201	Modification or training in use of voice prosthetic	$2.00	$44.92	$47.16

*Federal law permits states to charge Medicaid recipients copayments for certain services. Providers are required to request the copayment amount from recipients; however, they may not deny services to a recipient who fails to make a copayment. For a list of exemptions, refer to the Recipient Rights and Responsibilities section of the All-Provider Handbook.