Outpatient Speech-Language Pathology Benefits to Change for the CSHCN Services Program

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Note: For the purposes of this article, “advanced practice registered nurse (APRN)” includes nurse practitioner (NP) and clinical nurse specialist (CNS) providers only.

Effective for dates of services on or after January 1, 2014, benefit criteria for outpatient speech-language pathology (SLP) services will change for the Children with Special Health Care Needs (CSHCN) Services Program.

SLP services will be benefits of the CSHCN Services Program for clients with an acute or chronic medical condition when documentation from the prescribing physician and the treating therapist shows there is or will be progress made toward goals.

Note: An APRN or physician assistant (PA) may sign and date all documentation related to the provision of SLP services on behalf of the client’s physician when the client’s physician delegates this authority to the APRN or PA. The APRN or PA provider’s signature and license number must appear on the forms where the physician signature and license number are required.

Therapy goals for an acute or chronic medical condition include, but are not limited to, improving, maintaining, and slowing the deterioration of function.

SLP evaluations and treatment must be ordered or prescribed by the client’s physician, APRN, or PA and be based on medical necessity.

SLP and swallowing function evaluations are a benefit once per 180 rolling days, any provider. SLP re-evaluations will be a benefit when documentation supports one of the following:

- A change in the client’s status
- A request for extension of services
- A change of provider

Additional SLP evaluations or re-evaluations and swallowing function evaluations or re-evaluations that exceed these limits may be considered for reimbursement with documentation of one of the following:

- A change in the client’s medical condition
- A change of provider letter that is signed and dated by the client, parent, or guardian that documents all of the following:
  - The date the client ended therapy (effective date of change) with the previous provider
  - The names of the previous and new providers
  - An explanation why providers were changed

An evaluation or re-evaluation will be denied when billed by any provider for the same date of service as therapy treatment from the same discipline.

All documentation that is related to the therapy services that were prior authorized and provided, including medical necessity and the comprehensive treatment plan, must be maintained in the client’s medical record and made available upon request. For each therapy discipline provided,
the documentation that is maintained in the client’s medical record must identify the therapy provider’s name and include all of the following:

- Date of service
- Start time of therapy
- Stop time of therapy
- Total minutes of therapy
- Specific therapy performed
- Client’s response to therapy

Therapy sessions include the time the therapist is with the client, the time to prepare the client for the session, and the time the therapist uses to complete the documentation.

SLP evaluations or re-evaluations and swallowing function evaluations or re-evaluations may be considered for reimbursement on the same date of service.

**Prior Authorization**

Prior authorization for therapy services will be considered when all of the following criteria are met:

- The client has an acute or chronic medical condition that results in a significant decrease in functional ability and will benefit from therapy services in an office or outpatient setting.
- Documentation supports treatment goals and outcomes for the specific therapy disciplines requested.
- Services do not duplicate those provided concurrently by any other therapy.
- Services are provided within the provider’s scope of practice as defined by state law.

An initial prior authorization may be granted for a period not to exceed 180 days. Subsequent prior authorization requests may be requested for up to 180 days when submitted with documentation of a chronic condition.

SLP services that are billed in 15-minute units are limited to a combined maximum of four units (1 hour) per day. Additional services may be considered with documentation that supports the medical necessity for exceeding the limitation of 1 hour per day.

To complete the prior authorization process by paper, the provider must submit the prior authorization requirements documentation through fax or mail and must retain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the therapy provider’s place of business.

To complete the prior authorization process electronically, the provider must submit the prior authorization requirements documentation through any approved method and must retain a copy of the prior authorization request and all submitted documentation in the client’s medical record at the therapy provider’s place of business.

To avoid unnecessary denials, the physician, APRN, or PA must submit correct and complete information including documentation of medical necessity for the service requested. The ordering practitioner must maintain documentation of medical necessity in the client’s medical
record. The requesting therapy provider may be asked for additional information to clarify or complete a request for therapy.

**Initial Prior Authorization Requests**

The initial request for prior authorization must be received before therapy treatments are initiated. Requests that are received after therapy initiation will be denied for dates of service that occurred before the date that the request was received.

