

Health and Recovery Services Administration (HRSA)



Speech/Audiology Program Billing Instructions for Audiologists and Speech-Language Pathologists

ProviderOne Readiness Edition

[WAC 388-545-0700]

About This Publication

This publication supersedes all previous Department/HRSA *Speech/Audiology Program Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Hearing Aids and Services
- Home Health Services
- School-Based Healthcare Services
- Neurodevelopmental Centers
- Outpatient Hospital Services

Note: The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected

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How Can I Get Department/HRSA Provider Documents?

To download and print Department/HRSA provider numbered memos and billing instructions, go to the Department/HRSA website at <http://hrsa.dshs.wa.gov> (click the *Billing Instructions and Numbered Memorandum* link).

CPT is a trademark of the American Medical Association.

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Important Contacts

Note: This section contains important contact information relevant to the Speech/Audiology Program. For more contact information, see the Department/HRSA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	<p>See the Department/HRSA <i>Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html</p>
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Private insurance or third-party liability, other than Department managed care	
How do I obtain prior authorization or a limitation extension?	<p>For all requests for prior authorization or limitation extensions, the following documentation is “required:”</p> <ul style="list-style-type: none"> • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Physical, Occupational and Speech Therapy Limitation Extension Request Form, DSHS 13-786, and all the documentation listed on this form and any other medical justification. <p>Fax your request to: 1-866-668-1214. See the Department/HRSA <i>Resources Available</i> web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html</p>

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Department - The state Department of Social and Health Services (the Department).

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by the Department for specific services, supplies, or equipment.

Medical Identification card(s) – See *Services Card*.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.

For example: 123456789WA.

Revised Code of Washington (RCW) - Washington State laws.

Services Card – A plastic “swipe” card that the Department issues to each client on a “one- time basis.” Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client’s name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Client Eligibility

Who Is Eligible?

Please see the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Healthcare Services Table* web page at: <http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html> for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Department Managed Care Plan Eligible? [Refer to WAC 388-538-060 and 095 or WAC 388-538-063 for GAU clients]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, **managed care enrollment will be displayed on the Client Benefit Inquiry screen.** All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their managed care plan by calling the telephone number provided to them.

All medical services covered under a managed care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

Note: To prevent billing denials, please check the client's **eligibility prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. **See the Department/HRSA *ProviderOne Billing and Resource Guide* at:** http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

The Department pays only for covered speech/audiology services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- For conditions which are the result of medically recognized diseases and defects;
- Medically necessary, as determined by a health professional; and
- Begun within 30 days of the date prescribed.

What Is Covered? [WAC 388-545-0700 (4)]

Unlimited speech/audiology visits for clients 20 years of age and younger.

The Department covers the following services per client, per calendar year:

- One (1) medical diagnostic evaluation;
- Speech Therapy Re-Evaluation (CPT code S9152);

Covered once per calendar year, per client. Use CPT code S9152 when billing for the re-evaluation of a client who has been under a plan of care established by a physician or speech therapist. This re-evaluation is to assess the client's condition and revise the client's plan of care.

- Twelve (12) speech/audiology program visits; and
- Twenty-four (24) additional speech/audiology program visits (see next page).

Additional Coverage (Client 21 years of age and older) [WAC 388-545-0700 (4)(e)]

The Department will cover a maximum of 24 speech/audiology program visits in addition to the original 12 visits **only** when billed with one of the following **principle** HCPCS diagnosis codes.

HCPCS Diagnosis Codes	Condition
237.7-237.72	Neurofibromatosis
315.3-315.39, 315.5-315.9, 317-319	Medically necessary conditions for developmentally delayed clients
315.4,	Severe oral/motor dyspraxia
335.20	Amyotrophic lateral sclerosis (ALS)
340	Multiple sclerosis
343-343.9	Cerebral palsy (CP)
344.0	Quadriplegia
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
388.45	Acquired auditory processing disorder
436	Acute, but ill-defined, cerebrovascular disease
741.9	Meningomyelocele
749-749.25	Cleft palate and cleft lip
758.0	Down's syndrome
781.3	Lack of coordination
784.3	Severe aphasia
784.5	Other speech disturbance (severe Dysarthria)
787.2 – 787.29	Dysphagia
800-800.9	Fracture of vault of skull
801-801.9	Fracture of base of skull
803-803.9	Other and unqualified skull fractures
804-804.9	Multiple fractures involving skull or face with other bones
806.0-806.19	Fracture of cervical column, closed or open
807.5	Fracture of larynx and trachea, closed
807.6	Fracture of larynx and trachea, open
851.1-851.9	Cerebral laceration and contusion
852-852.5	Subarachnoid, subdural, and extradural hemorrhage, following injury
853-853.1	Other and unspecified intracranial hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature
900-900.9	Injury to blood vessels of head and neck
941.33,941.35,941.38,	Severe burn of face, head, and neck
941.43,941.45,941.48,	
941.53,941.55,941.58	
946.3-946.5	Burns of multiple specified sites
947.0-947.2	Burn of internal organs
952.0-952.09	Spinal cord injury without evidence of spinal bone injury-cervical

Are School-Based Healthcare Services Covered?

