



Utah Department of  
**Health & Human Services**  
Integrated Healthcare

# Utah Medicaid Provider Manual

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## Speech-Language Pathology and Audiology Services

**Division of Integrated Healthcare**

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## 1 General information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email [dmhfmedicalpolicy@utah.gov](mailto:dmhfmedicalpolicy@utah.gov) if any of the links do not function properly noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to [Section I: General Information](#), Chapter 1, General information.

### 1-1 General policy

Speech-language pathology and audiology services are federally mandated covered benefits for pregnant women and members eligible under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Speech-language and audiology services for eligible Medicaid members, who do not qualify for the pregnant women or EPSDT programs, see the [Utah State Medicaid Plan](#).

Speech-language therapy and/or audiology services must have a physician referral, be pre-authorized (if applicable), and be provided by a speech-language pathologist **Error! Bookmark not defined.** or audiologist, respectively. The total medical care of each speech-language and/or audiology member is under the direction of a physician. The provider reviews the plan of care and the results of treatment as often as the member's condition requires. If in their professional judgment, no progress is shown, the provider is responsible for discontinuing treatment and notifying the physician of treatment discontinuance.

### Medical necessity

For information regarding medical necessity refer to [Section I: General Information](#), Chapter 8-1 Medical necessity.

### Speech-language therapy and audiology services

Speech-language therapy evaluation should consider audiological issues and other physical (organic) conditions restricting proper speech and language development. These must be addressed in a comprehensive treatment plan which includes speech/language therapy. Speech-language therapy without such a plan may be denied until a comprehensive plan is documented and submitted for review.

## 1-2 Fee for service or managed care

This manual provides information regarding Medicaid policy and procedures for fee for service Medicaid members.

For more information about Accountable Care Organizations (ACOs), refer to [Section I: General Information](#), Chapter 2, Health plans.

For more information about Prepaid Mental Health Plans (PMHPs), refer to [Section I: General Information](#), Chapter 2-1.2, Prepaid Mental Health Plans, and the Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual.

A list of ACOs and PMHPs with which Medicaid has a contract to provide health care services is found on the Medicaid website Managed Care: Accountable Care Organizations.

## 1-3 Definitions

Definitions of terms used in other Medicaid programs are available in Section I: General Information of the Utah Medicaid Provider Manual ([Section I: General Information](#)). Definitions specific to this manual are provided below.

The information found in the [Speech-Language Pathology and Audiology Licensing Act, Title 58, Chapter 41](#) may supersede the definitions below.

**Audiologist:** An individual specifically trained and licensed to perform the functions of an audiologist as described in the state of Utah [Speech Pathology and Audiology Licensing Act Title 58, Chapter 41](#).

**Audiology aide:** An individual who meets the minimum qualifications as described in the state of Utah [Speech Pathology and Audiology Licensing Act Title 58, Chapter 41](#).

**Direct supervision/immediate supervision:** The supervising licensee is present and available for face-to-face communication with the person being supervised when and where services are being provided.

**Provider:** Speech-language pathologist or audiologist who is a Medicaid provider.

**Speech-language pathologist or speech therapist:**

An individual specifically trained and licensed to perform the functions of a speech-language pathologist as described in the state of Utah [Speech Pathology and Audiology Licensing Act Title 58, Chapter 41](#).

**Speech-language pathology aide:**

An individual who meets the minimum qualifications as described in the state of Utah [Speech Pathology and Audiology Licensing Act Title 58, Chapter 41](#).

## 2 Provider participation requirements

Refer to [Section I: General Information](#), Chapter 3, Provider participation and requirements.

## 3 Member eligibility

Refer to [Section I: General Information](#), Chapter 6, Member eligibility, for information about how to verify a member's eligibility, third party liability, ancillary providers, and member identity protection requirements. Medicaid members who are not enrolled in a managed care plan may receive services from any provider who accepts Medicaid and is an enrolled Utah Medicaid provider.

## 4 Program coverage

### Procedure codes

Procedure codes, with accompanying criteria and limitations, are now found on the [Coverage and Reimbursement Code Lookup](#).

