



**CHAPTER 530—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR SPEECH-
LANGUAGE PATHOLOGY AND AUDIOLOGY SERVICES
CHANGE LOG**

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	October 26, 2011	January 1, 2012

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal laws and regulations.



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CHAPTER 530—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item or situation not discussed in this chapter must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical, dental, and mental services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and complete documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

The Center for Medicare and Medicaid Services (CMS) require that all services provided to Medicaid members be medically necessary, cost effective, and provided in the appropriate setting by enrolled providers. As such, covered services are subject to nationally accredited, evidence based medical necessity guidelines, including but not limited to the medical necessity criteria utilized by the BMS' Utilization Management Contractor (UMC).

The National Correct Coding Initiative (NCCI) is used by West Virginia Medicaid as coding standards for procedures/services provided to Medicaid members. These standards, recommended by CMS and compiled by the American Medical Association (AMA), apply to Current Procedural Terminology (CPT numeric codes) and the Healthcare Common Procedure Coding System (HCPCS alpha-numeric codes). Services may also be subject to coding standards developed by BMS and/or its Fiscal Agent. Providers must use the most current CPT, HCPCS, and ICD diagnosis manuals applicable to the date of service when billing for services provided to Medicaid members. Providers are encouraged to implement Electronic Health Records (EHR). Information for EHR is available at www.cms.gov/EHRincentiveprogram.

WV Medicaid covers speech therapy, language and audiology services provided to Medicaid members admitted to an acute care hospital, a critical access hospital, or in an outpatient setting or in the member's home. Therapy services must be ordered by an enrolled treating/prescribing physician, APRN, or PA and provided by a Medicaid enrolled speech therapist/pathologist or audiologist. Any enrolled therapist/audiologist is eligible for direct billing and reimbursement of services provided by BMS.



Effective January 1, 2012, Outpatient speech/audiology services are not reimbursable directly to the hospital. Services must be billed by the therapists, who may have a pay-to of a medical group owned by the hospital.

Speech therapy and audiology services require prior authorization by the UMC prior to the provision of services. Evaluations and re-evaluations do not require prior approval unless they exceed the service limits. A recommendation or approval to seek medical care does not in itself make the care medically necessary or a covered service, nor does it mean that the member is eligible for Medicaid benefits. It is the provider's responsibility to verify Medicaid eligibility and obtain appropriate authorizations before services are provided.

Any covered speech-language and audiology service is available to Medicaid members up to 21 years of age. Limited services for members over 21 years of age include augmentative communication/speech generating systems, artificial larynx, tracheostomy speaking valves, speech therapy and limited evaluation function tests for specific medical conditions. Treatment visits are defined as face-to-face and encompass any covered speech-language and audiology services provided to Medicaid members at each visit. Prior authorization is required for medical necessity. Request for prior authorization does not guarantee approval or payment.

This chapter describes West Virginia's Medicaid coverage policies for speech-language and audiology services. Refer to the BMS' website at www.dhhr.wv.gov/bms, BMS' Fiscal Agent website www.wvmmis.org, and BMS' UMC website at www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx for covered services, service limits, when appropriate, prior authorization requirements and special instructions.

530.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Definitions and Acronyms*. In addition, the following definitions for speech-language and audiology services also apply.

Audiologist –A person who practices audiology in accordance with his/her licensure, scope of practice and licensed under either West Virginia State Code or the code of the State in which they are practicing and meets the qualifications established by the American Speech-Language Hearing Association (ASHA).

Augmentative Communication (AC)/Speech Generating Device – A speech aid that provides the ability to meet functional speaking needs of members with severe speech impairment.

Binaural – Pertaining to both ears. Only 1 unit and binaural procedure codes are to be billed when supplying hearing devices for both ears.

Communication Disorder – An impairment in a person's ability to receive, send, process, and comprehend concepts of verbal, nonverbal, and graphic symbol systems as defined by the American Speech-Language-Hearing Association (ASHA).



Cochlear Implant – An implanted electronic hearing device, designed to produce useful hearing sensations to a member with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear.

Direct Supervision –The supervising/teaching therapist/audiologist must be present at the out-patient site where Medicaid covered services are provided.

