

BEHAVIOR SERVICES

Behavior Analyst and Specialist Services – a unit of service is 15 minutes.

There are three service categories

- Behavior Analyst Assessment

- Behavior Analyst Plan Development and Training Staff on the Plan

- Behavior Analyst Presentation at Meetings

Behavior Analyst Assessment –

This is a hard cap. “Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment with a maximum of 2 assessments per year.” To monitor the usage and not to exceed the cap, this needs to be tracked based upon a WAIVER year which is currently the calendar year (January 1-December 31).

This is limited to 32 quarter hour units per assessment with a maximum of 2 assessments per recipient per Waiver year (January 1-December 31). The annual limit applies regardless of provider change. There are different service codes for the first and second assessment. Also, remember that the ISP year does not determine the tracking of the hard cap. It is determined by the Waiver year.

This service is not to be used for putting together materials for the yearly ISP cycle. Assessment is not your annual service evaluation. Clinical Service Monthly Reviews should be used to summarize progress and to request and justify services for the next ISP cycle. The behavior assessment code cannot be used to bill for this summary.

There are different service codes for the first and second assessment so individual tracking is possible.

Behavior Analyst Assessment Two

This is a hard cap. “Reimbursement for behavior assessments shall be limited to a maximum of 8 hours per assessment with a maximum of 2 assessments per year.” To monitor the usage and not to exceed the cap, this needs to be tracked based upon a Waiver year (currently January 1-December 31). **There are different service codes for the first and second assessment**

It is important to emphasize that any request for behavior assessment must be justified based upon medical necessity. The second assessment is to be used rarely, and only if behavior deterioration or changes in the types of behavior present additional barriers or health and safety risks. An example might be if you are treating elopement behavior with a BSP and the person begins to exhibit serious levels of pica behavior (e.g., ingesting metal items) you may need to

consider carrying out additional assessment. An urgent need has emerged which represents a change in the type of behavior and a health and safety risk.

This service is not to be used for putting together materials for the yearly ISP cycle. Assessment is not your annual service evaluation. Your Clinical Service Monthly Reviews should be used to summarize progress and to request and justify services for the next ISP cycle. The behavior assessment code cannot be used to bill for this summary.

Behavior Analyst Plan Development and Training Staff on the Plan -

This is a hard cap. “Reimbursement for behavior plan development resulting from such a behavior assessment and the training of staff on the plan during the first 30 days following its approval for use shall be limited to a maximum of 6 hours.” To monitor the usage and not to exceed the cap, this needs to be tracked based upon a Waiver year (Currently January 1-December 31).

This is limited to a maximum of 24 quarter hour units for each related BA Assessment. These also are limited to a maximum of 2 occurrences per Waiver year regardless of the provider.

The billing unit used represents a 15 minute interval. The service must be authorized.

If some immediate written directions need to be given to staff prior to the plan completion due to a crisis issue, this billing code is the only way to bill. Thus, it is **not** appropriate to request Behavior Services Other to accommodate this immediate need.

Behavior Analyst Presentation at Meetings –

This is a hard cap. As per the Medicaid Waiver definition this service is: “Presentation of enrollee behavior information at human rights committee meetings, behavior support committee meetings, and enrollee planning meetings. To monitor the usage and not to exceed the cap, this needs to be tracked based upon a Waiver year (currently January 1-December 31).

The limitation is 20 quarter hour units per provider, per enrollee per Waiver year. If there is a provider change, up to an additional 20 units could be approved.

It is not possible to always predict when enrollee planning meetings, behavior support committee meetings, or human rights committee meetings will be needed. These meetings should take place only as needed. The units should be only used as needed. The justification and request for the 20 units may be done at the beginning of the ISP cycle. “Projected dates” or “guessed at dates” are not

necessary. The provider shall bill for meetings as they take place. The provider must ensure that billing over the 20 units in a Waiver year does not occur.

Behavior Analyst Services, Other -

This is the face to face service that is provided as needed following the implementation of the treatment plan. This service is considered if you need to provide services after the plan has been implemented.

This cost center can **not** be used to bill for assessment, behavior plan development and training of staff on the plan, or presentation at meetings. Note also that the behavior service of “behavior plan development and staff training” specifically covers any needed training on the plan that occurs over the 30 days immediately following the plan’s approval.