### 4-1 Covered services

Information regarding speech-language pathology and audiology services for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible Medicaid members see the [EPSDT Services Manual](#).

#### **4-1.1 Speech-language**

##### **Overview**

Speech pathology services include evaluation, diagnosis and therapy services. Speech pathology services are provided to treat disorders related to traumatic brain injuries, cerebrovascular accidents, and disabilities which qualify members to receive speech-generating devices and to treat swallowing dysfunction.

##### **Plan of care required**

A written plan of care established by the speech-language pathologist is required. The plan of care must include:

1. Member information and history
2. Current medical findings
3. Diagnosis
4. Previous treatment (if applicable)
5. Planned treatment
6. Anticipated goals
7. The type, amount, frequency and duration of the services to be rendered

##### **Speech evaluation**

All eligible Medicaid members are allowed one speech evaluation per year.

##### **Speech augmentative communication devices, voice prosthetics, and voice amplifiers**

Information regarding specific codes can be found on the [Coverage and Reimbursement Code Lookup](#).

##### **Covered speech-language services for pregnant members**

Medicaid policy allows:

1. Diagnostic treatment for purposes of evaluation in instances where definitive examinations and tests are not possible to administer because of the condition of the member.
2. Fifteen (15) annual visits.

3. Initiating treatment without delay, where an evaluation indicates the need for immediate service.

### **Non-covered speech-language services for pregnant members**

The following services are not Medicaid benefits, including treatment for:

1. Social, education, or developmental needs.
2. Members who have stable, chronic conditions cannot benefit from communication services.
3. Members with no documented evidence of capability or measurable improvement.
4. Residents of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) (included in the per diem resident rate).
5. Voice anomalies such as pitch, tone, quality, or rhythm, except when due to accident, illness, birth defect, or injury.
6. Non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board or other procedures that may be carried out effectively by the member, family, or care givers.

### **Limitations**

Speech-language services are available for:

1. A diagnosis of cerebral vascular accident (CVA). Treatment must begin within 90 days of the incident.
2. A diagnosis of traumatic brain injury. Treatment must begin within 18 months of the injury.
3. Use of a speech generating device.
4. Treatment for swallowing dysfunction.

Speech therapy for cognitive purposes must be ordered by a physician and must include a plan of care. Speech therapy for cognitive disorders should typically begin after speech therapy for dysphagia and motor function speech issues have been addressed. Speech therapy for cognitive purposes is limited to 15 visits per 12-month period.

Speech therapy for the use of a speech generating device is limited to 8 visits per 12-month period.

Treatment for swallowing dysfunction and/or oral function is limited to 10 per 180-day period.

#### **4-1.2 Audiology services**

Audiology services include preventive, screening, evaluation, and diagnostic services.

##### **Pregnant members**

Audiology services include preventive care, screening, evaluation, diagnostic testing, hearing aid evaluation, and prescription for a hearing aid, ear mold services, fitting, orientation, and follow-up. A hearing aid battery provision is included in these services. Audiologic habilitation includes, but is not limited to speech, hearing, and gestural communication.

Medicaid reimburses two primary services and one subsequent service for Medicaid members: a diagnostic examination, an assessment for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also reimburses repairs on hearing aids.

##### **Examination and assessment**

Diagnostic audiology evaluations require a written physician's order and include procedures which may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis as ordered by the physician.

For specific code coverage refer to the [Coverage and Reimbursement Code Lookup](#).

If a recommendation for a hearing aid assessment is made, a written physician's referral or request is required. If subsequent hearing testing shows a change in the hearing thresholds or the need for a new hearing aid, then



medical clearance must be obtained before proceeding with the hearing aid refitting.

