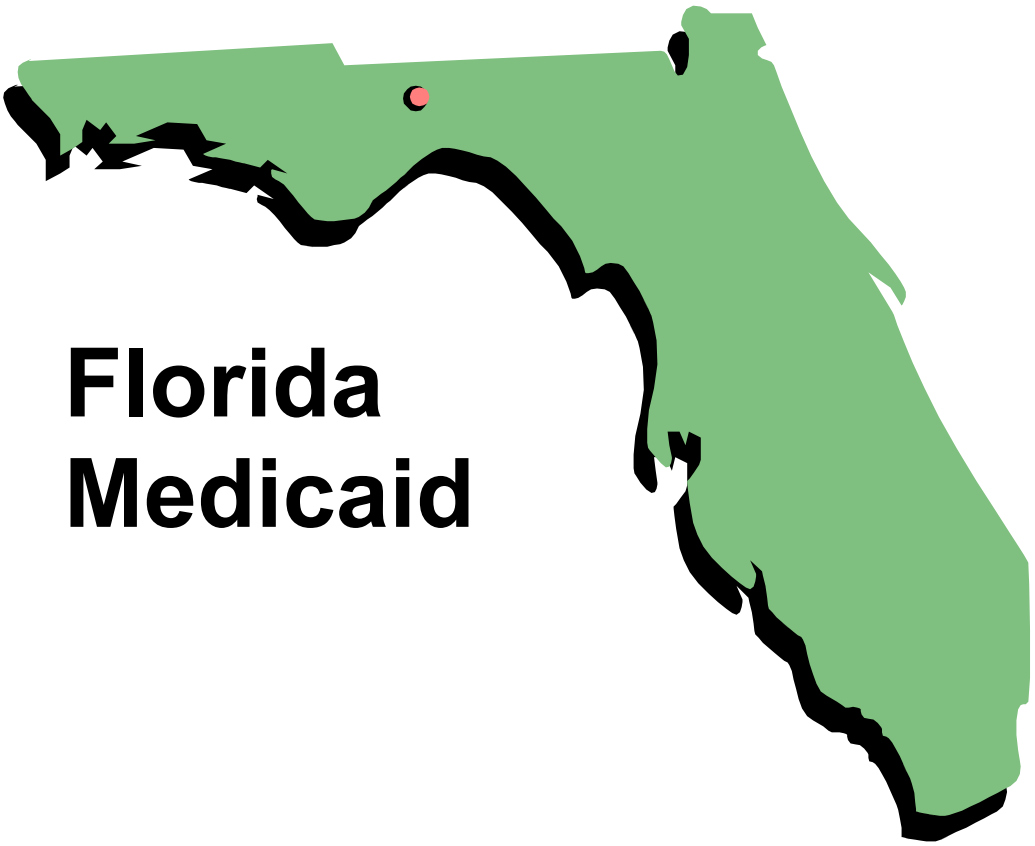


Florida Medicaid

Speech-Language Pathology Services Coverage Policy

Agency for Health Care Administration

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Incorporated by reference in Rule 59G-4.324, F.A.C.

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1.0 Introduction

Speech-language pathology services provide for the evaluation and treatment of speech-language disorders to remediate and maintain communication functioning, acquire a skill set, restore a skill set, and enhance communication.

1.1 Florida Medicaid Policies

This policy is intended for use by speech-language pathology providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.4) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at https://ahca.myflorida.com/medicaid/rules.html.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Speech-language pathology services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.110
- Sections 409.905 and 409.973, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Augmentative and Alternative Communication (AAC)

A device designed to allow individuals with severe, expressive communication disorders the capability to communicate.

1.4.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C., that provides instructions on how to bill for services.

1.4.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C., that contains coverage information about a Florida Medicaid service.

1.4.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients

1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.6 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.7 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.4.8 Therapy Treatment Visits
Active treatment sessions with a recipient for the purpose of providing therapy services.

2.0 2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary speech-language pathology services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, the service is covered for recipients of all ages.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid speech-language pathology services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Speech-language pathologists licensed in accordance with Chapter 468, Part I, F.S. who meet the requirements of 42 CFR 440.110
- Speech-language pathologists provisionally licensed in accordance with Chapter 468, Part I, F.S. who meet the requirements of 42 CFR 440.110
- Speech-language therapy assistants certified in accordance with Chapter 468, Part I, F.S. and working under supervision as defined in section 468.1125, F.S.

A licensed speech-language pathologist must supervise speech-language pathology students in accordance with Chapter 468, F.S. The speech-language pathologist must direct the care, make all clinical decisions, and be responsible for the recipient's assessment and treatment.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers the following in accordance with the American Medical Association (AMA) Current Procedural Terminology (CPT), the applicable fee schedule(s), or as specified in this policy:

- AAC evaluations
- AAC fitting, adjustment, and training sessions
- Services for recipients under the age of 21 years:
  - Speech-language pathology evaluations and re-evaluations
  - Therapy treatment
    - Group therapy must be at least 30 minutes in duration, and may include no more than six participants (the group may include non-Medicaid recipients)

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Developing and updating the plan of care (POC)
- Mileage and travel expenses
- Multiple AAC fitting, adjustment, and training visits on the same day
- Securing, installing, or maintaining therapy equipment
- Services not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with Rule 59G-1.057, F.A.C.
- Time spent supervising assistants and students
- Treatment visits provided on the same day as an evaluation service

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

Providers must develop and update a recipient's POC based on the results of the speech-language evaluation(s). The POC must include at least the following:

- Medical condition, including diagnostic codes
- Functional limitations

- Specific therapy to be provided
- Short and long-term therapeutic goals and objectives
- Medications, treatments, and equipment
- Treatment frequency, length, and duration
- Therapeutic methods and monitoring criteria
- Diet as indicated, if applicable
- Means of demonstrating and teaching the recipient, family and other relevant caregivers
- Coordination with other prescribed services

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization at least every 180 days, or upon a change in the recipient's condition requiring an alteration in services.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Untimed Codes

Untimed codes are reimbursed once per session, regardless of the time spent providing the service. Providers must not bill multiple units for untimed codes unless explicitly allowed in the applicable coverage policy. Documentation must support the fact that the complete service described by the CPT code was rendered during the session.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA website at https://ahca.myflorida.com/medicaid/rules.html.