Electronic Health Record – A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface—including evidence-based decision support, quality management, and outcomes reporting. It is important to note that an EHR is generated and maintained *within an institution*, such as a hospital, integrated delivery network, clinic, or physician office. An EHR is not a longitudinal record of all care provided to the patient in all venues over time. Longitudinal records may be kept in a nationwide or regional health information system. Refer to www.cms.gov/EHRincentiveprogram for additional information.

Evaluation – An initial assessment to determine the need for services and develop a plan of care.

Hearing Aid – An electronic device that increases the loudness of sounds and speech for the hearing impaired.

Hearing Aid Dealer – An individual who is licensed by the West Virginia Board of Hearing Aid Dealers or the State in which they operate and provides hearing aids to enrolled members based on medical necessity.

Indirect Supervision – The therapist/audiologist is on the premises when Medicaid covered services are rendered and is available for any emergency or questions that may arise.

Medical Necessity – Services and supplies that are appropriate and necessary for the symptoms, diagnosis, or treatment of an illness; provided for the diagnosis or direct care of an illness; within the standards of good practice; not primarily for the convenience of the Medicaid member or provider; and the most appropriate level of care that can be safely provided.

Monaural – Pertaining to one ear. Only 1 unit and the monaural procedure codes are to be billed when supplying a hearing device for 1 ear. Each ear cannot be billed separately.

Mountain Health Trust – The name of West Virginia Medicaid's Managed Care Program that consists of the Physician Assured Access System (PAAS) and the Medicaid Managed Care Organizations (MCOs).

National Provider Identification (NPI) – A unique 10-position, intelligence-free numeric identifier and must be used in lieu of legacy provider identifiers in the HIPAA standards transactions and providers



must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Plan of Care - A written document that outlines the progression of speech therapy and hearing devices that will be used in the course of treatment.

Primary Care Provider (PCP) – A physician, physician assistant or advanced practice registered nurse (APRN) associated with the health home that is the primary contact for provision and coordination of a member’s health care services or needs.

Re-Evaluation – A subsequent evaluation/examination of a member for the purpose of assessing the effectiveness of prior treatment and the plan of care.

Speech-Language Pathologist – A person who practices speech-language pathology in accordance with his/her licensure, scope of practice and licensed under either West Virginia State Code or the code of the State in which they are practicing and meets the qualifications established by the American Speech-Language Hearing Association (ASHA).

Speech-Language Pathologist Assistant – A person who practices speech-language pathology under the direction and supervision of a licensed speech-language pathologist, who does not act independently and is licensed under either West Virginia State Code or the code of the State in which they are practicing. These individuals are not eligible for enrollment in the West Virginia Medicaid Program.

530.2 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

To be eligible for participation and reimbursement for services provided to Medicaid members, all providers must:

- Meet all applicable licensing, accreditation, and certification requirements;
- Have a valid signed provider enrollment application/agreement on file; and,
- Meet and maintain all BMS provider enrollment requirements as outlined in *Chapter 300, Provider Participation Requirements*.

Important: Renewal of license and/or certification must be maintained in a current status and the documentation must be submitted to the BMS’ Provider Enrollment Unit for inclusion in the provider record. In order to be reimbursed for services related to skills attained after the initial enrollment, an individual must submit documentation of the new certifications and request additional services to their provider profile.

The BMS’ (Bureau of Medical Services) website www.dhhr.wv.org/bms , BMS’ Fiscal Agent website, www.wvmmis.org and BMS’ UMC website at www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx are the recommended methods for keeping current on updates and information regarding BMS. If the Internet is not available in your area, contact BMS’ Provider Enrollment to request a paper copy or CD of this chapter for the office.



Refer to *Common Chapter 300, Provider Participation Requirements*, for additional information.

530.3 COVERED SERVICES

Speech and audiology services must be ordered by an enrolled physician, physician assistant or advanced practice registered nurse and provided by or under the direction of an enrolled licensed speech therapist and or audiologist. Prior authorization is required for any covered service and when service limits for initial evaluation and re-evaluations are exceeded.

530.3.1 SPEECH-LANGUAGE THERAPY

Speech-language therapy requires a written referral from an enrolled physician, APRN, or PA and prior authorization before therapy is provided. Any covered speech-language services are available to Medicaid members up to the age of 21 years.

