Speech Therapy Stakeholder Engagement Questions & Answers

This document summarizes:

Stakeholder questions received during Colorado Department of Health Care Policy & Financing's (Department) stakeholder engagement on 8/23/23 regarding speech therapy.

Below each item, the Department has provided an *interim* response.

Important Note: There are several stages of policy development and implementation. Any responses in this document represent a snapshot of the Department's position as of 10/10/23 and should not be read as final policy.

Where can I find policy changes and updates shared in the stakeholder meeting, held on 8/23/23?

- The 8/23/23 meeting presentation and recording are posted on the Department's Outpatient Speech Therapy Benefit webpage under the webinars tab.
- This questions & answers document is also posted on the Department's Outpatient Speech Therapy Benefit webpage under the webinars tab.

What date is the prior authorization change effective?

- The prior authorization requirement after 12 sessions will be effective in December 2023.

Will the 12-session prior authorization change be retroactive or only apply to future sessions from the effective date?

- The 12-session prior authorization change will only apply to future sessions from the effective date.

Are the 12 sessions based on a rolling year or a calendar year?

- The 12 sessions are based on a rolling 12-month period.

Why is the prior authorization change implementation delayed?

- The implementation of 12 sessions of speech therapy before prior authorization required different limitation policies across Medicaid and the Alternative Benefit Plan (ABP), necessitating a more complex solution than was previously identified. It requires new limit audits to be coded in the claims system so that it can accurately account for sessions. Unfortunately, this could not be achieved with existing claims system limits and errors.

Do the prior authorization requirements apply to pediatric or adult outpatient speech therapy? Does it apply to home health?

- This change applies to both pediatric and adult outpatient speech therapy.
- No, home health is a different benefit than outpatient speech therapy. The footnote in the 2023 Long Bill only affects the outpatient speech therapy benefit.

Pediatric long-term home health PARS are still suspended until 3/31/2024. Does this change apply to long-term home health pediatric speech therapy and outpatient home health adult speech therapy?

- Adult and pediatric long term home health therapies are part of a different benefit. This change only applies to the outpatient speech therapy benefit.

What can the 12 sessions be used for? Does it include evaluations?

- The 12 sessions may be used for all allowed speech therapy codes, except 97755, which has a different function than other codes due to statutory requirements found in HB14-1211.
- Allowable codes and specific policies for some codes can be found in the Speech Therapy Billing Manual.

Where can I find the speech therapy CPT codes?

- All CPT codes and their associated instructions can be found in the Speech Therapy Billing Manual.

Is a physician referral/signature required to be on file prior to providing the 12 sessions?

- Yes, clinician orders are required for all services.

How do we know if patients previously received or are concurrently receiving services from another provider during the 12-month period?

- Providers should verify the remaining sessions before seeing the member to determine whether a member has utilized any sessions within the rolling 12-month period by:
  - checking the Provider Web Portal by following the Department's Quick Guide, or
  - contacting the Provider Services Call Center at 1-844-235-2387.
- The verification of sessions only reflects the number of sessions billed and paid at the time the verification is performed. Additional sessions could be billed and paid after you perform verification and prior to you billing a claim, which can result in a denial if the 12-session limit is exceeded and prior authorization for additional sessions is not yet submitted and approved.
- In the event of a claim denial, providers will need to submit a retrospective prior authorization request (PAR) for any sessions that were denied.
- Claim denial questions should be directed to the Provider Services Call Center at 1-844-235-2387.

For example, how many sessions can we provide before needing prior authorization if there were already eight sessions with another provider?

- The sessions are tracked by member, not provider. If a member utilizes eight sessions with a different provider, four sessions could be provided before prior authorization is required.

Will the used speech therapy sessions be listed on the Medicaid eligibility page, like physical therapy and occupational therapy?

- This functionality already exists. The available sessions displayed in the portal are based on processed claims and may not accurately reflect the total available sessions if all claims have not been submitted.

When should a prior authorization request (PAR) be submitted?

- PARs should be submitted before all 12 initial sessions are used to avoid disruption in services if a member may need more than 12 sessions due to medical necessity.

When will units begin to decrement against the prior authorization request (PAR)?

