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109.01 PURPOSE

The purpose of this rule is to provide medically necessary speech-language pathology and audiology services to MaineCare members who are adults (age twenty-one (21) and over) with rehabilitation potential or to those who have demonstrated medical necessity for speech therapy to avoid a significant deterioration in ability to communicate orally/visually, safely swallow or masticate that would result in an extended length in stay or placement in an institutional or hospital setting, and medically necessary speech-language pathology and audiology services to MaineCare members who are under age twenty-one (21).

Effective 12/01/11

109.02 DEFINITIONS

109.02-1 **Audiology Services** means those services requiring the application of theories, principles and procedures related to hearing and hearing disorders for the purpose of assessment and treatment.

109.02-2 **Augmentative and Alternative Communication Devices (AACD)** are electronic or non-electronic aids, devices, or systems and related components, accessories and supplies that assist in overcoming or ameliorating the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities.

109.02-3 **Augmentative and Alternative Communication Services (AACS)** are services provided to assist the individual in meeting the full range of his/her communication needs. The goal of AACS is to overcome or ameliorate the communication limitations that preclude or interfere with meaningful participation in current and projected daily activities.

109.02-4 **Hearing Aid Services**: Refer to Chapter II, Section 35, Hearing Aids and Services.

109.02-5 **Practitioner of the Healing Arts**: physicians and all others registered or licensed in the healing arts, including, but not limited to, nurse practitioners, podiatrists, optometrists, chiropractors, physical therapists, occupational therapists, speech therapists, dentists, psychologists and physicians' assistants.

109.02-6 **Rehabilitation Potential** is a documented expectation by the member's physician or PCP (Primary Care Provider for members receiving MaineCare Primary Care Case Management Services) that the member's condition will improve significantly in a reasonable predictable period of time as a result of the prescribed treatment plan. The physician or PCP's documentation of rehabilitation potential must include the reasons used to support the physician or PCP's expectation.

109.02 **DEFINITIONS** (Cont.)

109.02-8 **Speech and Hearing Agency** is a facility that offers, at a minimum, both speech-language pathology services and audiology services by qualified professional staff who are employees of the speech and hearing agency. Contracted staff are not considered employees.

109.02-9 **Speech-Language Pathology Services** are those services requiring the application of theories, principles and procedures related to the development and disorders of speech, voice, language, and oral pharyngeal and related functions, for purposes of assessment and treatment.

109.03 **ELIGIBILITY FOR CARE**

Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive. It is the responsibility of the provider to verify a member's eligibility for MaineCare, as described in Chapter I, prior to providing services.

109.04 **SPECIFIC ELIGIBILITY FOR CARE**

Services for members of all ages must be medically necessary and ordered by a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice. The Department or its authorized agent has the right to perform medical eligibility determination and/or utilization review to determine if services are medically necessary.

Effective 12/01/11 | Adult members (age twenty-one (21) and over) must have an initial evaluation by a physician or PCP documenting that the member has experienced a significant decline in his/her ability to communicate orally/visually, safely swallow or masticate, and that the member has rehabilitation potential; or that the member may suffer a significant deterioration in ability to communicate orally/visually, safely swallow or masticate that would result in an extended length in stay or placement in an institutional or hospital setting. This requirement will not apply to members with Medicare coverage or other third party health insurance until the coverage for speech therapy services by the other payer has been exhausted.

Effective 12/01/11 |

109.05 **DURATION OF CARE**

A. Each Title XIX and XXI member is eligible for as many covered services as are medically necessary as determined by the Department of Health & Human

109.05 **DURATION OF CARE** (Cont.)

Services. The Department reserves the right to request additional information to determine medical necessity; and

B. Members aged twenty-one (21) and older, who receive speech therapy services, must obtain a re-evaluation of their progress in speech therapy by a speech-language pathologist every six (6) months. The report of the speech-language pathologist's progress and prognosis for improved speech, oral/visual communication, swallowing or chewing functioning must be sent to a physician or PCP, who must in turn, determine if the member meets the criteria described in Section 109.04, Specific Eligibility for Care. Services will be covered only as long as the member meets the eligibility requirements in 109.04.