For members 21 years of age and older, speech therapy services are limited to specific medical/surgical conditions. The conditions include, but are not limited to, Cerebral Vascular Accident (CVA), tracheotomy or tracheostomy, laryngectomy, traumatic brain injury (TBI), nerve injuries (e.g., 5th, 7th-12th), amyotrophic lateral sclerosis (ALS), cerebral palsy, and dysarthria. Prior authorization and a referral from an enrolled physician, APRN, or PA are required before therapy is provided.

The initial evaluation for speech therapy is limited to 1 per calendar year; the re-evaluation is limited to 2 per calendar year. Prior authorization is required when service limits are exceeded and with a request for continuation of the approved initial speech therapy regimen. .

Speech therapy is deemed not medically necessary when the member has:

- Reached the highest level of functioning and is no longer progressing; OR
- The established plan of care goals and objectives are met; OR
- The established plan of care does not require the skills of a speech-language therapist/pathologist; OR
- The member or his/her legal representative has demonstrated the knowledge and skill of providing the speech therapy regime themselves.

530.3.2. AUGMENTATIVE COMMUNICATION/SPEECH GENERATING SYSTEMS AND DEVICES

Speech generating device, artificial larynx, tracheostomy speaking valve, and voice amplifier for communication are covered for children up to 21 years of age and adults 21 years of age and older. The device must be prescribed by a treating physician, APRN, or PA and provided under the direction of an enrolled Speech-Language Pathologist trained in augmentative communication/speech generating device and services. Prior authorization is required for medical necessity and when service limits are exceeded.



Accessories for the speech generating device (e.g., operating system, Word core software, battery charger, mounting plate, built-in stand, vocabulary software, USB cable, 1 battery pack, and a standard 1 year warranty) are included with the initial placement of the device and cannot be billed separately. Accessories not included in initial placement (e.g., cables, battery pack, carrying case, and picture communication symbols (PCS) are billed separately and require prior authorization for medical necessity and when service limits are exceeded.

Repair/modification to the augmentative communication/speech generating device requires prior authorization.

Artificial larynxes including an initial battery and tracheostomy speaking valves require prior authorization when service limits are exceeded.

530.3.3 Audiology/Hearing Aid Dealers

West Virginia Medicaid covers medically necessary audiology services to Medicaid members up to 21 years of age. Services provided on or after the 21st birthday are not available for reimbursement. Audiology covered services include mandatory newborn hearing screens, 1 initial evaluation per calendar year to determine hearing capability, 2 re-evaluations per calendar year, diagnostic audiology testing, hearing aids and batteries. Prior authorization is required for specified services as noted in this section.

- Hearing Aids

Hearing aids, approved by the Food and Drug Administration (FDA) are covered for members up to 21 years of age. The most economical hearing aid based on the member's basic healthcare need must be provided. Prior authorization for medical necessity, a referral from an enrolled physician, APRN, or PA with documentation of a medical examination and documentation of a hearing evaluation with audiometric results by an audiologist within the past 6 months is required before the hearing aid will be provided. An unaltered cost invoice must be submitted to the Utilization Management Contractor (UMC) for pricing within 30 days of providing the hearing aid. A cost quote is not accepted.

When a hearing aid is initially provided, the selection, ordering, modification, fitting, dispensing, cleaning, calibration, re-calibration, evaluation of appropriate amplification, orientation to use, adjustment, and batteries are included in the cost of the hearing aid.

Replacement hearing aid batteries require prior authorization when service limits are exceeded.

- Warranty of Hearing Aids

West Virginia Medicaid requires a 2 year hearing aid warranty which is included in the reimbursement of the hearing aid.

- Repair of Hearing Aids



Repair of hearing aids is covered when the medical need is expected to continue, the repair is more economical than a new purchase, and the 2 year warranty has expired. Note: When the warranty is in effect, the hearing aid repair will not be reimbursed. An unaltered cost invoice for the repair must be submitted with the claim form to the BMS' Fiscal Agent for payment consideration. A cost quote is not accepted. Prior authorization for repair is required when service limits are exceeded.

- Replacement of Hearing Aids

Hearing aid replacements require an enrolled physician, APRN, or PA referral and prior authorization. Replacements are covered due to growth or changes in the member's physical condition, wear, theft (with the submission of a police report), irreparable damage, or loss by disaster. When documentation of malicious damage, neglect, or misuse of the hearing aid is reported and confirmed, the request is denied.