This cost center may be used for face to face services during the treatment phase, and “consultations with the enrollee’s treating physician or psychiatrist during an office visit when the enrollee is **present.**” The consultation with the treating physician or psychiatrist shall include review of relevant behavioral data.

The unit of service is 15 minutes.

Behavior Specialist Services

The unit of service is 15 minutes.

Other Information

To bill for **any** of the Behavior Services, the specific service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8 minutes cannot be billed. There can be no accumulation of partial units from previous days or partial units from different services when billing. Reimbursement can **not** be made for travel time to meetings or for telephone consultations.

NURSING SERVICES – RN and LPN

A unit of service is 15 minutes.

State and Waiver Nursing Services must be physician, physician assistant, or nurse practitioner ordered and falls within the scope of the Nurse Practice Act. They can not replace any services available through TennCare or any other funding source. Nursing services must be provided face to face. The person must require a specifically identified skilled nursing service, excluding nursing assessment and oversight. Nursing services are not intended to replace services that can be appropriately provided by unlicensed direct

care staff. Individuals under age 21 must request these services through EPSDT, not through DIDD funded State or Waiver services.

Those in Medical Residential, which has nursing as a component of the rate, are not eligible for quarter hour nursing.

The combination of all nursing services (LPN + RN) is limited to 48 quarter hour units (12 hours) per day.

To bill for **any** of the Nursing Services, the specific service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8 minutes cannot be billed. There can be no accumulation of partial units from previous days or partial units from different services when billing.

DENTAL SERVICES

The amendment adds anesthesiologists and nurse anesthetists as provider types for dental anesthesia services provided **in a dentist's office**. A dentist may bill the waiver for dental anesthesia services administered in the dentist's office by the dentist or by an employee who is a nurse anesthetist or anesthesiologist. If such dental anesthesia services are administered in the first dentist's office by an oral surgeon, the oral surgeon would be the provider who bills the waiver. The maximum reimbursement rates are specified in the dental addendum of the TennCare Maximum Reimbursement Rate Schedule for the applicable waiver. Anesthesia provided in an ASTC or in a hospital (inpatient or outpatient) cannot be paid for through the Waiver.

Dental services are limited to \$5,000 per year AND \$7,500 per 3 waiver year period.

DAY SERVICES

Day services are limited to 5 days per week and 243 days per Waiver year (currently January thru December). The expectation is that a person who receives Day Services will receive 6 hours of such services for each day billed, unless there is justification and documentation of an exception listed in the waiver service definition. The following summarizes the requirements:

Community Based Day-

To be eligible, Community Based Day must be provided between the hours of 7:30 am and 6 pm and limited to week days Monday thru Friday. The per diem

may be billed if at least 2 hours of services were provided **WHEN** there is documentation that the person was unable to complete the full 6 hours for reasons beyond the control of the provider. Examples would be: sickness of person, behavioral issues, refusal by the person to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the person, individual or family/conservator requested 5 or fewer hours per day on an ongoing basis. Reimbursement cannot be made for periods when natural supports are utilized (i.e., services provided by natural supports are not billable to the waiver).

If an individual receives up to 6 hours of a combination of Community Based and Facility Based services on the same day, the service where the individual spent the majority of the day should be billed.

If an individual receives **more** than 6 hours of a combination of Community Based and Facility Based services on the same day, the service where the individual spent a majority of the **first** 6 hours of services should be billed.

Facility Based day -

To be eligible, Facility Based Day must be provided between the hours of 7:30 am and 6 pm and limited to week days Monday thru Friday. The per diem may be billed if at least 2 hours of services were provided **WHEN** there is documentation that the person was unable to complete the full 6 hours for reasons beyond the control of the provider. Examples would be: sickness of person, behavioral issues, refusal by the person to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the person, individual or family/conservator requested 5 or fewer hours per day on an ongoing basis. Reimbursement cannot be made for periods when natural supports are utilized (i.e., services provided by natural supports are not billable to the waiver).

If an individual receives up to 6 hours of a combination of Community Based and Facility Based services on the same day, the service where the individual spent the majority of the day should be billed.

If an individual receives **more** than 6 hours of a combination of Community Based and Facility Based services on the same day, the service where the individual spent a majority of the **first** 6 hours of services should be billed.

Facility Based Day Services provider can on an exception basis carry the person out of the facility and still receive credit for providing facility-based services. This should not occur daily or weekly but rather as a unique event. At minimum, Facility Based staffing requirements would be in effect.

