# Speech-Language Pathology Services

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.1 Enrollment</td>
<td>20-2</td>
</tr>
<tr>
<td>20.2 Reimbursement</td>
<td>20-2</td>
</tr>
<tr>
<td>20.3 Benefits and Limitations</td>
<td>20-2</td>
</tr>
<tr>
<td>20.4 Authorization Requirements</td>
<td>20-2</td>
</tr>
<tr>
<td>20.5 Coordination With the Public School System</td>
<td>20-4</td>
</tr>
<tr>
<td>20.6 Claims Information</td>
<td>20-4</td>
</tr>
</tbody>
</table>
20.1 Enrollment

To enroll in the CSHCN Services Program, speech-language pathology (SLP) providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state SLP providers must be located in the United States, within 50 miles of the Texas state border, and be approved by the Department of State Health Services (DSHS).

Refer to: Section 3.1, “Provider Enrollment,” on page 3-2 for more detailed information about CSHCN Services Program provider enrollment procedures.

20.2 Reimbursement

Speech-language therapy services are reimbursed at the lower of the billed amount or the amount allowed by the Texas Medicaid Program.

Therapy sessions include the time the therapist is with the client, time spent preparing the client for the session, and the time spent completing documentation. Evaluation, re-evaluation, and therapy services may not be billed on the same date of service. Reimbursement of an evaluation is limited to once every six months. Reimbursement for re-evaluation is limited to once per month, and modifier U4 must be used with the evaluation code 1-92506 to indicate re-evaluation. Providers must bill the appropriate national procedure code for the SLP service provided: 1-92506, 1-92507, 1-92526, 1-92610, or 1-97535. Speech-language therapy treatment codes (procedures 1-92507, 1-92526, and 1-92535) must be billed in 15-minute increments as prescribed and are authorized up to a maximum of one hour (4 treatment units) per day. Procedure codes 1-92506 and 1-92510 are billed in an increment of one service per day.

Note: Services related to audiological testing, hearing exams, and amplification devices for clients under 21 years of age are coordinated through the Program for Amplification for Children of Texas (PACT).

20.3 Benefits and Limitations

SLP services for a client must be medically necessary, prescribed by a physician, and provided by a speech-language pathologist that is licensed by the State of Texas.

The CSHCN Services Program coverage of SLP services may be limited to certain conditions, by type of service, by age, by the client’s medical status, and whether the client is eligible for services that a school district is legally responsible to provide. SLP services are benefits when provided to clients experiencing speech-language difficulty because of a disease or trauma, developmental delay, oral motor problem, or congenital anomaly.

Clients can receive SLP services from both the CSHCN Services Program and from other sources, such as from school districts, only when the therapy provided by the CSHCN Services Program addresses different client needs. Therapy provided by the CSHCN Services Program is not intended to duplicate, supplement, or replace services that are the legal responsibility of other entities or institutions. The CSHCN Services Program encourages the private therapist to coordinate with other therapy providers to avoid treatment plans that might compromise the client’s progress.

Specific procedure or diagnosis codes related to program benefits and coverage are listed in this chapter. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, codes are added, deleted, or revised. Coverage and coding information is updated in the CSHCN Provider Bulletin. Call the TMHP-CSHCN Contact Center at 1-800-568-2413 with questions about procedure or diagnosis codes.

20.4 Authorization Requirements

The initial SLP evaluation does not require authorization. Only one evaluation is considered for payment per six-month period without authorization or written documentation of medical necessity. An evaluation is not considered for reimbursement, if it’s performed on the same date of service as treatment.
All other SLP services must be authorized. Use the Authorization Request for Initial Outpatient Therapy (TP1) form or the Authorization Request for Extension of Outpatient Therapy (TP2) form to submit authorization requests or a request for extension. Examples of these forms are provided in Appendix B, “Authorization Request for Initial Outpatient Therapy (TP1),” on page B-39, and Appendix B, “Authorization Request for Extension of Outpatient Therapy (TP2),” on page B-40.

