Speech-Language Therapy Services
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ Summit ElderCare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

This payment policy addresses reimbursement for speech-language therapy services, also known as speech-language pathology services provided by speech-language pathologists in private practice and in other outpatient clinical settings such as rehabilitation agencies and hospital outpatient departments. This policy shall remain intact unless a health service agreement indicates otherwise.

- For Fallon Medicare Plus, NaviCare, PACE and Community Care plan members, speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.
    - Speech-language pathology services must be provided by an individual who meets the qualifications for a speech-language pathologist in 42 CFR § 484.115 and only under the conditions specified in 42 CFR § 410.62. Independently practicing speech-language pathologists may be reimbursed directly for speech-language pathology services. Services provided by speech-language pathologists may also be billed by contracted rehabilitation agencies and outpatient departments of hospitals. When speech-language pathology services are billed by physicians or nonphysician practitioners (NPPs), they may be covered under Medicare's "incident to" provision. "Incident to" services are defined as those furnished as an integral, although incidental, part of the physician's or NPPs personal professional services in the course of diagnosis or treatment of an injury or illness.
    - For additional information on incident-to billing, refer to **Speech-language pathology services provided incident to the services of physicians and non-physician practitioners (NPP) for Medicare and Community Care plan members**, under **Reimbursement** below.
- For MassHealth ACO plan members, speech-language therapy services include diagnostic evaluations and therapeutic interventions designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech-language communication and swallowing functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, including congenital anomalies, or injuries.
    - Speech-language therapy services must be provided by or under the supervision of a speech-language pathologist who is currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-Language Pathology and Audiology as a speech-language pathologist. Speech-language pathologists may be reimbursed for their services and for services rendered by a licensed speech-language pathologist assistant

(SLPA) under their supervision, subject to the requirements of 130 CMR 432.404(D) (5) and (6).

- Therapy group practices as described in 130 CMR 432.404(E) may be reimbursed for the services of a speech-language pathologist or SLPAs subject to the supervision requirements of 130 CMR 432.404(D). Supervision of SLPAs must be performed following state regulatory guidance. See **260 CMR 10.00: Use and Supervision of Speech-Language Pathology and Audiology Assistant**. Acute outpatient hospitals may be reimbursed for speech-language pathology services when billed in accordance with 130 CMR 410.451, 410.452 and 410.453. MassHealth does not permit incident to billing of speech-language pathology services by physicians or NPPs.

Plan of Care
All speech-language pathology services must be provided under a written plan of care (also known as a treatment plan) established individually for the member. The plan of care must be established before treatment is begun. For Medicare plan members, the plan of care must meet requirements specified in Medicare Benefit Policy Manual, Chapter 15, Section 220.1.2. For MassHealth ACO members, the plan of care must meet requirements in 130 CMR 432.416(C).

Speech-Language Pathology Assistants
Effective for dates of service on or after November 26, 2021, subject to the supervision requirements set forth in 130 CMR 432.000, MassHealth will reimburse for services of speech-language pathology assistants (SLPAs). This applies to both individually enrolled therapy providers and to therapy group practices under 130 CMR 432.404(E) (MassHealth Transmittal Letter THP-27, November 2021). This change in MassHealth policy regarding services rendered by therapy assistants also applies to the Plan's MassHealth ACO members.

Services of SLPAs are not eligible for coverage for Medicare members (Medicare Benefit Policy Manual, Chapter 15, Section 230.3 - Practice of Speech-Language Pathology).

Fallon Health does not cover services provided by SLPAs for Community Care members.

Flexibilities after the end of the Covid-19 Federal Public Health Emergency (FPHE) for MassHealth ACO members
Note: this section does not apply to Medicare or Community Care members.

MassHealth Therapist Bulletin 18 (April 2023) communicated provider requirements that were suspended during the COVID-19 FPHE and that will be enforced after the FPHE ends. This Bulletin also communicates changes in requirements implemented during the FPHE that will continue past the end of the FPHE and provides an update to telehealth policies for providers of therapy services. Therapist Bulletin 18 replaces all prior FPHE-related bulletins, specifically Therapist Bulletins 15, 16 and 17.