The Department covers occupational therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to the current Department/HRSA *School-Based Healthcare Services Billing Instructions*. See the *Important Contacts* Section.

What Is Not Covered? [WAC 388-545-0700 (6)]

The Department does not cover speech/audiology services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Coverage Table and Fee Schedule

Note: Due to its licensing agreement with the American Medical Association, the Department publishes only the official, brief CPT® code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Audiologists and Speech Therapy Pathologists				
92506		Speech/hearing evaluation		Limit of one per year, per client
92507*		Speech/hearing therapy		
92508*		Speech/hearing therapy		
92551		Pure tone hearing test, air		
92611		Motion fluoroscopy/swallow		
92630		Aud rehab pre-ling hear loss		
92633		Aud rehab postling hear loss		
97532*		Cognitive skills development		One 15 minute increment equals one visit
97533*		Sensory integration		One 15 minute increment equals one visit
Audiologists				
69210		Remove impacted ear wax		
92540		Basic vestibular evaluation		
92540	26	Basic vestibular evaluation		
92540	TC	Basic vestibular evaluation		
92541	26	Spontaneous nystagmus test		
92541	TC	Spontaneous nystagmus test		
92541		Spontaneous nystagmus test		
92542	26	Positional nystagmus test		
92542	TC	Positional nystagmus test		
92542		Positional nystagmus test		
92543	26	Caloric vestibular test		
92543	TC	Caloric vestibular test		
92543		Caloric vestibular test		
92544	26	Optokinetic nystagmus test		
92544	TC	Optokinetic nystagmus test		
92544		Optokinetic nystagmus test		

An asterisk (*) means the code is included in the 12 visit limitation (applies to clients 21 and over).

Speech/Audiology Program

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Audiologists Continued				
92545	26	Oscillating tracking test		
92545	TC	Oscillating tracking test		
92545		Oscillating tracking test		
92546	26	Sinusoidal rotational test		
92546	TC	Sinusoidal rotational test		
92546		Sinusoidal rotational test		
92547		Supplemental electrical test		
92550		Tympanometry & reflex thresh		
92552		Pure tone audiometry, air		
92553		Audiometry, air & bone		
92555		Speech threshold audiometry		
92556		Speech audiometry, complete		
92557		Comprehensive hearing test		
92567		Tympanometry		
92568		Acoustic reflex testing		
92570		Acoustic immittance testing		
92579		Visual audiometry (vra)		
92582		Conditioning play audiometry		
92584		Electrocochleography		
92585	26	Auditor evoke potent, compre		
92585	TC	Auditor evoke potent, compre		
92585		Auditor evoke potent, compre		
92586		Auditor evoke potent, limit		
92587	26	Evoked auditory test		
92587	TC	Evoked auditory test		
92587		Evoked auditory test		
92588	26	Evoked auditory test		
92588	TC	Evoked auditory test		
92588		Evoked auditory test		
92601		Cochlear implt f/up exam < 7		
92602		Reprogram cochlear implt < 7		
92603		Cochlear implt f/up exam 7 >		
92604		Reprogram cochlear implt 7 >		
92620		Auditory function, 60 min		

Speech/Audiology Program

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
Audiologists Continued				
92621		Auditory function, + 15 min		
92625		Tinnitus assessment		
92626		Eval aud rehab status		
92627		Eval aud status rehab add-on		
Speech Language Pathologists Only				
S9152		Speech therapy re-eval		One per calendar year per client.
92526		Oral function therapy		
92597		Oral speech device eval		
92605		Eval for nonspeech device rx		Included in the primary services. Bundled service
92606		Non-speech device service		
92607		Ex for speech device rx, 1hr		
92608		Ex for speech device rx addl		
92609		Use of speech device service		
92610		Evaluate swallowing function		
96125		Cognitive test by hc pro		Limit: One hour per calendar year, per client

Fee Schedule

You may view the Department/HRSA *Speech and Audiology Program Fee Schedule* online at

<http://hrsa.dshs.wa.gov/RBRVS/Index.html>

Speech-Language Pathology

For the Department to pay for speech-language therapy, a client must have a medically recognized disease or defect which requires speech-language therapy services.

Who Is Eligible To Provide Speech-Language Therapy? [WAC 388-545-0700 (1)(a)(b)]

Speech-language therapy must be provided by a speech-language pathologist who has been granted a certificate of clinical competence by the American Speech, Language, and Hearing Association or by an individual who has completed the equivalent educational and work experience necessary for such a certificate.

Swallowing Evaluations

Swallowing (dysphagia) evaluations must be performed by a speech-language pathologist who:

- Holds a master's degree in speech-language pathology; and
- Has received extensive training in the anatomy and physiology of the swallowing mechanism, with additional training in the evaluation and treatment of dysphagia.

