Speech Therapy

Page updated: August 2020

This section contains information about speech therapy services and program coverage (*California Code of Regulations* [CCR], Title 22, Section 51309). For additional help, refer to the speech therapy billing example section in the appropriate Part 2 manual.

Program Coverage

Medi-Cal covers speech therapy services only when ordered on the written referral of a physician or dentist. (CCR, Title 22, Section 51309[a].)

Eligibility Requirements

Providers should verify the recipient's Medi-Cal eligibility for the month of service.

Medi-Services

A Medi-Service reservation is necessary for each outpatient speech therapy visit provided by an independent practitioner. Visits to a Medi-Cal recipient in a nursing facility do not require a Medi-Service reservation; however, a *Treatment Authorization Request* (TAR) is required.

Information about how to reserve a Medi-Service is contained in the following documents:

- If using the Automated Eligibility Verification System (AEVS), refer to the *AEVS: Transactions* section of the Part 1 manual.
- If using the internet, refer to the *Medi-Cal Web Site Quick Start Guide*.

"Visit" Defined

"Visit" is defined as any covered speech therapy procedure or combination of procedures performed on the same day.

Recipients Under Age 21

Additional speech therapy services for full-scope Medi-Cal recipients under 21 years of age are available through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services, and require a Medi-Service reservation, where medically necessary.

Per CCR, Title 22, Section 51013, Medi-Cal eligible recipients under 21 years of age with hearing loss are to be referred to California Children's Services (CCS) for case management and authorization of services. Medical eligibility for the CCS program for hearing loss is defined in CCR, Title 22, Section 41839. Refer to the *California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP)* section in the appropriate Part 2 manual for additional information.

Written Referral Requirements

Speech pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.

The Medi-Cal program definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. It is important that the referring practitioner supply the therapist with the information required to document the medical necessity.

The following information must be included on the written referral:

- Signature of the referring practitioner
- Name, address and telephone number of the referring practitioner
- Date of the referral
- Medical condition necessitating the service(s) (diagnosis)
- Supplemental summary of the medical condition or functional limitations must be attached or included in the referral
- Specific services (for example, evaluation, treatments, modalities) requested
- Frequency of services
- Duration of medical necessity for services – specific dates and length of treatment should be identified if possible. Duration of therapy should be set by the referring practitioner; however, referrals are limited to six months.
- Anticipated medical outcome as a result of the therapy (therapeutic goals)
- Date of progress review (when applicable)

Speech Generating Devices: Related Speech Therapy Services

Speech therapy services related to speech generating devices are reimbursable. Speech therapy codes X4310 and X4312 are reimbursable for all recipients.

Recipient Information

The following recipient information should be included on each written referral, when applicable:

- Age
- Developmental status and rate of achievement of developmental milestones
- Mental status and ability to comprehend
- Related medical conditions

The goal of therapy should be achievement of intelligibility rather than age-specific qualities or previous condition status, such as with a stroke victim.

Authorization

Treatment Authorization Requests (TARs) for speech therapy for Medi-Cal-only recipients must be submitted to the TAR Processing Center.

Speech therapy services rendered in an outpatient setting are limited to a maximum of two services per month subject to the availability of Medi-Service reservations. Initial and six-month evaluations (HCPCS codes X4300 and X4301) do not require a Medi-Service reservation.

Certified Rehabilitation Centers and Nursing Facilities

Authorization procedures for speech therapy services rendered in a certified rehabilitation center or Nursing Facility Level A (NF-A) or Level B (NF-B) are:

- The Medi-Service reservation limitation of two services per month does not apply.
- Initial and six-month evaluations (HCPCS codes X4300 and X4301) do not require a TAR. For billing instructions, refer to “Initial and Six-Month Evaluations” in this section.
- A TAR is required for any additional speech therapy service beyond the initial and six-month evaluation.

Nursing Facility Prior Authorization Requirements: (Valdivia v. Coye)

Speech therapy services rendered to NF-A or NF-B recipients require prior authorization. A TAR must be submitted for services that are not included in the Medi-Cal inclusive per diem rate for an NF. For specific TAR requirements, refer to the *TAR Criteria for NF Authorization (Valdivia v. Coye)* section in this manual.

Initial and Six-Month Evaluations

Initial and six-month evaluations billed with HCPCS code X4308 (speech) require only that the recipient be eligible for the Medi-Cal month during which the service is performed in a certified rehabilitation center, NF-A or NF-B, or pediatric subacute care facility on the written order of the attending physician.

Claim Information

The statement "Initial evaluation visit" or "Six-month re-evaluation visit" must be entered in the *Remarks* area/*Additional Claim Information* field (Box 19) of the claim when speech therapy services are billed. The initial evaluation document is not required as an attachment to the claim form.

Note: Services provided in a board and care facility are billed with a Place of Service code "12" (home) and require a Medi-Service reservation.

Required Professional Experience Services: Reimbursable

Licensed speech pathologists may be reimbursed for covered Medi-Cal services performed by unlicensed speech pathologists working under their direct supervision to fulfill Required Professional Experience (RPE) for licensure.

Requirements for this policy are:

- The RPE trainee must have completed the required academic training and be acquiring the RPE as necessary for licensure.
- Speech pathologists wishing to use an RPE trainee to treat Medi-Cal recipients must be approved by the Provider Services Section of the Department of Health Care Services (DHCS). The supervising provider must apply to DHCS to obtain an RPE trainee rendering provider number for the trainee. This number will have an automatic expiration date.
- Interested providers must contact DHCS RPE Services at (916) 323-1945 for approval to bill RPE services.

The supervising provider must bill for the services and enter the RPE trainee's provider number in the *Additional Claim Information* field (Box 24K) of the claim. Providers billing for services performed by an RPE trainee must add modifier YW to HCPCS codes X4300 thru X4320 for speech therapy.

Speech Generating Devices (SGD)

For more information, refer to the *Speech Generating Devices (SGD)* section in this manual.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.