The purpose of the physician's medical clearance is to determine if the change requires medical intervention; if not then a hearing aid assessment may be performed with a referral. The hearing aid assessment, to determine candidacy for amplification, must include the following: pure-tone air conduction and bone conduction thresholds; speech reception thresholds and speech discrimination scores for each ear; most comfortable loudness (MCLs) and uncomfortable loudness (UCLs); diagnosis as to the type of hearing loss for each ear (i.e. conductive, sensorineural, or mixed); and the pure-tone average (PTA) loss for 500 Hz, 1000 Hz, and 2000 Hz in each ear.

### **Hearing aids**

Hearing aids require prior authorization (see 6-2 Hearing aids). The hearing aid may be provided by an audiologist or by a provider of hearing aid supplies. All services, including conformity evaluation and initial ear molds, are included in each rate to cover a period of 12 months.

### **Limitations**

1. Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
2. The initial ear mold, fitting of the hearing aid on the member, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately. The global rate covers a period of 12 months.
3. If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within the 60 days allowed by retailers. No rental may be charged.
4. The provider must accept the return of a new hearing aid within 60 days if the physician or audiologist determines that the hearing aid does not meet specifications.

5. Services requested for members who reside in an ICF/ID facility are the responsibility of the facility under "active treatment" regulation. Exception: This does not include the provision of the hearing aid appliance which may be billed separately to Medicaid.
6. The physician's statement must be retained on file by the provider of the hearing aid for a period of 3 years.
7. Hearing aids may be replaced every 5 years when medically appropriate. Exceptions may be made for unusual circumstances, e.g., accident, surgery, or disease.

### **Assistive listening device**

Assistive listening devices require prior authorization. The hearing loss criteria are the same as that for hearing aids. This device can be provided in lieu of a hearing aid for members who are not capable of adjusting to a hearing aid. If the member meets the hearing loss criteria, the audiologist shall look at various facts including the member's ability to care for hearing aids, whether the member will wear the hearing aid, whether the member desires a hearing aid, and what are the expected results, in order to determine whether a hearing aid or an assistive listening device would be the most appropriate item, to meet the hearing needs of the member.

### **4-1.3 Hearing aid replacement, repair, and rental replacement**

Hearing aid replacement is authorized when medically necessary at an interval of 3 years for EPSDT-eligible beneficiaries. When requesting a replacement hearing aid, a new medical examination, referral letter, and audiology evaluation is required. Documentation showing the Manufacturer Suggested Retail Price (MSRP) must be submitted with the prior authorization request.

#### **Repair**

1. Hearing aid repairs and related services do not require prior authorization.
2. Repairs over \$15 must be itemized. Medicaid will only reimburse the actual cost of the parts.

3. Medicaid reimburses using code V5014 for hearing aid repairs. If the repair is sent out of a vendor's facility for repair, the vendor will be reimbursed for the manufacturer's invoice plus an additional \$15. When billing, attach a copy of the manufacturer's original invoice to the request. If the repair is completed by the vendor directly, the vendor will be reimbursed for the vendor's invoice which must include the cost for time and parts, plus an additional \$15.
4. Hearing aid repairs are only available to EPSDT-eligible members and pregnant women.

### **Rental**

Prior authorization is required for hearing aid rental. If a hearing aid must be sent away for repair Medicaid will pay for a rental hearing aid if a member requires a "loaner" hearing aid. This service is not to exceed 2 months.

## 5 Non-covered services and limitations

For further information and additional non-covered services and limitations refer to the [Coverage and Reimbursement Code Lookup](#).

## 6 Prior authorization

For information regarding prior authorization, see [Section I: General Information](#), Chapter 10, Prior authorization. Additional resources and information may be found on the [Utah Medicaid Prior Authorization](#) website.

For information on codes requiring prior authorization, manual review, or non-covered status, refer to the [Coverage and Reimbursement Code Lookup](#).

### **6-1 Speech-language pathology**

Some therapy sessions require prior authorization. Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization before providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

A prior authorization request includes a [Request for Prior Authorization form](#) (PA request) and a plan of care for the member or a document outlining all of the following:

1. Diagnosis and severity of the condition
2. Prognosis for progress
3. Objectives of the specific treatment
4. Detail of the method(s) of treatment
5. Frequency and length of treatment sessions and duration of the program

A prior authorization will be given for a maximum of a 6-month treatment period.