Supported Employment-

Supported Employment may be provided any day of the week and at any time of the day but is limited to a total of 5 units/days per week. The provider of Supported Employment Day Services reimbursed on a per diem basis must:

1. Have a job coach employed by the Day Services provider on site who is supervising the enrollee; or
2. The Day services provider shall oversee the enrollee's supported employment services including on-site supervisors, shall have a minimum of 3 contacts per week with the enrollee including at least one contact per week at the work site, and shall have a job coach employed by the Day Services provider who is available on call if needed to go to the work site.

To bill for Supported Employment services, a provider must document 6 hours of SE; or 6 hours of a combination SE, CB, and/or FB with minimum of 2 hours being SE. The DAY Service per diem for Supported Employment may be billed if at least 2 hours of services were provided WHEN there is documentation that the person was unable to complete the full 6 hours for reasons beyond the control of the provider. Examples would be: sickness of person, behavioral issues, refusal by the person to continue, weather-related or environmental issues, medical appointments, family/conservator picked up the person, individual or family/conservator requested 5 or fewer hours per day on an ongoing basis.

If an individual receives 6 hours or more of Supported Employment combined with either Community Based or Facility Based services on the same day, Supported Employment should be billed.

RESIDENTIAL SERVICES

Medical residential services –

The Medical Residential Service definition indicates the provider shall be responsible for an appropriate level of services and supports 24 hours per day and shall be responsible for the cost of Day Services needed by the enrollee. The need for Medical Residential to be ordered by the individual's physician, physician assistant, or nurse practitioner, who shall document the medical necessity of the services and specify the nature and frequency of the nursing services, has not changed. The rate includes 24 hour nursing supports and a staffing component for day services. A provider of this service (whether Residential or Supported Living) can not bill for any Day Services or for Nursing Services for an individual receiving the Medical Residential service. The Medical Residential Services provider is responsible for all nursing care and Day Services that the person may require.

Supported Living –

The definition was changed to remove the clause that allowed individuals within a supported living home to “select the Supported Living provider of their choice”.

Clarification was given to reinforce that unless a residence is individually licensed or inspected by a public housing agency using the HUD Section 8 safety checklist, the residence must pass a DIDD home inspection.

Behavioral Respite –

Behavioral Respite is a 24 hour rate and provider is responsible for the cost of any associated Day services.

Restraints shall not be used unless recommended by a human rights committee and unless used in accordance with the approved Individual Support Plan and DIDD requirements.

The limitation for Behavioral Respite is 60 days within a Waiver year. Persons in residential services as well as those not in residential services are eligible for this service.

Transportation costs are included within the Behavioral Respite service.

Respite –

The per diem rate includes any needed day services. The limit remains 30 days during a calendar year. Individuals receiving residential services remain ineligible for this type of respite service.

Respite Sitter –

The unit of service for reimbursement is per 15 minutes. Individuals receiving residential services remain ineligible for this type of respite service.

To bill for Respite Sitter, the specific service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Anything less than 8 minutes cannot be billed. There can be no accumulation of partial units from previous days or partial units from different services when billing.

Personal Assistance –

The unit of service for reimbursement changed is per 15 minutes. To bill for PA, the specific service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8

minutes cannot be billed. There can be no accumulation of partial units from previous days or partial units from different services when billing.

A maximum of 860 units per month may be provided.

Hospital Attendant –

The unit of service for reimbursement is per 15 minutes. To bill for Hospital Attendant, the specific service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Anything less than 8 minutes cannot be billed. There can be no accumulation of partial units from previous days or partial units from different services when billing.

TRANSITION SERVICES

Transitional Case Management –

This applies to Medicaid eligible individuals transitioning out of an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and entering either the Arlington or Statewide Waiver. It allows for waiver billing of “ISC Transition” for up to the last 180 consecutive days of the institutional stay prior to being discharged and enrolled in a HCBS waiver. Person must have been approved for and receiving state funded “ISC Transition”. The date the person leaves the ICF/MR and is enrolled in the waiver shall be the date of service for billing purposes. At this point, funding for ISC Transition (up to 6 months) will be reversed and funding changed to Waiver. The cost plan span will be one day, the first day of Waiver services- the Waiver enrollment day. There are six service codes. One for each of the number of months a person could have been in eligible transition. This does not apply to respite stays.

