

CHAPTER 530 SPEECH AND AUDIOLOGY SERVICES

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BACKGROUND

The West Virginia Bureau for Medical Services (BMS) covers speech-language/therapy and audiology services provided to Medicaid members by enrolled Speech-Language Pathologists and/or Audiologists. A referral for these services must be provided by the treating and/or referring and/or prescribing physician, advanced practice registered nurse (APRN), clinical nurse specialist (CNS), or a physician assistant (PA). Speech-language/therapy and or Audiologist services may be provided in an inpatient or outpatient setting or in the home. Any enrolled Speech-Language Pathologist or Audiologist is eligible for direct billing and reimbursement of services provided to members by BMS.

POLICY

530.1 COVERED SERVICES

Audiology and speech therapy services must be ordered by an enrolled physician, PA, APRN, and CNS provided by or under the direction of an enrolled licensed audiologist. Prior authorization is required for specified services.

Covered speech-language and audiology services are available to Medicaid members up to 21 years of age. For members 21 years of age and over, limited services such as augmentative communication(AC)/speech generating systems, artificial larynx, tracheostomy speaking valves, speech therapy, and function tests for specific medical conditions are covered.

Covered speech-language and audiology services require the provider to submit and maintain a treatment plan of care documenting measurable goals, objectives, and prognosis to the Utilization Management Contractor (UMC) via the [web portal](#) for prior authorization review. A copy of the written Individualized Education Program (IEP) developed by the West Virginia Department of Education must be submitted to the UMC for all school-aged children when prior authorization is required. Treatment visits must be face-to-face and encompass all covered services provided to Medicaid members at each visit.

For members of the expansion population under the alternative benefits plan, service limits include both rehabilitative and habilitative services. Please see [Chapter 400, Member Eligibility](#) for additional information.

Documentation required for individual medical records includes the treatment plan of care, a written referral from the treating/prescribing practitioner, progress notes, the hearing aid description, make, model, date of purchase, instructions for use and care, measurement and narrative of the fitting, the signature and title of the individual providing the hearing aid, an audiology evaluation with audiometric results, warranty information, and a copy of an IEP, if applicable. All documentation must be made available to BMS or its designee upon request.

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 rendered.

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530.1.1 School Services vs. Services Provided By Private Practitioners

Parents have the freedom to choose services from Medicaid providers outside the school system. However, West Virginia cannot cover this duplication of services, that is, pay claims for the same services provided in the school system and also outside the school system by private practitioners for the same Medicaid member. Therefore, the parent/guardian must notify the school district to not seek Medicaid reimbursement for the relevant services. Please refer to [Chapter 538, School-Based Health Services](#) for additional information.

When school is not in session, continuation of speech therapy services, if necessary, is to be coordinated with a speech therapist in private practice. The written IEP established by the school system must include the continuation of the treatment plan by the private practitioner.

530.1.2 Birth-to-Three

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. The Program must also coordinate the member's transition to the school system after the age of three years.

530.1.3 Speech-Language Therapy

All covered speech-language therapy services are covered for Medicaid members up to 21 years of age. For members 21 years of age and older, speech-language therapy is limited to one evaluation for medical/surgical conditions which include, but are not limited to: cerebral vascular accident (CVA), tracheotomy, tracheostomy, laryngectomy, traumatic brain injury (TBI), nerve injuries (e.g., 5th, 7th – 12th), amyotrophic lateral sclerosis (ALS), cerebral palsy, and dysarthria. Speech language therapy requires prior authorization beyond the initial evaluation.

Speech-language 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 necessary to providing the speech therapy regime themselves.

530.1.4 Augmentative Communication(AC)/Speech Generating Systems and Devices

Speech generating device and accessories (e.g., operating system, Word core software, battery charger, mounting plate, built-in stand, vocabulary software, USB cable, one battery pack and a standard one year warranty) are included with the initial placement of the device and is not reimbursed separately. Accessories not included in initial placement (e.g., cables, battery pack, carrying case, and picture communication symbols (PCS) may be billed separately. These services are covered for all ages and must be provided under the direction of an enrolled Speech-Language Pathologist trained in augmentative communication(AC) /speech generating devices and services. Prior authorization is required.

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Repair and/or modification to the augmentative communication(AC)/speech generating device requires prior authorization.

Artificial larynxes including an initial battery, tracheostomy speaking valves, and voice amplifier are covered for all ages. Prior authorization is required when service limits are exceeded.

530.1.5 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 that meets the member's basic healthcare need must be provided. Before the hearing aid is considered reimbursable, the following must be provided:

- Prior authorization for medical necessity
- A referral from an enrolled physician, APRN, CNS or PA with documentation of a medical examination and
- Documentation of a hearing evaluation with audiometric results by an Audiologist within the past six months.