Verbal medical referral
For historical context prior to May 12, 2023, if a therapy provider was unable to secure a written prescription for the initiation and recertification of therapy services, the therapy obtained a verbal medical referral (oral prescription) from a physician or nurse practitioner. The written record of an oral prescription for therapy services included the date and time acquired, as well as the signature of the licensed therapist obtaining the oral prescription and must be maintained in the member's record. The therapy provider acquired the written prescription for therapy services before billing the Plan and complied with recordkeeping requirements of regulations 130 CMR 450.000 and 130 CMR 432.000.

On May 12, 2023, the flexibility, which allowed therapy providers to secure a verbal medical referral (oral prescription) for therapy services ended, and the Plan resumed applying the provisions of 130 CMR 432.415. This regulation provides that therapy providers must obtain a written prescription before a member can begin therapy services, and every 60 days thereafter.

Therapy telehealth guidance

After the end of the FPHE, consistent with the federal Consolidated Appropriations Act of 2023, the Plan will continue to cover speech-language therapy services provided via telehealth until December 31, 2024, or when specified by MassHealth via regulation or Congress. See Consolidated Appropriations Act, 2023, H.R.2617, Sec. 4113, 117th Cong. (2022).[1] Please see below for additional telehealth guidance for speech-language therapy services.

Service delivery requirements

The Plan is not imposing specific requirements for technologies used to deliver services via telehealth and will reimburse speech-language therapy services delivered via telehealth for MassHealth ACO members, as long as such services

- are medically necessary;
- are clinically appropriate;
- meet requirements within 130 CMR 432.000 and 130 CMR 450.000; and
- meet all additional requirements of the therapy telehealth guidance in MassHealth Therapist Bulletin 18.

Providers are encouraged to use appropriate technologies to communicate with individuals and should, to the extent possible, ensure the same rights to confidentiality and security as provided in face-to-face services. Providers must inform members of any relevant privacy considerations.

Telehealth visits may be used for speech-language therapy services that

- require the member's consent, documented as described below; and
- are follow-up visits that do not require any hands-on care.

Live video telehealth may be used, with the member's consent, to conduct the comprehensive evaluation or reevaluation under 130 CMR 432.411, 432.415, and 432.416 for MassHealth ACO members receiving speech-language therapy services.

Telehealth may not be used for any speech-language therapy service specifically requiring hands-on care.

Member consent

Providers must get verbal consent from a member, and the member's caregiver or legal guardian if applicable, before starting telehealth, and must document the consent in the member's record.

When requesting the member's consent, MassHealth speech and language therapy providers must provide the member with a statement explaining

- what a telehealth visit entails;
- what is expected from the member and the therapy provider;
- any relevant privacy considerations; and
- that the member may take back their consent for telehealth services at any time.

Information provided to members should be given in their preferred method of delivery and must be documented within the members' medical record.

Billing instructions and payment rates for therapist services delivered via telehealth

Speech and language therapy providers must include Place of Service 02 or 10 and modifier "GT" when submitting claims for services delivered via telehealth. See **Billing/coding guidelines** below for procedure codes payable via telehealth (i.e., when submitted with modifier GT).

Rates of payment for speech-language therapy services delivered via telehealth will be the same as rates of payment for speech-language therapy services delivered via traditional (e.g., in-person) methods.

[1] Congress has extended the Medicare fee-for-service telehealth flexibilities that were originally implemented during the COVID-19 public health emergency multiple times, with the latest extension expiring January 31, 2026.

Failure to include modifier “GT” when submitting claims for Speech-Language Services delivered via telehealth may result in the imposition of sanctions pursuant to 130 CMR 450.238-450.240.

Important note: Although MassHealth allows reimbursement for delivering of certain services through telehealth, MassHealth does not require providers to deliver services via telehealth.

Documentation of telehealth services and encounter requirements
All documentation requirements of 130 CMR 450.000 and 130 CMR 432.000 apply when services are delivered via telehealth. The documentation must also include in the visit note:

- that the service was provided via telehealth; and
- a description of the rationale for service via telehealth.