Effective 12/01/11

109.06 **SETTING**

MaineCare will reimburse speech and hearing services when provided in appropriate settings. Approved settings for these services are the practitioners' office, speech and hearing agencies, members' homes, and schools for members under age 21.

Services may be provided in an alternative setting at the practitioner's discretion when the following conditions are met:

1. The services are medically necessary.

2. The setting is conducive to the services being provided.

For speech and hearing services provided in a nursing facility or an ICF-MR by a speech-language pathologist or audiologist, refer to Chapter II, Section 67, Nursing Facility Services, or Section 50, ICF-MR Services.

109.07 **COVERED SERVICES**

A covered service is a service for which the member is eligible and payment can be made by the Department. All covered services provided under this Section must be ordered or requested in writing by a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice. Covered services are also limited to the following:

109.07-1 **Covered Services for All Members**

The following services are covered for all members:

109.07 **COVERED SERVICES**(continued)

A. **Speech, Voice and Language Evaluation, Diagnosis and Plan of Care by Speech-Language Pathologist**

A direct encounter between a licensed speech-language pathologist and the member to determine the status of both receptive and expressive communication skills.

B. **Speech, Voice and Language Therapy and/or Aural Rehabilitation, Individual.**

The process of producing behavioral change in the member with a communication disorder involving a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

C. **Speech, Voice and Language Therapy and/or Aural Rehabilitation, Group.**

The process of producing behavioral change in the member with a communication disorder involving other than a one-to-one relationship by a licensed speech-language pathologist or a registered speech-language pathology assistant and following a plan of care.

D. **Speech and Language Periodic Re-Evaluation**

A direct encounter between member and speech-language pathologist to determine current status with periodicity determined by plan of care. At minimum, re-evaluations will occur and plans shall be updated within six (6) months of the date of the plan of care.

E. **Speech Pathology Diagnostic Services at Physician or PCP's Request**

Specialty testing by speech-language-pathologist to assist in diagnosis and development of a medical plan of care. Report will include speech-language pathologist's recommendations. Currently acceptable medical tests and procedures are to be utilized as medically necessary.

F. **Hearing Screening by a Speech-Language Pathologist**

Pure tone air conduction testing by a speech-language pathologist as part of a hearing screening program.

G. **Speech, Voice and/or Language Screening**

Speech, voice and/or language screening performed by a licensed speech-language pathologist or a registered speech-language pathology assistant as part of screening.

109.07 **COVERED SERVICES**(continued)

H. **Augmentative and Alternative Communication Evaluation Services**

The scope of augmentative and alternative communication evaluation services including: diagnostic, screening, preventive, and corrective services provided by a licensed speech-language pathologist or, as appropriate, a registered speech-language pathology assistant. Specific activities include: evaluation for, recommendations of, design, set-up, customization, reprogramming, maintenance, and training related to the use of an AACD. Refer to Chapter II, Section 60, Durable Medical Equipment, of the MaineCare Benefits Manual for criteria for augmentative communication devices.

I. **Therapeutic Adaptations and Set-Up for Assistive/Adaptive Equipment**

This shall include customizing the operational characteristics of an AACD in order to meet the needs of the individual member and to maximize the use and effectiveness of the device.

This service shall be performed by a licensed speech-language pathologist who is familiar and has experience with augmentative communication devices.

J. **Reprogramming**

This shall include any necessary reprogramming of AACD equipment when performed by a licensed speech-language pathologist or registered speech-language pathology assistant who is familiar and has experience with augmentative communication devices.

K. **Audiologic Evaluation, Diagnosis and Plan of Care, by Audiologist**

A direct encounter between a member and an audiologist to determine the member's hearing status.

