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Clarification of Augmentative Communication Device Repair and Modification Procedure Codes

Wisconsin Medicaid is clarifying the use of two procedure codes commonly submitted by providers when billing for repair and modification services performed on augmentative communication devices.

Procedure Code Descriptions

Wisconsin Medicaid is clarifying the use of two procedure codes commonly submitted by providers when billing for repair and modification services performed on augmentative communication devices. These two procedure codes are:

- **Healthcare Common Procedure Coding System (HCPCS) procedure code V5336** (Repair/modification of augmentative communicative system or device [excludes adaptive hearing aid]).
- **Current Procedural Terminology (CPT) procedure code 92609** (Therapeutic services for the use of speech-generating device, including programming and modification).

Criteria for Use of HCPCS Procedure Code V5336

HCPCS procedure code V5336 is used for repairs or modifications due to a *mechanical* failure or to enhance the *physical* operating condition of the augmentative communication device. This

procedure code does *not* cover the creation of communication pages or any other services involved in programming the device by a speech-language pathologist. Providers are required to retain documentation of services provided.

Criteria for Use of CPT Procedure Code 92609

Current Procedural Terminology procedure code 92609 is used for delivering direct therapeutic services for the use of a speech-generating device, including programming the augmentative communication device, adapting the device to the recipient's needs, or training him or her in the proper use of the device. As required with Medicare, the provider is required to spend at least eight minutes of face-to-face time with the recipient during the delivery of these services. Providers are required to document services provided in the daily note of the recipient's medical record.

Reimbursement for Both Procedure Codes

Both mechanical repair and therapeutic services may be reimbursed for the same date of service; however, the provider is required to document in the daily note of the recipient's medical record the services provided under each of the procedure codes.

Information Regarding Medicaid HMOs

This *Wisconsin Medicaid and BadgerCare 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 dhfs.wisconsin.gov/medicaid/.

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