Failure to maintain documentation requirements for services delivered via telehealth, may result in the sanctions pursuant to 130 CMR 450.238–240.

CMS flexibilities to fight COVID-19 for Fallon Medicare Plus, NaviCare, PACE and Community Care members
CMS waived the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners who may bill for their services when furnished as Medicare telehealth services from a distant site. The waiver of these requirements expands the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services. As a result, a broader range of practitioners, such as physical therapists, occupational therapists, and speech language pathologists can use telehealth to provide many Medicare services. After the PHE ends, the Consolidated Appropriations Act, 2023 provides for an extension for this flexibility through December 31, 2024 (Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19, available at: https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf).[2]

Reimbursement

Speech therapy services are reimbursed according to fee schedule arrangements.

Speech-language pathologist assistant services for MassHealth ACO members
Speech-language pathologist assistant services provided to MassHealth ACO members must be billed under the name and NPI of the supervising speech-language pathologist.

For MassHealth ACO members, in accordance with 130 CMR 432.425, the Plan only pays for those speech-language therapy services for which the therapist has obtained a written prescription from the member’s prescribing provider. Electronic prescriptions (e-scripts) are allowable if they comply with state and federal requirements and are transmitted by the member’s prescribing provider in accordance with the MassHealth agency’s administrative and billing instructions.

HCPCS codes V5362, V5363 and V5364
Effective for dates of service on or after March 1, 2022, the following HCPCS codes will deny vendor liable for all lines of business:

Code	Description
V5362	Speech screening
V5363	Language screening
V5364	Dysphagia screening

[2] Congress has extended the Medicare fee-for-service telehealth flexibilities that were originally implemented during the COVID-19 public health emergency multiple times, with the latest extension expiring January 31, 2026.

Speech-language pathology services provided incident to the services of physicians and non-physician practitioners for Fallon Medicare Plus, NaviCare, PACE and Community Care plan members

A speech-language pathologist may be licensed under State law to perform speech-language therapy services without physician supervision and have the service separately covered and reimbursed by the Plan as a speech-language pathology service. In order to have that same service covered as incident to the services of a physician or nonphysician practitioners (NPP) for Medicare or Community Care plan members, the service must be performed under the direct supervision of the physician/NPP, as an integral part of the physician/NPP's personal service. Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in Medicare Benefit Policy Manual, Chapter 15, Section 230.5, and also in Chapter 15, Section 60.

- NPP means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services (Medicare Benefit Policy Manual, Chapter 15, Section 220).
- The therapy services provided must relate directly to the physician/NPP service to which they are incident. This means that must have been a direct, personal, professional service furnished by the physician/NPP to initiate the course of treatment of which the therapy service being performed by the speech-language pathologist is an incidental part, and there must be subsequent services by the physician/NPP of a frequency that reflects the physician/NPP's continuing active participation in and management of the course of treatment.
- This does not mean that to be considered incident to, each occasion of service by speech-language pathologist needs also always be the occasion of an actual rendition of a personal professional service by the physician/NPP. Such a service could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.
- The direct supervision requirement must be met with respect to every nonphysician service. Direct supervision means that the supervising physician/NPP must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician/NPP must be present in the same room in the office where the service is performed.
- For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure as defined in Medicare Benefit Manual, Chapter 15, Section 230.3 (B) does not apply; all other personnel qualifications do apply.
- The supervising physician or NPP must be legally authorized to practice speech-language pathology services by the state in which he or she performs direct supervision.
- Services must be furnished under a plan of care as described in section 220.1.2 of Chapter 15 of the Medicare Benefit Manual.
- Speech-language pathology services provided incident to the services of physicians and NPPs apply to therapy services performed in the physician/NPP's office.

Multiple procedure payment reduction for outpatient therapy services for Fallon Medicare Plus, NaviCare, PACE and Community Care plan members

Effective for dates of service on or after April 1, 2026, the Plan applies a multiple procedure payment reduction (MPPR) to professional claims for therapy codes with a Multiple Procedure (MULT PROC) Indicator of "5" on the Medicare Physician Fee Schedule (MPFS). Therapy codes with a Multiple Procedure (MULT PROC) Indicator of "5" on the Medicare Physician Fee Schedule (MPFS) are "always therapy" codes.