L. **Audiologic Evaluation for Persons Difficult to Test**

Based on a written plan of care serial evaluation for persons difficult to test in order to obtain reliable audiologic information necessary for case management.

M. **Audiologic Evaluation for Site of Lesion**

A direct encounter between a member and an audiologist which determines site of lesion; this may include, but is not limited to, the following tests: pure tone air, pure tone bone, speech audiometry,

109.07 **COVERED SERVICES** (continued)

Bekesy, tonedecay, short increment sensitivity index (SISI), impedance, alternate binaural loudness balance tests (ABLB).

N. **Audiologic Evaluation as a Result of Change in Hearing Status Because of Disease, or Trauma**

Audiologic evaluation necessitated by an observed or suspected change in a member's hearing status because of disease or injury, on referral from a physician or PCP.

O. **Audiologic Diagnostic Services at Physician or PCP's Request**

Specialty testing performed by an audiologist to assist in diagnosis and developing a medical plan of care. The report shall include audiologist's recommendations.

P. **Aural or Language Rehabilitation (including speech reading), Individual, by Audiologist**

The process of producing behavioral change in the member presenting communication disorders related to auditory function, involving a one-to-one relationship, and following a plan of care. This includes cochlear implant follow-up aural rehabilitation services.

Q. **Aural or Language Rehabilitation (including speech reading), Group, by Audiologist**

The process of producing behavioral change in the member presenting a communication disorder related to auditory function involving other than a one-to-one relationship and following a plan of care.

NOTE: "Group" is defined as two to four individuals with one clinician. When services are provided, a brief notation must be made for each individual in his/her medical record.

109.07-2 **Covered Services for Members under the Age of Twenty-One (21)**

Coverage of the following services is limited to members under the age of twenty–one (21):

A. **Hearing Aid Evaluation and Related Procedures, by Audiologist**

Demonstrating a hearing aid; the process of familiarizing a member with the basic features of a hearing aid by providing the opportunity to experience hearing with a hearing aid, and comparing hearing performance with and without amplification as part of a program of rehabilitation.

109.07 **COVERED SERVICES** (continued)

Coverage requires an audiologist's report, which includes recommendations for amplification and data to support the recommendations.

If a hearing evaluation demonstrates the need for a hearing aid, procedures for purchase of hearing aid should be followed. Refer to the MaineCare Benefits Manual, Chapters II and III, Section 35, Hearing

Aids and Services, for requirements regarding coverage for the purchase of a hearing aid.

B. **Hearing and/or Hearing Aid Periodic Recheck**

A direct encounter between the member and the audiologist to determine current hearing and/or hearing aid status with periodicity of return outlined in plan of care.

C. **Hearing Screening for Children up to Age Five (5) by an Audiologist**

D. **Ear Molds**

109.08 **LIMITATIONS**

109.08-1 **Audiology Evaluation**

If such an evaluation has already been performed by another audiologist within the previous four (4) months, prior authorization (PA) by the Department is required. Refer to Section 109.09-5, below, for procedure to request PA.

109.08-2 **Adult Speech-Language Pathology Services**

The member must also receive an initial evaluation by a speech-language pathologist that supports the physician or PCP's determination that the member meets the eligibility criteria described in Section 109.04, Specific Eligibility for Care. If speech-language pathology services are to be continued beyond a period of six (6) months, a re-evaluation by a speech-language pathologist must be completed every sixth month from the initial determination of rehabilitation potential, in order to determine that eligibility continues to exist. A report of the results of the speech-language pathologist's six-month re-evaluation must be sent to the member's physician or PCP, who will use that information to decide if eligibility continues to exist. If the physician or PCP agrees in writing that eligibility continues to exist, the member may continue to receive speech-language pathology services for an additional six (6) month period.

109.09 POLICIES AND PROCEDURES

109.09-1 Records

The provider will maintain an individual record for each member eligible for MaineCare reimbursement, including but not limited to:

A. Name, birthdate, MaineCare ID Number.

B. Referral from a practitioner of the healing arts as allowed by the respective licensing authority and his or her scope of practice, made in writing or by telephone prior to the delivery of service. Written referral confirming a telephone referral must be included in the record within thirty (30) days of the original order.