- Ear Molds/Impression

Ear molds, including fitting and adjustment and In-the-ear hearing aid impressions, after the member has received the aid, are available to children up to 21 years of age. Prior authorization for medical necessity is required when service limits are exceeded.

- Cochlear Implant

Cochlear implants, approved by the FDA, are covered for members up to 21 years of age with severe to profound nerve deafness and there is reasonable expectation that a significant benefit must be achieved from the implant. The cochlear implant includes all internal and external components when initially provided and must not be billed separately. Prior authorization is required.

- Replacement of Cochlear Implant/Accessories

Replacement of a cochlear implant and/or its external components (e.g., speech processor, microphone headset and audio input selector) is considered medically necessary when the existing device cannot be repaired OR when replacement is required because a change in the member's condition makes the present unit non-functioning AND improvement is expected with a replacement unit. Prior authorization is required.

Replacement of accessories for the cochlear implant (headset/headpiece, microphone, transmitting coil, and transmitter cable) requires prior authorization and may be billed separately. Batteries do not require prior authorization unless limits have been exceeded.

- Newborn Hearing Screen

Newborn hearing screenings are covered for Medicaid members. When testing is performed while the infant is in the hospital the screening is included in the DRG or the hospital's per



diem rate and therefore, not reimbursed separately. Newborn hearing screenings are a covered service for the first 90 days of life using the HCPCS Code V5008. This code covers screenings completed using either OAE (Otoacoustic Emissions) or ABR (Auditory Brainstem Response) testing. The policy governing this service can be found at www.wvdhhr.org/nhs.

530.4 NON-COVERED SERVICES

Speech-language and audiology services not covered by West Virginia Medicaid include, but are not limited to, the following:

- Experimental/investigative services/procedures for research purposes
- Evaluations provided by an employee or an individual that has a financial interest with providers of devices.
- Evaluations by the Speech-Language Pathology Assistant (SLPA).
- Speech therapy services provided:
 - to a member in a nursing facility (included in the nursing facility per diem rate)
 - to individuals who are not Medicaid eligible on the date of service
 - by persons not duly certified to provide the services
 - to members showing no progress in treatment/therapy
 - to members by out-of-network providers
- Upgrades to, or subsequent versions of the speech generating device software program or memory modules that may include enhanced features or other improvements
- Any device that is not a dedicated augmentative communication/speech generating device or can run software for purposes other than speech generating device (e.g., word processing application, accounting program, or other non-medical functions)
- Augmentative communication (AC)/speech generating systems or devices intended to meet social, educational, vocational or non-medical needs
- Any device that allows input of information via a pen-based system using a stylus and handwriting recognition software, keyboard, or downloaded from a personal computer using special cables and software
- Handheld devices, such as personal digital assistants, that integrate the functions of a small computer with features such as a cell phone, personal organizer, electronic mail, or pager
- Multiple AC's or software programs that perform the same essential function are considered a duplication of services and are not medically necessary
- Laptop computers or desktop computers which may be programmed to perform the same function as a speech generating device
- Printers (which are not a built-in component of a augmentative communication/speech generating device), printer paper, printer cables
- Environmental control devices which are not a built in component
- Purchase of a new PC, repair or replacement of a previously owned PC or any related hardware
- Extended vocabulary software packages
- An AC device provided without severe speech impairment
- Rental of hearing aids
- Hearing aids, hearing aid evaluations and fittings for members 21 years and older
- Personal FM Systems



- Assistive technology devices that are maintained at a school facility for the general use of disabled students and assistive technology services related to the use of such devices
- Upgrading of hearing aids to accommodate school facility FM systems

Non-covered services are not eligible for a Department of Health and Human Resources (DHHR) fair hearing or a document/desk review.

530.5 PRIOR AUTHORIZATION

All requests for covered services requiring prior authorization must be submitted to the UMC. Nationally accredited, evidence-based, medically appropriate criteria, such as InterQual or other medical appropriateness criteria approved by BMS is utilized for review of services requested.

Prior authorization is required for any covered service and when service limits for initial evaluation and re-evaluations are exceeded. It is recommended that the UMC's web portal at www.wvmi.org/corp/web_sites/links_wvmedicaid.aspx be utilized for submitting any request for services requiring prior authorization. Providers using the UMC password protected web portal for requests may also use the password protected web portal to obtain the approval with an assigned prior authorization number or the denial and the reason(s) for the denial after submitting the request and clinical documentation. Support clinical documentation must not be more than 6 months old when submitted for prior authorization. If the covered services are provided before the prior authorization is confirmed, the services will be denied and is not eligible for reimbursement by BMS. The request for prior authorization does not guarantee approval or payment.