When the 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. A two-year hearing aid warranty is required and included in the reimbursement of the hearing aid. Replacement of hearing aid batteries require prior authorization when service limits are exceeded.

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 two-year warranty has expired. 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 is required when four repairs per year is exceeded.

Replacement of hearing aids is covered due to growth or changes in the member's physical condition, wear, theft (submission of police report required), irreparable damage, or loss by disaster. Prior authorization is required. When documentation of malicious damage, neglect, or misuse of the hearing aid is reported and confirmed, the request will be denied.

530.1.5.1 Cochlear Implant

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

REPLACEMENT

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

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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 cochlear accessories (headset, headpiece, microphone, transmitting coil and transmitter cable) is covered for Medicaid members up to 21 years of age AND Medicaid members 21 years of age and older IF the member received a cochlear implant and BMS paid for it before they reached the age of 21 years. Batteries for the implant require prior authorization when service limits are exceeded.

530.1.6 Newborn Hearing Screen

Newborn hearing screens are covered within the first 90 days of life 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.

For additional information, refer to the Office of Maternal, Child and Family Health (OMCFH) at www.wvdhhr.org/nhs.

530.2 PRIOR AUTHORIZATION

It is the responsibility of the treating/prescribing physician, APRN, CNS, or PA to submit a referral with a diagnosis code and clinical documentation for audiology services to the servicing Audiologist, Hearing Aid Dealer, or Speech/Language Pathologist before services are provided. The Audiologist, Hearing Aid Dealer, or Speech/Language Pathologist 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. 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.

Retrospective authorization 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.

Refer to [Chapter 100, General Administration and Information](#) for additional information.

530.3 DOCUMENTATION REQUIREMENTS

The Audiologist or Speech/Language Pathologist documentation must include, but is 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 is not limited to, the member's name, date of

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- referral, type of service requested, frequency and duration of treatment, diagnosis, and physician, APRN, CNS, or PA's signature. Supporting documentation must not be more than six 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, or hearing devices for the member 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 required prior authorization approval with assigned prior authorization 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 six 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 IEP, if applicable.

Progress/improvement must be documented for continuing coverage of rehabilitative 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.

530.4 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID), PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF), AND NURSING FACILITY

Any service required in an ICF/IID, PRTF or Nursing Facility by the member is reimbursed as an all-inclusive rate. If the facility does not provide the required speech-language or audiology service(s) on-site, a written agreement between the facility and the outside source must be developed and implemented to provide these services.

The facility is responsible for reimbursement of any therapy service provided by an outside source. Services provided by outside sources are included in the facility rate and must not be billed separately.

530.5 OUTPATIENT SETTING

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

530.6 BILLING AND REIMBURSEMENT

When billing for hearing aids, one 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

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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.

530.7 NON-COVERED SERVICES

Non-covered speech-language and audiology services include, but are not limited to:

- Experimental/investigative services/procedures for research purposes
- Evaluations provided by an employee of an individual who has a financial interest with providers of devices
- Rental of hearing aids
- Hearing aids, hearing aid evaluations, and fittings for members 21 years of age and older
- Personal FM systems
- Assistive technology devices that are maintained at a school facility for the general use of challenged students and assistive technology services related to the use of such devices
- Upgrading of hearing aids to accommodate school facility FM systems
- Evaluations by the Speech-Language Pathology Assistants (SLPA)
- Speech therapy services provided:
 - to a member in a nursing facility, PRTF or an ICF/IID (included in the 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; or
 - to members by out-of-network providers not enrolled in West Virginia Medicaid.
- Upgrades to, or subsequent versions of the speech generating device software program of 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 ACs 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 an augmentative communication/speech generating device), printer paper, printer cables
- Environmental control devices which are not a built-in component
- Purchase of a new personal computer, repair or replacement of a previously owned personal computer or any related hardware
- Extended vocabulary software packages
- An AC device provided without severe speech impairment.

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

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

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 one unit and binaural procedure codes are to be billed when supplying hearing devices for both ears

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

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

Hearing Aid Dealer: An individual or group that is licensed by the West Virginia Board of Hearing Aid Dealers or the State in which they operate and provides hearing aids

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

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.

REFERENCES

West Virginia State Plan references audiology, hearing aid, speech, and language services at sections [3.1-A\(11\)](#), [3.1-B\(11\)](#), [supplement 2 to attachments 3.1-A and 3.1-B\(11\)\(a\) and \(b\)](#) and reimbursement at [4.19-B\(11\)](#). Attachment [3.1-L](#) addresses benefits for the adult expansion population under the alternative benefits plan.



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CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Speech and Audiology Services		October 1, 2015

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. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.