A swallowing evaluation includes:

- An oral-peripheral exam to evaluate the anatomy and function of the structures used in swallowing;
- Dietary recommendations for oral food and liquid intake therapeutic or management techniques; and
- (May include) A videofluoroscopy for further evaluation of swallowing status and aspiration risks.

Visit Limitations

Note: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

If time is included in the CPT procedure code description, the beginning and end times of each therapy modality must be documented in the client's medical record

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other speech-language allowed CPT procedure codes.
- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.
- The Department allows evaluation of speech (CPT procedure code 92506) once per year, per client, per provider and it is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.19	Intracranial injury of other and unspecified nature
- Duplicative services for Occupational, Physical, and Speech Therapy are not allowed for the same client when both providers are performing the same or similar intervention(s).

How Do I Request Approval To Exceed the Limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request Department approval to exceed the limits. The request for additional services must state the following in writing:

1. The name and **ProviderOne Client ID** of the client;
2. The therapist's name, **NPI**, and fax number;
3. The prescription for therapy;
4. The number of visits were used during that calendar year;
5. The number of additional visits are needed;
6. The most recent therapy evaluation/note;
7. Expected outcomes (goals);
8. If therapy is related to an injury or illness, the date(s) of injury or illness;
9. The primary diagnosis or ICD-9-CM diagnosis code and description; and
10. The place of service.

Send your request to **the Department (see the Important Contacts section)**.

Audiology

The Department may pay for speech/audiology program services for conditions that are the result of medically recognized diseases and defects.

Who Is Eligible To Provide Audiology Services?

[WAC 388-545-0700 (1)(c)]

Audiologists who are appropriately licensed or registered to provide speech/audiology services within their state of residence to Department clients.

What Type of Equipment Must Be Used?

Audiologists must use yearly calibrated electronic equipment, according to RCW 18.35.020.

What About Children with Special Health Care Needs?

Refer to the current Department/HRSA [Hearing Aid Program Billing Instructions](#) for information regarding Children with Special Health Care Needs (CSHCN).

Visit Limitations

Note: Beginning and ending times of each therapy encounter must be documented in the client's record.

Visits are based on the CPT procedure code description. If the description does not include time, the procedure is counted as one visit, regardless of how long the procedure takes.

- Cognitive Skills (CPT procedure codes 97532 and 97533) is considered a speech/audiology program visit and is part of the 12-visit speech/audiology program visit limitation. Each 15-minute increment will be counted as one speech/audiology program visit. These procedure codes can be billed alone or with other audiology allowed CPT procedure codes.
- Procedures counted in the 12-visit limitation are CPT procedure codes 92507, 92508, 97532, and 97533.

- Evaluation of speech (CPT procedure Code 92506) is allowed once per year, per client, per provider and is not included in the 12-visit limitation. A second evaluation will be allowed at time of discharge for the following diagnosis codes:

348.1	Anoxic brain damage
436	Acute, but ill-defined, cerebrovascular disease
852-852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
854-854.1	Intracranial injury of other and unspecified nature
- For caloric vestibular testing (CPT procedure code 92543), bill one unit per irrigation. If necessary, you may bill up to four units for each ear.
- For sinusoidal vertical axis rotational testing (CPT procedure code 92546), bill 1 unit per velocity/per direction. If necessary, you may bill up to 3 units for each direction.

How Do I Request Approval To Exceed the Limits?

For clients 21 years of age and older who need therapy visits above those allowed by diagnosis, the provider must request Department approval to exceed the limits. The request for additional services must state the following in writing:

11. The name and **ProviderOne Client ID** of the client;
12. The therapist's name, **NPI**, and fax number;
13. The prescription for therapy;
14. The number of visits were used during that calendar year;
15. The number of additional visits are needed;
16. The most recent therapy evaluation/note;
17. Expected outcomes (goals);
18. If therapy is related to an injury or illness, the date(s) of injury or illness;
19. The primary diagnosis or ICD-9-CM diagnosis code and description; and
20. The place of service.

Send your request to **the Department (see the Important Contacts section)**.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/HRSA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to the Speech/Audiology Program:

Field No.	Name	Entry										
19.	Reserved for Local Use	Enter "T" for school contracted services that are noted in the client's IEP or IFSP.										
24B.	Place of Service	These are the only appropriate codes for this program: <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th>Code Number</th> <th>To Be Used For</th> </tr> </thead> <tbody> <tr> <td>11</td> <td>Office</td> </tr> <tr> <td>12</td> <td>Home</td> </tr> <tr> <td>22</td> <td>Outpatient</td> </tr> <tr> <td>99</td> <td>Other</td> </tr> </tbody> </table>	Code Number	To Be Used For	11	Office	12	Home	22	Outpatient	99	Other
Code Number	To Be Used For											
11	Office											
12	Home											
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