

SC Department of Health and Human Services
Speech Therapy
Questions & Answers
03/23-26/2010

Note: This is a record of questions asked and answers given during the South Carolina Department of Health and Human Services' Speech Therapy workshops. It is intended as a rough guide to topics covered during those sessions. For program-specific policy information, you should always contact your program representative and/or refer to your program manual.

Answers to questions are typed in **RED**.

Florence, March 23, 2010:

If you do a three-year re-evaluation, do you need a form to cover that?

A re-evaluation is required annually. Medicaid will reimburse for up to 2 evaluations per contract year (July 1st – June 30th). The re-evaluation must be properly documented in the records.

Should a release form be signed annually or once in a lifetime?

A release form is required at least once in a lifetime. Extenuating circumstances (i.e., a break in service) may warrant the provider having the release of information/consent to bill completed more than once.

Can an audiologist refer a patient to a speech therapist?

Yes. A physician or other Licensed Practitioner of the Healing Arts acting within the scope of his or her practice under state law must make the referral. For listing of LPHAs, refer to Section 2 of the Private Rehabilitative Therapy and Audiological Services Manual.

Do supervisors have to sign off on everything?

Yes. The supervisor is responsible for all of the services provided by non-licensed staff that he or she agrees to directly supervise.

When doing an evaluation, should goals be on a separate form?

Goals may be listed on separate forms.

Any service cuts anticipated?

We do not anticipate any changes. Providers will be notified of any program changes through a Medicaid Bulletin.

If you have a child receiving therapy and they change providers, do you need a new evaluation?

No, however an evaluation must be properly documented in the records.

Is there a way to find out how many Medicaid visits have been used?

Providers are responsible for tracking service provision to ensure they do not exceed the maximum units.

Greenville, March 24, 2010

Regarding MIVS, what does it mean if I find they have other sources of insurance?

Since Medicaid is the payer of last resort, providers must bill other insurance sources before billing Medicaid.

What if the State doesn't know about other carriers?

The provider is responsible for notifying the state when other insurance sources are identified. You can use the HIRF form to add or update information. The form outlines what information is needed and provides you with a mailing address or fax number. The member may also go to the county DHHS eligibility office to update third party information.

What is the best way to know if a denial is valid?

Providers should refer to the Edit Codes (Appendix A) in the provider manual. You will find steps for resolving any denials/claim edits.

If a member has other insurance and it does not cover Speech Therapy services, do you have to file a claim with the other insurance company?

A provider who accepts a Medicaid beneficiary as a patient is required to request payment from all available third party resources prior to billing Medicaid.

How long are private practices required to keep documentation?

Providers must retain medical records for at least five years.

On supervisor notes, is a rubber stamp admissible?

No, it must be an original signature.

Can the release of information/consent to bill be dated before or on the date of service?

The release of information/consent to bill must be completed prior to providing the therapy service.

Is a separate referral needed for the speech therapy service?

No, a referral is needed before an initial evaluation is performed and annually thereafter.

If a provider is unaware of a prior evaluation from another agency, will it be denied?

Yes, any subsequent billing for an evaluation will deny.

Is there a plan to coordinate CPT codes?

Not at this time.

Is the ITP separate or can it be included in the plan?

The ITP can be included with the evaluation; however, each must be properly labeled.

Can four units of service be provided in outpatient and school setting on the same date of service?

If the service is provided on the same date of service, the claim will reject. The provider must submit documentation to your program manager for review and possible payment.

What happens if you are working on the same goals as the schools?

Documentation must support the reason it is medically necessary for both providers to work with a child on the same goals.

Columbia, March 25, 2010

Is time spent documenting a part of the direct service?

No, reimbursement is not available for time spent documenting services or traveling to or from services, or for cancelled visits and missed appointments.

Will they be adding a code for augmentative communication?

No, providers should be using the appropriate codes listed in Section 4 of the provider manual.

Is there a statement of medical necessity on the agency's website?

You should refer to your provider manual which is located on the agency's website.

What is the SC State Plan?

Each state has a state plan. It is the basic rules that each state must follow according to the Centers for Medicare and Medicaid Services.

Are the requirements the same across the board for medical necessity?

Yes.

Is it progress notes or billing notes that require a sign-off by a licensed speech pathologist?

All Clinical Service Notes made by staff who require supervision must be co-signed by the supervisor.

Is just a referral required from the doctor with straight Medicaid?

A referral from a physician or LPHA is required.

If an annual re-evaluation comes up, is there any leeway?

An annual re-evaluation must be conducted.

Does the release of information/consent to bill form have to be signed annually?

A release of information is only required once. Extenuating circumstances (i.e., change of provider, a break in service) may warrant the provider having the release of information/consent to bill completed more than once.

If the child is not there for the evaluation, should we reschedule the appt?

The child must be present for an evaluation.

What if an evaluation is started, but not completed?

A provider should only bill for a service when it is completed.

Can services be provided without a treatment plan?

No, you must have a treatment plan.

Should my evaluation that includes the Individual Treatment Plan be separated?

The ITP can be included with the evaluation; however, each must be properly labeled.

On the Web Tool will there be a visit count for speech therapy?

Not at this time.

Do we have up to 75 hours for the entire year?

No, the limit is 75 hours for the fiscal year – July 1 through June 30th.

Do we need to wait until the 75-hour limit is reached to request more time?

No, the provider should submit a request as soon as he determines the 75 hours are not adequate.

Does the 75-hour limit refer to schools and private providers?

No, the limit refers to only private therapy providers.

Is the 75 group hours/75 individual hours the same limit?

Providers are allowed 75 hours for each code (group and individual).

If you bill group/individual for the same day, will the claim deny?

If the provider is billing for two separate procedure codes the claim will not deny.

Is a re-evaluation required for a continuation of treatment every six months?

A re-evaluation should be conducted annually for each beneficiary; however, a re-evaluation can be within a six-month time frame.

Does the diagnosis count as the reason for the referral?

Yes, a valid diagnosis is a reason for a referral.

Charleston, March 24, 2010

Can a doctor's prescription be used as a referral?

Yes, if it has all the components of a referral.

Should referrals be updated annually?

Yes, a referral is required every 12 months to continue services.

Does a plan of care count as a referral?

No.

When the annual referral comes back and you do the assessment, is that a re-evaluation?

It may be considered a re-evaluation if it includes all the required components.

Do prescriptions need reason?

Yes, the prescription must justify the need for services.

Who can be authorized to sign for a child?

Legal guardians only.

What code is feeding and swallowing under?

Refer to the procedure codes in Section 4 of the provider manual.

What happens if I get a patient that had an evaluation elsewhere? What do I do?

Unless the patient has a different diagnosis, the new provider may request the evaluation from the previous service provider. An evaluation must be properly documented in the record.

If a client dismisses therapy on their own, what do you do?

Document and close the file.

If a client cancels, can we do two sessions the following week?

Only if it is medically necessary and properly documented.

Should details be specific in treatment per visit?

Yes

Can summary notes be included in on-going treatment plans?

Yes, as long as it's labeled.

Can a patient be seen privately, in a school, and a hospital?

A patient may be seen in any setting; however, the services must be medically necessary.

What does a re-evaluation actually entail?

Speech re-evaluation includes a face-to-face interaction between the Speech-Language Pathologist and the child for the purpose of evaluating the child's progress and determining if there is a need to continue therapy. Reevaluation must include a written report with recommendations.