For example:

If in transition for 1 month before discharge from ICF/MR to Waiver, use Cost Center 6C631 or 6C631Q @ \$232.00.

If in transition for 2 months before discharge from ICF/MR to Waiver, use Cost Center 6C632 or 6C632Q @ \$464.00.

If in transition for 3 months before discharge from ICF/MR to Waiver, use Cost Center 6C633 or 6C633Q @ \$696.00.

If in transition for 4 months before discharge from ICF/MR to Waiver, use Cost Center 6C634 or 6C634Q @ \$928.00.

If in transition for 5 months before discharge from ICF/MR to Waiver, use Cost Center 6C635 or 6C635Q @ \$1,160.00.

If in transition for 6 months before discharge from ICF/MR to Waiver, use Cost Center 6C636 or 6C636Q @ \$1,392.00.

If the individual began the transition process on April 1, 2006 and left the ICF/MR on June 30, going directly into the Waiver, the cost center used would be 6C633. The start and stop dates of the cost plan would be June 30.

Transitional Environmental Accessibility Modifications (included in the waiver service definition of Environmental Accessibility Modifications)–

This service is specific to Environmental Accessibility Modifications made during the last 180 days of a person’s ICF/MR or other institutional setting stay (who has been determined to qualify for HCBS waiver services) prior to being discharged and enrolled in a waiver. It applies to all 3 waivers. The service date for this service will be the Waiver enrollment date. If this has been paid previous to the enroll date with a state cost center, the state cost center will need to be errored out and payment reversed so the appropriate waiver may be billed. The completion date for Waiver services will be the date the person leaves the ICF/MR and is enrolled in the waiver. This will be the billing date. The individual limit is \$15,000 over 3 waiver years for any combination of Transitional and/or other Environmental Accessibility Modifications.

Therapeutic Services

Nutrition –

Assessments

The unit of service for nutrition assessments is per visit. This will be shown as per “day” on the cost plan and in the web based billing application, Provider Claims Processing (PCP). The following stipulations apply:

- For individuals under age 21, EPSDT must be accessed.
- Nutrition assessments are limited to 1 assessment per person, per waiver (calendar year). The “per day” Nutrition assessment reimbursement unit is based on an average of 4 hours (16 units).
- An assessment may last more than 4 hours or less than 4 hours, completed in one day or span multiple days or “visits”, depending on the needs of the individual, however, only one “per day” assessment may be billed.
- The billing calendar should reflect the date the assessment was initiated with the person as the date of service.
- The assessment must still be completed within the authorized time frame on the signed service plan.
- As a part of the assessment, the Nutritionist may utilize some non-face-to-face time to develop the plan of care based on the assessment of the person.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person to complete the assessment must be maintained to support the billing. This includes the contact made to initiate the

assessment and any other face-to-face contacts made to complete the assessment.

- Assessment rates for nutrition are tiered based on the number of miles traveled one way from the town where the agency is based or the town of the nutritionist's home, whichever is closest to where the services are being provided, according to Mapquest.

Services

The unit of service for nutrition services is per visit. This will be shown as per "day" on the cost plan and in the web based billing application, Provider Claims Processing (PCP). The following stipulations apply:

- For individuals under age 21, EPSDT must be accessed
- Nutrition service visits are limited to 1 per person, per provider, per day.
- The "per day" Nutrition service unit is based on 1 and ½ hours.
- Nutrition providers are not limited to spending only 1.5 hours at one time with an individual when providing services.
- A visit to provide services may last more than 1.5 hours or less than 1.5 hours, depending on the needs of the individual; however, only one "per day" service visit may be billed each day.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person must be maintained to support the billing.
- Service rates for Nutrition services are tiered based on the number of miles traveled one way from the town where the agency is based or the town of the nutritionist's home, whichever is closest to where the services are being provided, according to Mapquest.

A maximum of 6 total units of nutrition may be utilized per waiver year. If an assessment is utilized, it is included in the 6 unit annual maximum..