C. Pertinent medical information, as available, regarding the member's condition.

D. Appropriate hearing and/or speech-language evaluation and diagnosis.

E. A plan of care which includes identified problems, treatment in relation to the problems, and obtainable goals. This plan shall be updated in relation to the member's progress in reaching the goals.

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F. Documentation of each visit, showing the date of service, the service performed, the start time and stop time of the service, indicating the total time spent in delivering the service, and the signature of the individual performing the service.

G. Progress notes written regularly (at least quarterly), which state the progress which the member has made in relation to the plan of care.

H. A discharge summary with a copy sent to the referring practitioner of the healing arts.

I. Copies of prior authorization or any other pertinent information concerning the member.

Members' records will be kept current and available to the Department as documentation of services included on invoices.

109.09-2 Audiology Reports and Plan of Care

The report of hearing evaluation or specific audiology procedures will include a plan of care based on audiologic and other data obtained. The plan of care is a prerequisite to aural rehabilitation and speech-language therapy, and should include but not be limited to: Diagnosis with severity rating, short and long-term goals(s) and objectives, method of evaluating member change, estimated

109.09 **POLICIES AND PROCEDURES** (continued)

time to achieve goal(s) and objectives, frequency and duration of therapy contacts, and periodicity of review.

109.09-3 **Qualified Professional Staff**

A. A speech-language pathologist must hold a valid license from the State or Province in which the services are provided in order to receive reimbursement.

B. Audiologists must hold a valid license for the State or Province in which the services are provided in order to receive reimbursement.

C. A speech-language pathology assistant must be registered as a speech-language pathology assistant by the Maine Board of Examiners on Speech-Language Pathology and Audiology, as documented by written evidence from such Board, or be registered in accordance with the licensure of the State or Province in which services are provided. A speech-language pathology assistant must be supervised by a licensed speech-language pathologist.

D. A speech and language clinician must be a licensed speech-language pathologist.

109.09-4 **Division of Program Integrity**

Members under the age of twenty-one (21) may get the speech and hearing services for which they qualify, and which are covered in the MaineCare Benefits Manual. However, the Department or its authorized agent will review speech and hearing services for children under the age of twenty-one (21) for medical necessity as outlined in Chapter I of this Manual.

See Chapter I of this Manual for additional information on Division of Program Integrity activities.

109.09-5 **Procedure to Request Prior Authorization**

To request prior authorization of adult services, the request must be made in writing to:

Prior Authorization Unit
Division of Health Care management
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011

109.10 REIMBURSEMENT

The maximum amount of payment for services rendered is the lowest of the following:

A. The provider's usual and customary charge,

B. The amount listed in Chapter III, Section 109 of the MaineCare Benefits Manual,

C. The lowest amount allowed by Medicare Part B, when applicable.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing MaineCare.

109.11 COPAYMENTS

109.11-1 Copayment Amount

Effective 12/01/11

A. A copayment will be charged to each MaineCare member receiving speech pathology services, with the exception of those exempt, as specified in the MaineCare Eligibility Manual, such as children. The amount of the copayment shall not exceed $2.00 per day for services provided, according to the following schedule:

MaineCare Payment for Service	Member Copayment
$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 or more	$2.00

B. The member shall be responsible for copayments up to $20.00 per month whether the copayment has been paid or not. After the $20.00 cap has been reached, the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement for covered services.

C. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve his/her liability for a copayment.

109.11 **COPAYMENTS** (Cont.)

D. Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

109.11-2 **Copayment Exemptions and Dispute Resolutions**

See Chapter I of this Manual for information on copayment exemptions and dispute resolutions.

109.12 **BILLING INFORMATION**

Providers must bill in accordance with the Department's "Billing Instructions for the CMS1500 Claim Form."