### **6-1.1 Extended service requests**

A new prior authorization request must be submitted for an extended service request. The request must include the same elements as the first PA request, as well as a:

1. New plan of treatment
2. Progress report on the previous treatment objectives
3. Medical evaluation from both the clinician and the physician
4. The evaluation includes supplemental data such as:
  - a) Post-treatment progress made
  - b) Family problems that may hinder progress
  - c) Expected treatment termination date

### **6-2 Hearing aids**

To receive prior authorization, all the following are required for pregnant members:

1. A physician's order stating the member has been medically cleared for hearing aid use. Retained in the member's file.
2. The results of a comprehensive audiometric exam performed by the audiologist to identify the kind of hearing loss (i.e. conductive loss, sensorineural loss, or mixed loss), speech testing to include the speech reception thresholds and speech discrimination scores, and the pure-tone average.
3. The kind of hearing loss, conductive loss, sensory-neuro loss, or mixed.
4. The type of hearing aid requested; monaural or binaural, and the respective code.

5. An audiogram or form that reports the hearing evaluation test or decibel loss will include for both right and left ears: Hearing thresholds at 250, 500, 1000, 2000, 4000 and 8000 Hz.
6. Final unaltered purchase invoice of the hearing aid(s) requested.

Additional information for pregnant members:

1. If the hearing test shows an average hearing loss in one ear of 35 dB or greater, based on the standard PTA (500, 1000, 2000 hertz) for that ear, a monaural aid may be authorized.
2. Binaural hearing aids are reimbursed only under one of two circumstances:
  - a) Must be verified with an average hearing loss of 30 dBs based on the standard PTA for both ears.
  - b) The member is blind, and a monaural hearing aid may be contraindicated.

Note: A binaural hearing aid is one unit for billing purposes.

## 7 Billing

Refer to [Section I: General Information](#), Chapter 11, Billing Medicaid, for more information about billing instructions. For further information refer to the [Coverage and Reimbursement Code Lookup](#).

## 8 Resource table

The following table is designed to provide hyperlinks to relevant documents, forms, and information to be used in conjunction with this provider manual.

<b>For information regarding:</b>	
<a href="#">Administrative Rules</a>	<ul style="list-style-type: none"> <li>• <a href="#">Utah Administrative Code Table of Contents</a></li> <li>• <a href="#">Medicaid Policy for Experimental, Investigational or Unproven Medical Practices. R414-1A.</a></li> <li>• <a href="#">General Rule of the Division of Occupational and Professional Licensing. R156-1.</a></li> </ul>

	<ul style="list-style-type: none"> <li>• <a href="#">Global Definitions of Levels of Supervision. R156-1-102a.</a></li> <li>• <a href="#">Speech-Language Pathology and Audiology Licensing Act Rule. R 156-41.</a></li> <li>• <a href="#">Services Available. R414-1-6(q).</a></li> </ul>
<p>General information including:</p> <ul style="list-style-type: none"> <li>• Billing</li> <li>• Fee for service and managed care</li> <li>• Member eligibility</li> <li>• Prior authorization</li> <li>• Provider participation</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Section I: General Information</a></li> <li>• <a href="#">Claims</a></li> <li>• <a href="#">Managed Care: Accountable Care Organizations</a></li> <li>• <a href="#">Utah Medicaid Prior Authorization</a></li> </ul> <p>Administrative Rules</p> <ul style="list-style-type: none"> <li>• <a href="#">Eligibility Requirements. R414-302.</a></li> <li>• <a href="#">Medicaid General Provisions. R414-301.</a></li> <li>• <a href="#">Program Benefits and Date of Eligibility. R414-306.</a></li> <li>• <a href="#">Utah Medicaid Program. R414-1.</a></li> </ul>
<p>Information including:</p> <ul style="list-style-type: none"> <li>• Coverage and reimbursement resources</li> <li>• National correct coding initiative</li> <li>• Procedure codes with accompanying criteria and limitations</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Office of Coverage and Reimbursement Policy</a></li> <li>• <a href="#">Coverage and Reimbursement Code Lookup</a></li> <li>• <a href="#">The National Correct Coding Initiative in Medicaid</a></li> </ul>
<p>Information including policy and rule updates:</p> <ul style="list-style-type: none"> <li>• Medicaid Information Bulletins (Issued bimonthly)</li> <li>• Medicaid Provider Manuals</li> <li>• Utah State Bulletin (Issued on the 1<sup>st</sup> and 15<sup>th</sup> of each month)</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Official Publications</a></li> <li>• <a href="#">Utah State Bulletin</a></li> </ul>
<p>Medicaid forms including:</p> <ul style="list-style-type: none"> <li>• Hearing Request</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Forms</a></li> </ul>