Occupational Therapy Initial Assessment and Plan Development –

Occupational Therapy Initial Assessment and Plan Development is a "per day" unit for reimbursement. This is limited to 1 per person, per month, per provider with a maximum of 3 per person, per calendar year, per provider. In the case of a provider change, there is a remote possibility of 2 assessments in a month by two different providers. The following stipulations apply:

- For individuals under age 21, EPSDT must be accessed.
- An assessment may last more than 4 hours or less than 4 hours, completed in one day or span multiple days or "visits", depending on the needs of the individual, however, only one "per day" assessment may be billed.
- The billing calendar should reflect the date the assessment was initiated with the person as the date of service.
- The assessment must still be completed within the authorized time frame on the signed service plan.

- As a part of the assessment, the Occupational Therapist may now utilize some non-face-to-face time to develop the plan of care based on the assessment of the person.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person to complete the assessment must be maintained to support the billing. This includes the contact made to initiate the assessment and any other face-to-face contacts made to complete the assessment.

The not assessment Occupational Therapy service unit is a quarter hour.

Both the Assessment and Service rates continue to be tiered based on the number of miles traveled one way from the town where the agency is based or the town of the Occupational Therapist's home, whichever is closest to where the services are being provided, according to Mapquest.

Occupational Therapy Initial Assessment and Plan Development for Assistive Technology/Specialized Equipment –

This assessment code has been moved from under the specialized medical equipment, supplies and assistive technology definition. Providers must be separately approved by DIDD to provide and bill for this service. This code applies to Occupational Therapists who have specialized training and expertise in assessing for assistive technology such as seating and positioning (i.e. including mat examinations, simulation, and fittings).

The same limitations that apply for the Occupational Therapy Initial Assessment and Plan Development apply to this assessment code.

Occupational Therapy Service for Assistive Technology/Specialized Equipment –

A non-assessment category exists for Occupational Therapy Service for Assistive Technology/Specialized Equipment. Providers must be separately approved by DIDD to provide and bill for this service. This service code applies to Occupational Therapists who are specifically approved to provide Assistive Technology/Specialized Equipment assessments and it covers training of the person and his/her support staff/family as applicable on the assistive technology.

When billing for this code, the service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8 minutes cannot be billed as a unit. There can be no accumulation of partial units from previous days or partial units from different services when billing.

Orientation and Mobility Training Assessment with Plan Development- Assessment

Orientation and Mobility Training Assessment and Plan Development is a per diem unit for reimbursement. This is limited to 1 per person, per month, per provider with a maximum of 3 per person, per calendar year, per provider. In the case of a provider change, there is a remote possibility of 2 assessments in a month. The following stipulations apply:

- The “per day” Orientation and Mobility Training Assessment unit is based on 4 hours (16 units) of the previous 15 minute unit rate.
- An assessment may last more than 4 hours or less than 4 hours, completed in one day or span multiple days or “visits”, depending on the needs of the individual; however, only one “per day” assessment may be billed.
- The billing calendar should reflect the date the assessment was initiated with the person as the date of service.
- The assessment must still be completed within the authorized time frame on the signed service plan.
- As a part of the assessment, the Orientation and Mobility Specialist may now utilize non-face-to-face time to develop the plan of care based on the assessment of the person.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person to complete the assessment must be maintained to support the billing. This includes the contact made to initiate the assessment and any other face-to-face contacts made to complete the assessment.
- Assessment rates continue to be tiered based on the number of miles traveled one way from the town where the agency is based or the town of the Orientation and Mobility Specialist’s home, whichever is closest to where the services are being provided, according to Mapquest.

Services

For Orientation and Mobility services other than assessment, the annual limit is 208 quarter hour units (52 hours). The following stipulations apply:

- When billing for non-assessment Orientation and Mobility, the service must be pre authorized and the billing calendar must reflect the day the service was provided.
- A unit of service is 15 minutes.
- To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8 minutes cannot be billed. There can be no accumulation of partial units from previous days or partial units from different services when billing.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person must be maintained to support the billing.

- Service rates continue to be tiered based on the number of miles traveled one way from the town where the agency is based or the town of the Orientation and Mobility Specialist's home, whichever is closest to where the services are being provided, according to Mapquest.