- The MPPR applies to claims submitted on the same date of service for the same member by the same provider. For therapy services furnished by a group practice or incident to a physician's service, the MPPR applies to all services furnished to a patient on the same day,

regardless of whether the services are provided in one therapy discipline or multiple disciplines, e.g., physical therapy, occupational therapy, or speech-language pathology.
- Eligible therapy procedures will be grouped based on the same member and same date of service. Within a “group,” claim lines will be sorted and ranked according to the highest non-facility Practice Expense RVU. For the procedure code that is ranked first and submitted with a quantity of one, no reduction will be applied. To determine which services will receive the MPPR, the Plan will rank services according to the applicable practice expense (PE) relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services**.**

Outpatient therapy services provided by skilled nursing facilities and home health agencies to Medicare members with Part B coverage
When allowed by their provider contract with the Plan, SNFs and home health agencies may provide outpatient therapy services under a therapy plan of care to Medicare members with Medicare Part B coverage in accordance with Medicare Benefit Policy Manual Chapter 15, Sections 220 and 230 and Medicare Claims Processing Manual, Chapter 5. Outpatient therapy services provided under a therapy plan of care must be billed with therapy procedure codes (CPT/HCPCS) therapy revenue codes (042X, 043X, 044X), therapy modifiers (GN, GO and GP) and therapy assistant modifiers (CQ and CO), as applicable.
- SNFs may bill for outpatient therapy services provided to residents who are not in a covered SNF stay and to nonresidents who are receiving outpatient rehabilitation services from the SNF.
- Home health agencies may bill for outpatient therapy services provided to patients who are not homebound or otherwise receiving services under a home health plan of care.

Referral/notification/prior authorization requirements

Referral and prior authorization requirements vary according to product; contact Customer Service for eligibility and benefits.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering provider must be reported on the claim.

Unlisted codes require prior authorization from the Plan.

Billing/coding guidelines

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider. The principal diagnosis code must best describe the patient's condition for which the service was performed.

Providers are required to report line item dates of service for outpatient rehabilitation services. Claim lines that span two or more dates and claim lines without dates of service are subject to denial.

Speech-Language Pathologist Assistant Services for MassHealth ACO Members
Services provided to MassHealth ACO members by speech-language pathologist assistants must be billed under the name and NPI of the supervising speech-language pathologist.

Therapy modifiers
To align with the Centers for Medicare & Medicaid Services (CMS), effective for dates of service on or after March 1, 2021, the Plan will require therapy modifiers on all claims for outpatient therapy services. This requirement applies to providers submitting professional claims (CMS-1500) including physicians, qualified non-physician practitioners (physician assistants, nurse practitioners, and certified nurse specialists), physical therapists in private practice (PTPPs), occupational therapists in private practice (OTPPs), speech-language pathologists in private practice (SLPPs), as well as to providers submitting institutional claims (UB-04), including acute outpatient hospitals, comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs) and home health agencies.

Claims for outpatient physical, and occupational therapy and speech-language pathology services must include one of the following modifiers to identify the plan of care under which the service was delivered:

- GP modifier – Services delivered under an outpatient physical therapy plan of care; or
- GO modifier – Services delivered under an outpatient occupational therapy plan of care.
- GN modifier - Services delivered under a speech-language therapy plan of care

Only one of these modifiers is allowed per claim line.

Claims containing any of the “always therapy” codes must always be furnished under an SLP, OT or PT plan of care, regardless of who furnishes them; as such, must always be accompanied by one of the therapy modifiers (GN, GO, GP). All outpatient therapy services furnished by therapists in private practice are always considered therapy services, regardless of whether they are designated as “always therapy” or “sometimes therapy,” and the appropriate therapy modifier must be included on the claim. It may be clinically appropriate for physicians and NPPs to furnish outpatient therapy services that have been designated “sometimes therapy” outside of a therapy plan of care – in these cases, therapy modifiers are not required (Transmittal R3936CP).