- Sessions will decrement in the claims system from the number of approved PAR sessions once the 12 initial sessions have been utilized and subsequent claims are submitted.

Is billing based on units or sessions?

- Billing is based on one date of service which is equal to one session.

Can the first 48 units be used for speech therapy, occupational therapy, and physical therapy?

- Forty-eight units are available before prior authorization is required in the physical therapy and occupational therapy benefits.
- Speech therapy is a separate benefit, and 12 sessions are available before prior authorization is required.

Are there any changes to modifiers or the process of using modifiers?

- There are no anticipated changes to existing modifiers.
- Modifiers must be included on both the prior authorization request (PAR) and claim. A system modification will begin to enforce modifier usage for claims in December 2023.
- Please see the speech therapy modifier chart below, found on page 18 of the Speech Therapy Billing Manual:

Outpatient Therapy Type	Modifier 1	Modifier 2
Rehabilitative Speech Therapy	GN	97
Habilitative Speech Therapy	GN	96
Early Intervention Speech Therapy	GN	TL

What if a patient requires two services/codes in the same day, such as swallowing and speech? Should they be billed as one session or two sessions?

- Providers should ensure that they are meeting the Medically Unlikely Edits (MUEs) and Department policies for all allowed speech therapy codes. Any services delivered on the same day should be billed on the same claim as one session, which will count as one date of service and one session.
- Please reference National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUEs) information here.

Can providers bill codes 92507 and 92508 for individual and group services on the same day?

- Per the Speech Therapy Billing Manual, page 24:

- A single practitioner <u>should</u> <u>not</u> report CPT codes **92507** (treatment of speech, language, voice ..., individual) and/or **92508** (treatment of speech, language, voice . . ., group) on the same date of service as HCPCS/CPT codes **97127** (therapeutic interventions that focus on cognitive function . . .), or **97533** (sensory integrative techniques to enhance . . .), or **G0515** (development of cognitive skills to improve . . .).
- However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity. For example, if a speech-language pathologist performs the procedures described by CPT codes **92507** and/or **92508** on the same date of service that an occupational therapist performs the procedures described by HCPCS/CPT codes **97127, 97533,** and/or **G0515**, a provider entity that employs both types of practitioners may report both services utilizing a NCCI PTP-associated modifier. (CPT code 97532 was deleted on January 1, 2018.)
- Please reference National Correct Coding Initiative (NCCI) and Medically Unlikely Edits (MUEs) information here.

Why is speech language pathology the only therapy service that does not allow for adult habilitative services?
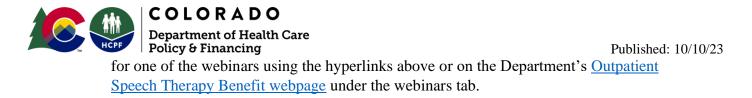
- Current Department policy allows for habilitative speech therapy services for adult members who qualify for the Alternative Benefit Plan (ABP).
- Coverage of habilitative speech therapy for adult members who qualify for Title XIX is limited by the Department's budgetary authority.

Why can't patients on waivers (e.g., SLS, CES, EBD) also be on the Alternative Benefit Plan (ABP)?

- There are various reasons why a member might not qualify for both the Alternative Benefit Plan and a waiver at the same time. This can include age, income, and other eligibility requirements. Eligibility for waivers and the Alternative Benefit Plan are determined on a case-by-case basis.
- Members can contact their county human services department with eligibility questions.

Will the Department have another stakeholder meeting?

- The Department will host a Speech Therapy Prior Authorization Questions & Answers Session on Wednesday, November 1st, 10:00-11:00 AM and Friday, November 3rd, 9:00-10:00 AM, so that providers have another opportunity to ask questions before the prior authorization requirements become effective in December 2023. Individuals can register

for one of the webinars using the hyperlinks above or on the Department's Outpatient Speech Therapy Benefit webpage under the webinars tab.

What if I have additional questions?

- Contact information is below:
    - Claims questions: Provider Services Call Center at 1-844-235-2387
    - Prior authorization requests (PARs) questions: ColoradoPAR program
    - Speech therapy policy-related questions: Devinne Parsons at Devinne.Parsons@state.co.us