SLP services may be authorized, if the client meets one of the following criteria:

- Meets other program criteria and has a cleft lip or palate or other craniofacial anomaly
- Has dysphagia/swallowing disorder
- Meets SLP guidelines as detailed below:
  - Children who have a condition other than cleft palate or craniofacial anomaly may be eligible to receive services, if they have a voice articulation and/or expressive/receptive language disorder and if they are expected to make measurable progress toward their individual SLP treatment goals.
  - The CSHCN Services Program may authorize and reimburse SLP services for dysphagia/swallowing disorders, cleft palate, or other craniofacial anomalies whether or not the patient is school-aged and in special education. If the client is school-aged, a copy of the individual educational plan (IEP) or statement from the independent school district that the child is not eligible for the same services through the school should be submitted with the authorization request.

Authorization requests must be received in writing and may be granted for:

- SLP re-evaluation, which may be reimbursed only once per month.
- SLP evaluation of swallowing and oral function for feeding.
- Sessions that do not exceed one hour in length.
- Treatment plans (not to exceed six months) and extensions.
- The speech-language pathologist may assist a dentist, radiologist, orthodontist, or surgeon with diagnostic procedures based on the diagnostic procedure’s schedule as set by the dentist, radiologist, orthodontist, or surgeon.
- Treatment of new conditions may be approved for up to five times a week for three months beginning no later than one year after date of onset. Based on need, this may be extended for up to one year (after one year, refer to medical review). Examples of new conditions include, but are not limited to traumatic brain injury, brain tumor, stroke, brain embolism, and other new conditions that affect voice, articulation, and/or expressive/receptive language.
- One equipment assessment for ACDs and systems or other communication technology may be authorized prior to getting the equipment through purchase or rental arrangement. Time for the adjustment of the ACD is included as part of the therapy session. The CSHCN Services Program Provider Manual Part II has more detailed information about ACD reimbursement, benefits, and authorizations.
- Training sessions in the use of technology, including augmentative communication devices/systems and their required adjustments/modifications, may be approved for up to five times a week for a period of one month after receipt of the device/new technology and then three times a week for two months. Additional requests require medical review.
- In children up to 3 years of age, SLP services may be authorized no more than twice a week for developmental conditions including, but not limited to cleft palate, cerebral palsy, or significant hearing loss when there is a voice, articulation, or expressive/receptive language disorder, or with a swallowing dysfunction and/or oral dysfunction for feeding. This may be extended without medical review upon receipt of the Authorization Request for Extension of Outpatient Therapy (TP2) form. Refer the client to a public school for services for children from 3 to 21 years of age, unless the child is ineligible or has a new condition. Requests for a frequency rate greater than two times a week requires medical review.
- Rehabilitation post-cochlear implant.

Exceptions to the limitations listed may be made when appropriate and after medical review.

SLP services may be authorized following cochlear implant surgery as follows:
• For nonschool-based treatment after a cochlear implant, SLP treatment may be scheduled up to five times a week for three months beginning four to six weeks post-operatively. This may be extended based on medical need for up to one year (after one year, refer to medical review for requests for continuation of the five times a week frequency).

• Up to three times a week, for the second and third years after cochlear implant placement (after the third year post-operatively), refer to medical review for requests for extension of treatment.

If the child is receiving these services through a school-based therapist, the CSHCN Services Program does not duplicate these services, but can provide additional therapy, if the school is unable to provide therapy at the required/recommended frequency. For example, if the school is providing therapy three times a week, the CSHCN Services Program can provide additional outpatient therapy services two times a week during the first year post-cochlear implant.

20.5 Coordination With the Public School System

To assure there is no duplication of therapy services, any child eligible for special education services must have a copy of their individual education plan (IEP) or a statement from the independent school district to verify that the child is not eligible for the same services through the school included with an authorization request in order to submit claims for reimbursement of therapy services.

20.6 Claims Information

Outpatient therapy services provided by outpatient facilities and SLP providers must be submitted to TMHP in an approved electronic format or on a CMS-1500 claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Instructions for proper completion of claims are provided in Appendix B, “CMS-1500 Claim Form Instructions,” on page B-2. Blocks that are not referenced are not required for processing by TMHP and may be left blank.