**Note:** If medically necessary services are provided after hours or on a recognized holiday or weekend, services may be authorized when the request is submitted on the next business day. A completed prior authorization form and supporting documentation must be received within these deadlines for prior authorization to be considered. Extensions to these deadlines will not be given by the CSHCN Services Program for providers to correct incomplete prior authorization requests.

The following supporting documentation must be submitted for an initial prior authorization request:

- A completed CSHCN Services Program Authorization Request for Initial Outpatient Therapy (TP1) form. The request form must be signed and dated by the ordering physician, APRN, or PA.
  
  **Note:** A request received without the ordering practitioner’s signature will not be processed and will be returned to the provider.

- A current therapy evaluation that documents the client’s age at the time of the evaluation.
  
  **Note:** A therapy evaluation is current when it is performed within 30 days before the initiation of therapy services.

- A client-specific comprehensive treatment plan that was established by the ordering physician, APRN, PA, or therapist to be followed during treatment in the therapy setting and includes all of the following:
  
  o Date and signature of the licensed therapist
  o Diagnosis(es)
  o Treatment goals that are related to the client’s individual needs for the requested therapy discipline and associated disciplines
  o A description of the specific therapy disciplines being prescribed
  o Duration and frequency of therapy
  o Date of onset of the illness, injury, or exacerbation that require the therapy services
  o Requested dates of service

**Subsequent Prior Authorization Requests**

A prior authorization request for subsequent services must be received within 30 days before the current authorization expires. Requests for subsequent services that are received after the current prior authorization expires will be denied for dates of service that occurred before the date the submitted request was received.
Prior authorization requests for subsequent services may be considered for increments up to 180 days for each request with documentation that supports medical necessity and includes all of the following:

- A completed CSHCN Services Program Authorization Request for Extension of Outpatient Therapy (TP2) form that has been signed and dated by the ordering physician, APRN, or PA
  
  **Note:** A request received without the ordering practitioner’s signature will not be processed and will be returned to the provider.

- A current therapy evaluation or re-evaluation that documents the client’s age at the time of the evaluation or re-evaluation.
  - A therapy evaluation or re-evaluation is current when it is performed within 30 days before the request for subsequent services

- An updated, client-specific comprehensive treatment plan that was established by the ordering physician, APRN, PA, or therapist to be followed during treatment and includes all of the following:
  - Date and signature of the licensed therapist
  - Diagnosis(es)
  - Updated treatment goals that are related to the client’s individual needs for the therapy discipline and associated disciplines requested
  - A description of the specific therapy disciplines that are being prescribed
  - Duration and frequency of therapy
  - Date of onset of the illness, injury, or exacerbation that requires the therapy services
  - A brief summary of the outcomes of the previous treatment as it relates to the client’s debilitating condition
  - Requested dates of service

**Revisions to Existing Prior Authorization Requests**

A prior authorization request for revisions to services may be considered up to the end of the current approved prior authorization.

Requests for revisions to an existing prior authorization must be received no later than the next business day after the date that the revised therapy treatments are initiated. Requests that are received more than one day after the initiation of the revised services will be denied for dates of service that occurred before the date that the request was received.

If a provider or client discontinues therapy during an existing prior authorized period and the client requests services through a new provider, the new provider must submit all of the following:

- A new therapy request form that has been signed by the ordering practitioner
- A new evaluation with required documentation of medical necessity
- A change-of-provider letter, which has been signed and dated by the client, parent, or guardian and documents the date that the client ended therapy (effective date of change) with the previous provider, the names of the previous and new providers, and an explanation of why providers were changed.
A change of provider during an existing authorization period will not extend the original authorization period approved to the previous provider. Regardless of the number of provider changes, clients may not receive therapy services beyond the limitations outlined in this article.

**Noncovered Services**

The following services will not be a benefit of the CSHCN Services Program:

- Emotional support, adjustment to extended hospitalization, or disability, and behavioral readjustment
- Treatment solely for the instruction of other agency or professional personnel in the client’s speech therapy program
- Training in nonessential tasks, such as homemaking, gardening, recreational activities, cooking, driving, assistance with finances, scheduling, or teaching a second language
- Group therapy procedure code 92508
- Procedure code 97014 (Unattended services are not covered)
- *VitalStim* therapy for dysphagia

For more information, call the TMHP-CSHCN Services Program Contact Center at 1-800-568-2413.