<ul style="list-style-type: none"> <li>• PA Request</li> </ul>	
Modifiers	<ul style="list-style-type: none"> <li>• <a href="#">Section I: General Information</a></li> </ul>
Patient (Member) Eligibility Lookup Tool	<ul style="list-style-type: none"> <li>• <a href="#">Eligibility Lookup Tool</a></li> </ul>
Pharmacy	<ul style="list-style-type: none"> <li>• <a href="#">Drug Criteria Limits</a></li> <li>• <a href="#">Generic Prescriptions List</a></li> <li>• <a href="#">ICD-10 Reference Chart Pharmacy</a></li> <li>• <a href="#">Medicaid Pharmacy Program</a></li> <li>• <a href="#">OTC Drug List</a></li> <li>• <a href="#">Pharmacy Provider Manual</a></li> <li>• <a href="#">Medicaid Policy for Pharmacy Program. R414-60.</a></li> </ul>
Primary Care Network plan services	<ul style="list-style-type: none"> <li>• <a href="#">Primary Care Network (PCN) Provider Manual</a></li> <li>• <a href="#">Medicaid Primary Care Network Services. R414-100.</a></li> </ul>
Prior authorization	<ul style="list-style-type: none"> <li>• <a href="#">Prior Authorization Form</a></li> <li>• <a href="#">Utah Medicaid Prior Authorization</a></li> </ul>
Provider portal access	<ul style="list-style-type: none"> <li>• <a href="#">Provider Portal Access</a></li> </ul>
Provider training	<ul style="list-style-type: none"> <li>• <a href="#">Utah Medicaid Provider Training</a></li> </ul>
Other	<ul style="list-style-type: none"> <li>• <a href="#">Baby Your Baby</a></li> <li>• <a href="#">CDC Vaccines for Children Program.</a></li> <li>• <a href="#">Dental, Oral Maxillofacial, And Orthodontia Provider Manual</a></li> <li>• <a href="#">Hospice Provider Manual</a></li> <li>• <a href="#">Medicaid.gov</a></li> <li>• <a href="#">Podiatric Services Provider Manual</a></li> <li>• <a href="#">Rehabilitative Mental Health and Substance Use Disorder Services Provider Manual</a></li> <li>• <a href="#">RHC-FQHC Provider Manual</a></li> <li>• <a href="#">Vision Care Services Provider Manual</a></li> <li>• <a href="#">Women, Infants and Children (WIC)</a></li> </ul>
References including: <ul style="list-style-type: none"> <li>• Social Security Act</li> <li>• Code of Federal Regulations</li> <li>• Utah Code</li> </ul>	<ul style="list-style-type: none"> <li>• 42 CFR 440.110(c)</li> <li>• 42 CFR 485.711(b)</li> <li>• Social Security Act 1905(a)</li> <li>• Social Security Act 1861 (r)</li> <li>• Utah Annotated Code Title 58</li> </ul>

	<ul style="list-style-type: none"><li>• <a href="#">Utah State Statute Title 26</a></li></ul>
Tobacco cessation resources	<ul style="list-style-type: none"><li>• Utah Tobacco Quit Line (1-800-QUIT-NOW)</li><li>• <a href="#">Way to Quit</a></li></ul>