Effective for dates of service on or after April 1, 2026, the Plan has implemented edits that will deny professional claims for “always therapy” codes when they do not contain the appropriate therapy modifier for the applicable HCPCS code, regardless of the provider who furnishes them.

All outpatient therapy services furnished by physical therapists, occupational therapists or speech-language pathologists, regardless of whether they are designated as “always therapy” or “sometimes therapy” are considered therapy services and must be delivered under a therapy plan of care. Effective for dates of service on or after April 1, 2026, the Plan has implemented edits that will deny professional claims outpatient therapy services furnished by physical therapists, occupational therapists or speech-language pathologists when the claim line does not contain the appropriate therapy modifier for the applicable HCPCS code.

Institutional claims for outpatient physical, occupational or speech-language pathology services delivered under a therapy plan of care, may only report revenue code 042X with claim lines containing the GP modifier, revenue code 043X with claim lines containing the GO modifier and revenue code 044X with claim lines containing the GN modifier, along with the procedure code for the service.

Effective for dates of service on or after July 1, 2026, the Plan will deny institutional claims for outpatient therapy services that do not meet this requirement will be returned to the provider.

Reporting of service units with HCPCS

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (“untimed” HCPCS), the provider enters “1” in the field labeled units. For timed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition.

To eliminate improper payment for outpatient therapy services, the Plan has implemented edits, effective for dates of service on or after April 1, 2026, which will deny claims for “untimed” service codes billed with units exceeding the allowed units. Some untimed codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP). Effective April 1, 2026, the Plan has implemented edits which will deny an untimed code billed by the wrong discipline.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report these “timed” procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15 minute units of service.

For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23

minutes, through and including 37 minutes, then 2 units should be billed. When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed. Refer to Medicare Claims Processing Manual, Chapter 5, Section 20.2. D. for examples of how to count the appropriate number of units for the total therapy minutes provided.

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as “intra-service care” begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated.

Modifiers for speech-language therapy services for MassHealth ACO Members
The following modifiers must be used on claims for speech-language therapy services for MassHealth ACO members in accordance with MassHealth Therapist Manual Subchapter 6.

Modifier	Description
HA	Service provided to patients aged 21 years or younger
TF	Service provided to developmentally disabled adults aged 22 years of age and older

Outpatient cognitive rehabilitation services (CPT 97129 And 97130) for Community Care members
Cognitive rehabilitation, as a distinct and definable component of the rehabilitation process, may be considered medically necessary in the rehabilitation of plan members with cognitive impairment due to COVID-19.

As required by Section 70 of Chapter 260 of the Acts of 2020, effective for dates of service on or after 01/01/2021, Fallon Health will waive cost-sharing for commercial plan members for cognitive rehabilitation (CPT 97129 and 97130) related to the treatment of COVID-19 when provided by both in-network and out-of-network providers.

Massachusetts Division of Insurance (DOI) Bulletin 2021-08 further requires these services to be provided without the use of prior authorization processes.

Per ICD-10-CM instructions, for sequela of COVID-19, assign a code(s) for the specific symptom(s) or condition(s) first, followed by U09.9, Post COVID-19 condition, unspecified, in a secondary position.

- For dates of service 01/01/2021 through 09/30/2021, ICD-10-CM diagnosis code B94.8, Sequelae of other specified infectious and parasitic diseases, will waive cost-sharing.
- For dates of service 10/01/2021 and onward, ICD-10-CM diagnosis code U09.9, Post COVID-19 condition, unspecified, will waive cost-sharing.

Code	Description
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and

	sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)

Speech-language therapy services procedure codes
The following codes are included for informational purposes only. Inclusion or exclusion of a code does not constitute or imply coverage or reimbursement.

Note: Additional information on billing and coding for speech-language pathology services for Medicare members can be found in National Government Services, Inc. Local Coverage Article Billing and Coding: Speech-Language Pathology A52866.

MPFS (Medicare Physician Fee Schedule) Relative Value Files available at: https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files.