Physical Therapy Initial Assessment and Plan Development –

Physical Therapy Initial Assessment and Plan Development is a “per day” unit for reimbursement. This is limited to 1 per person, per month, per provider with a maximum of 3 per person, per calendar year, per provider. In the case of a provider change, there is a remote possibility of 2 assessments in a month by two different providers. The following stipulations apply:

- For individuals under age 21, EPSDT must be accessed.
- An assessment may last more than 4 hours or less than 4 hours, completed in one day or span multiple days or “visits”, depending on the needs of the individual; however, only one “per day” assessment may be billed.
- The billing calendar should reflect the date the assessment was initiated with the person as the date of service.
- The assessment must still be completed within the authorized time frame on the signed service plan.
- As a part of the assessment, the Physical Therapist may now utilize non-face-to-face time to develop the plan of care based on the assessment of the person.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person to complete the assessment must be maintained to support the billing. This includes the contact made to initiate the assessment and any other face-to-face contacts made to complete the assessment.

The Physical Therapy non assessment service unit is a quarter hour.

Both the Assessment and Service rates are tiered based on the number of miles traveled one way from the town where the agency is based or the town of the Physical Therapist's home, whichever is closest to where the services are being provided, according to Mapquest.

Physical Therapy Initial Assessment and Plan Development for Assistive Technology/Specialized Equipment –

This assessment code has been moved from under the specialized medical equipment, supplies and assistive technology definition. Providers must be separately approved by DIDD to provide and bill for this service. This code applies to Physical Therapists who have specialized training and expertise in assessing for assistive technology such as seating and positioning (i.e. including mat examinations, simulation, and fittings).

The same limitations that apply for the Physical Therapy Initial Assessment and Plan Development apply to this assessment code.

Physical Therapy Service for Assistive Technology/Specialized Equipment –

A non-assessment category exists for Physical Therapy Service for Assistive Technology/Specialized Equipment. Providers must be separately approved by DIDD to provide and bill for this service. This service code applies to Physical Therapists who are specifically approved to provide Assistive Technology/Specialized Equipment assessments and it covers training of the person and his/her support staff/family as applicable on the assistive technology.

When billing for this code, the service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8 minutes cannot be billed as a unit. There can be no accumulation of partial units from previous days or partial units from different services when billing.

Speech, Language, and Hearing Services Initial Assessment and Plan Development

Speech, Language, and Hearing Services Initial Assessment and Plan Development is a “per day” unit for reimbursement. This is limited to 1 per person, per month, per provider with a maximum of 3 per person, per calendar year, per provider. In the case of a provider change, there is a remote possibility of 2 assessments in a month by two different providers.

- For individuals under age 21, EPSDT must be accessed.
- An assessment may last more than 4 hours or less than 4 hours, completed in one day or span multiple days or “visits”, depending on the needs of the individual, however, only one “per day” assessment may be billed.
- The billing calendar should reflect the date the assessment was initiated with the person as the date of service.
- The assessment must still be completed within the authorized time frame on the signed service plan.
- As a part of the assessment, the Speech Language Pathologist or Audiologist may utilize non-face-to-face time to develop the plan of care based on the assessment of the person.
- Contact notes, including time-in and time-out, for all face-to-face contacts made with the person to complete the assessment must be maintained to support the billing. This includes the contact made to initiate the assessment and any other face-to-face contacts made to complete the assessment.

Speech, Language, and Hearing Services non assessment is a quarter hour service unit.

Both the Assessment and Service rates continue to be tiered based on the number of miles traveled one way from the town where the agency is based or the town of the Speech Language Pathologist's or Audiologist's home, whichever is closest to where the services are being provided, according to Mapquest.

Speech, Language, and Hearing Services Initial Assessment and Plan Development for Assistive Technology/Specialized Equipment –

This assessment code has been moved from under the specialized medical equipment, supplies and assistive technology definition. Providers must be separately approved by DIDD to provide and bill for this service. This code applies to Speech Language Pathologists who have specialized training and expertise in assessing for assistive technology such as augmentative alternative communication systems.

The same limitations that apply for the Speech, Language, and Hearing Services Initial Assessment apply to this assessment code.

Speech, Language, and Hearing Service for Assistive Technology/Specialized Equipment –

This service applies to Speech Language Pathologists providers who are specifically approved to provide Assistive Technology/Specialized Equipment assessments and it covers training of the person and his/her support staff/family as applicable.

When billing for this code, the service must be pre-authorized and the billing calendar must reflect the day the service was provided. A unit of service is 15 minutes. To determine the number of units for a particular day, divide the number of valid service minutes by 15. If 8 or more minutes remain, that may be rounded up and an additional unit billed. Only whole units can be billed. Anything less than 8 minutes cannot be billed as a unit. There can be no accumulation of partial units from previous days or partial units from different services when billing.