When a request for service is denied, the denial is communicated to the provider of service via the UMC's password protected web portal with the reason(s) for denial and their right for reconsideration of the denial. The member or their legal representative is notified of the denial with information related to their right of a fair hearing with a copy of the Request for Fair Hearing Form for submission to BMS

It is the responsibility of the treating/prescribing physician, APRN, or PA to submit a referral with a diagnosis code and clinical documentation for speech, language and audiology services to the servicing Speech/, Language Pathologist, Audiologist or Hearing Aid Dealer before services are provided. The Speech/Language Pathologist, Audiologist or Hearing Aid Dealer is responsible to submit a copy of the practitioner's referral and the individual plan of care to the UMC.

The use of an unlisted code is prohibited when an appropriate code is available. Therefore, unlisted codes for procedures/services require prior authorization by the UMC. The practitioner must provide medical documentation and the reason(s) why an unlisted code must be utilized for the specific procedure/service requested.

530.5.1 RETROSPECTIVE REVIEW

Retrospective review is available by the UMC in the following circumstances:

- A procedure/service denied by the member's primary payer providing all requirements for the primary payer have been followed including appeal processes; or



- Retroactive West Virginia Medicaid eligibility.

A request for consideration of retrospective authorization does not guarantee approval of review or payment.

530.6 DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements identified in Common Chapter 300, Provider Participation Requirements, providers submitting claims for Medicaid reimbursement of services provided to a Medicaid member must maintain complete, individual, accurate and legible medical records. Records must include documentation of medical necessity for the procedures/services provided and be available to BMS or its designee upon request. When documentation is not available, BMS will recover payments made to the provider.

Electronic health records (EHR) for Medicaid members are recommended. Information for EHR and EHR Incentive Program is available on the BMS' website at <http://www.dhhr.wv.gov/bms/ehr> or refer to *Common Chapter 100, General Information*.

The Speech/Language Pathologist and Audiologist documentation must include, but not limited to, the following:

- A written referral from the treating/prescribing practitioner with pertinent clinical documentation for service(s) requested. The referral must include, but not limited to, the member's name, date of referral, type of service requested, frequency and duration of treatment, diagnosis, and physician, APRN, or PA's signature. Supporting documentation must not be more than 6 months old.
- The plan of care which must include, but is not limited to, the date the plan was developed, diagnosis, short and long-term functional goals, measurable treatment objectives, frequency and duration of treatment, education/training in speech therapy or hearing devices for the member or their legal representative to attain maximum rehabilitation, prognosis, date discussed with member or legal representative, signature and date of the member or legal representative agreeing to the treatment, date, and signature and title of the individual providing treatment.
- The progress notes which must be written at each face-to-face visit and signed and dated by the individual providing the service.
- A copy of the prior authorization approval with assigned PA number received from the UMC or a copy of the denial with reason(s) of denial, when appropriate.
- The hearing aid description, make, model, date of purchase, instructions for use and care, measurement and narrative of the fitting, and the signature and title of the individual providing a hearing aid to Medicaid members. Any supplies or accessories for the aid must be documented.
- An audiology evaluation with audiometric results which cannot be more than 6 months old prior to dispensing the hearing aid.
- Warranty information.



- A copy of CMS 1500 claim form utilized for billing of services provided.
- A copy of an Individual Education Plan (IEP), if applicable

Progress/improvement must be documented for continuing coverage of therapy. The provider must document the member's compliance or noncompliance with therapy and the home regimen plan. Continuation of services may be considered when an exacerbated episode is clearly documented. Prior authorization is required.

530.7 OTHER SERVICES

530.7.1 SCHOOL BASED VERSUS PRIVATE PRACTICE SERVICES

Parents have the freedom to choose services from Medicaid providers outside the school system. However, West Virginia Medicaid does not reimburse private practice providers for the same services provided in the school system. This constitutes duplication of services. If a parent or legal representative chooses therapy to be provided by a private practice provider, the parent or legal representative must notify the school district, the Regional Education Services Agency, school or county board in writing not to seek Medicaid reimbursement for therapy services. A copy of the correspondence must be attached to the request for prior authorization to the UMC by the private practitioner chosen by the parent or legal representative to provide the services.