Code	Description	Comments
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	
92508	Treatment of speech, language, voice, communication and/or auditory processing disorder; group, two or more individuals	
92521	Evaluation of speech fluency (eg, stuttering, cluttering)	
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);	
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	
92524	Behavioral and qualitative analysis of voice and resonance	
92526	Treatment of swallowing dysfunction and/or oral function for feeding	
92605	Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; first hour	Not separately reimbursed (NSR) for Medicare Advantage, Fallon Health Weinberg PACE and Community Care members (MPFS SI = B).
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	Not separately reimbursed (NSR) for Medicare Advantage, Fallon Health Weinberg PACE and Community Care members (MPFS SI = B).

		Nonpayable for MassHealth ACO members (Therapist Manual Subchapter 6 THP-26 eff 8/1/21).
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour (maximum one unit per evaluation)	
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure) (service code may only be billed after 92607) (maximum two unit per evaluation)	
92609	Therapeutic services for the use of speech-generating device, including programming and modification (maximum one unit per visit)	
92610	Evaluation of oral pharyngeal swallowing function	
92618	Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	Not separately reimbursed (NSR) for Medicare Advantage, Fallon Health Weinberg PACE and Community Care members (MPFS SI = B). Nonpayable for MassHealth ACO members (Therapist Manual Subchapter 6 THP-26 eff 8/1/21).
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Nonpayable for MassHealth ACO members (Therapist Manual Subchapter 6 THP-26 eff 8/1/21).
97130	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or	Nonpayable for MassHealth ACO members (Therapist Manual Subchapter 6

	schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)	THP-26 eff 8/1/21).

Speech-language pathology services that may be delivered via telehealth for MassHealth ACO members until January 30, 2026
In accordance with MassHealth Therapist Bulletin 19, issued April 2023, the Plan will cover the following speech-language therapy services when provided via telehealth until December 31, 2024, or when specified by MassHealth via regulation or Congress.

Providers must include Place of Service 02 or 10 and modifier "GT" when submitting claims for speech-language therapy services delivered via telehealth. For additional requirements, refer to "Flexibilities After the End of the COVID-19 Federal Public Health Emergency (FPHE) for MassHealth ACO Members" in the **Policy** section above.

Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding (maximum one unit per visit)
92605	Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; first hour
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour (maximum one unit per evaluation)
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure) (service code may only be billed after 92607) (maximum two unit per evaluation)
92609	Therapeutic services for the use of speech-generating device, including programming and modification (maximum one unit per visit)
92610	Evaluation of oral and pharyngeal swallowing function (per hour, maximum of one hour)

Policy history

Origination date: 04/01/2016
Previous revision date(s): 07/01/2016 – Introduced policy.

Connection date & details:	May 2017 – Updated authorization requirements and added GN modifier. July 2018 – Annual review, no updates. July 2019 – Annual review, no updates. June 1, 2020 - Updates for COVID-19 for MassHealth ACO and NaviCare in accordance with MassHealth LTSS guidance. June 26, 2020 - Updates for COVID-19 for Summit ElderCare in accordance with MassHealth LTSS guidance. January 2021 - Added requirement for therapy modifier on claims for speech therapy services July 2021 – Clarified modifier requirements under Billing/coding guidelines. January 2022 – Updated to include coverage for services of speech-language pathology assistants (SLPAs) for MassHealth members for dates of service on or after November 26, 2021; notification that HCPCS codes V5362, V5363, V5364 will deny vendor liable effective for dates of service on or after March 1, 2022. April 2022 – Billing/coding guidelines updated to include cognitive rehabilitation services. January 2024 – Policy updated to include subsections for (1) flexibilities after the end of the COVID-19 FPHE for MassHealth ACO members, and (2) CMS flexibilities for Medicare Advantage, NaviCare and PACE plan members; added new subsection for incident to services under Reimbursement; updated procedure code table under Billing/coding guidelines and added new table for SLP services that may be delivered via telehealth for MassHealth ACO members. January 2026 – Under Reimbursement, added new section for Multiple Procedure Payment Reduction for Outpatient Therapy Services for Fallon Medicare Plus, NaviCare, PACE and Community Care Members; under Billing/coding guidelines, updated Therapy Modifiers section and added new section for Reporting of Service Units with HCPCS.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply, and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.