When school is not in session, continuation of therapy services, if necessary, is to be coordinated with a qualified therapist in private practice and the written Individualized Education Plan (IEP) established by the school system must include the continuation of the treatment plan by the private practitioner.

Speech therapy services are covered to members, from 3 years of age up to 21 years of age, when the services are requested by a practitioner and provided by an enrolled Speech-Language Pathologist employed by the West Virginia Department of Education. Reimbursement is based on the Medicaid Fee for Service Rate and apportioned based on a 15 minute unit of service.

530.7.2 BIRTH TO THREE SERVICES

The Birth-to-Three Program must coordinate the treatment plan of care between the providing therapists and the Program providers to avoid duplication of speech therapy and coordinate the member's transition to the school system after the age of 3 years.

530.7.3 EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

West Virginia Medicaid's EPSDT Program offers screenings and other preventive health services at regularly scheduled intervals to Medicaid members up to 21 years of age. These services target early detection of disease and illness to correct or ameliorate a physical or mental condition and provide referral of members for necessary diagnostic and treatment services. Prior authorization of speech therapy is required.

530.7.4 INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)



Any service required in an ICF/MR by the member is reimbursed as an all inclusive rate. However, if the ICF/MR does not provide the required service(s) on-site, such as speech, language or audiology services, a written agreement between the ICF/MR and an outside source must be developed and implemented to provide these services. The ICF/MR is responsible for reimbursement of therapy services to the provider. Services provided by outside sources are included in the ICF/MR rate and must not be billed separately. Refer to *Chapter 511, Intermediate Care Facility for the Mentally Retarded* for more information.

530.7.5 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

All services provided to a member in a PRTF are reimbursed to the PRTF in an all inclusive rate. However, if the PRTF does not provide the required service(s) on-site, such as speech, language or audiology services, a written agreement between the PRTF and an outside source must be developed and implemented to provide these services. The PRTF is responsible for reimbursement of therapy services to the provider. Services provided by outside sources are included in the PRTF rate and must not be billed separately. Refer to *Chapter 531, Psychiatric Residential Treatment Facility* for additional information.

530.7.6 NURSING FACILITY

Speech, language and audiology services are not eligible for reimbursement as a direct billing to Medicaid if the Medicaid member is a resident of the facility at the time the services are provided. Refer to *Chapter 514, Nursing Facility Services*, for additional information.

530.7.7 INPATIENT HOSPITAL

Speech therapy by enrolled Medicaid therapists may be provided to Medicaid members who are inpatients of acute care and critical access hospitals. Reimbursement of speech therapy for inpatients is included in the DRG or hospital's per diem rate, and will not be reimbursed separately.

530.7.8 OUTPATIENT SETTING

Speech therapy and/or audiology services may be provided in an outpatient setting by Medicaid enrolled speech therapists and/or audiologists. Acute care and critical access hospitals are not eligible for direct reimbursement for outpatient therapy services.

530.8 BILLING/REIMBURSEMENT

530.8.1 Billing

West Virginia Medicaid utilizes Current Procedural Terminology (CPT) and/or Healthcare Procedure Coding System (HCPCS) procedure codes for billing of services provided to Medicaid members. Only enrolled providers are eligible for reimbursement of services provided. Billing prior to providing services is prohibited. Providers must not directly bill a Medicaid member for any non-covered service without first informing the member that the service is not covered by Medicaid AND obtaining a written and signed agreement by the member or his/her legal representative, signifying that they accept responsibility for payment of the billed charged by the provider.

Any enrolled therapist/audiologist is eligible for direct billing and reimbursement of covered speech/audiology services provided by BMS. Outpatient speech and audiology services are not



reimbursable directly to the hospital.

Claims must be submitted to the BMS' Fiscal Agent within 12 months of the date of service and a separate claim must be completed for each individual member for payment consideration. Place of service must be included on the claim form.

Providers are encouraged to bill electronically. The professional paper claim form, CMS 1500, or electronic transmission of ASCX12N837P (004010X098A1) must be used to bill covered services/procedures provided by practitioners. The date of service on the claim must be the day the service occurred or was provided.

Some services are not assigned a CPT or HCPCS code; therefore, an unlisted code may be available for the service provided. The appropriate unlisted code with the documentation describing the service performed must be submitted on a paper claim for payment consideration. Unlisted procedure codes require prior authorization. The use of an unlisted code when a national code is available is not reimbursable.

Clinical auditing bundling software for prepayment review of claims is utilized by WV Medicaid. When the RBRVS (Relative-based Resource Value Scale) schedule identifies procedure codes as Status Code "B" indicating the services are bundled, procedures will not be reimbursed as payment is included in other procedures performed.

When billing for hearing aids, 1 unit of service must be billed for Monaural and Binaural codes in accordance with the code description. Monaural cannot be billed separately for each ear. If hearing aids are needed for both ears, the binaural code must be used. When billing for Hearing Aids all discounts given to dispensers must also be reflected on the cost invoice submitted to the UMC.

530.8.2 Reimbursement Methodology

Reimbursement to Medicaid enrolled providers is considered payment-in-full. The Bureau for Medical Services does not negotiate fees.

Speech-language and audiology services are reimbursed based on:

- Resource-Based Relative Value Scale (RBRVS)
- Medicare fee schedule less 20%
- Lesser of the upper limits of established fees or the provider's usual customary charge for the service to the general public
- Unaltered cost invoice.

The current RBRVS (Relative-based Resource Value Scale) Spreadsheet is available at www.dhhr.wv.gov/bms. The RBRVS identifies resource-based relative value units (RBRVUs) for services provided in facility and non-facility settings, other billing information, and identifies service coverage with the established fees assigned to each service.



Medicaid is the payer of last resort. Medicaid participating providers must always seek reimbursement from other liable resources, including private or public insurance entities.

WV Medicaid utilized the Third-Party Liability (TPL) information regarding other liable parties from the member's files to ensure that Medicaid is the last payer to reimburse for covered services. The TPL may be an individual, institution, corporation of a public/private agency liable for all or part of the member's medical costs; e.g., private health insurance, United Mine Worker's of America (UMWA) benefits, Veterans Administration benefits, CHAMPUS, Medicare, West Virginia Division of Vocational Rehabilitation (DVR), etc. No Medicaid reimbursement may be made if the service is the responsibility of a public or private Workers Compensation Plan. Subsequent establishment of liability that provides compensation and payment for the costs of such medical/surgical care requires an adjustment by the provider or other health care professionals to the Medicaid agency for benefits paid.

Prior authorization is not required for services reimbursed by TPL. However, if the primary payer denies a Medicaid covered service, an explanation of benefits noting the denial must be submitted with the documentation to the UMC for review.

Refer to *Common Chapter 600, Reimbursement Methodologies*, and/or the RBRVS schedule available at www.dhhr.wv.gov/bms .

530.9 MANAGED CARE

If the Medicaid member is enrolled in a Medicaid Managed Care Organization (MCO), MCO requirements must be met for reimbursement. The MCO is responsible for all covered speech-language and audiology services. If the Medicaid member is enrolled in an MCO, MCO requirements must be met for reimbursement.

530.10 PHYSICIAN ASSURED ACCESS SYSTEM (PAAS)

If a Medicaid member is enrolled in the PAAS Program, the member's PAAS Primary Care Provider (PCP) must provide a referral for all services ordered prior to rendering the service. Medicaid does not reimburse for services provided when PAAS requirements are not met.

519. 11 MOUNTAIN HEALTH CHOICES

Mountain Health Choices program is offered by West Virginia Medicaid for certain eligibility categories. It includes a choice of benefit package and primary care provider (PCP), encourages personal responsibility, and provides care coordination for its members through the member's medical home.

Providers can view the member's benefit plan designation on the member's Medicaid card. Providers may also call the provider eligibility telephone line or utilize the Medicaid Management Information System (MMIS) vendor web portal to determine member eligibility and benefit package. The following will be noted on the member's card to identify the benefit plan in which the member is enrolled:



- “TR” Traditional Medicaid Benefit Package
- “BA” Basic Adult Benefit Package
- “EA” Enhanced Adult Benefit Package
- “BC” Basic Child Benefit Package
- “EC” Enhanced Child Benefit Package.

See *Chapter 527 Mountain Health Choices* for information on the Basic and Enhanced Packages, which can be found on BMS’ website at www.dhhr.wv.gov/bms.

