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Insurance Survival Kit

for SLPs in Private Practice

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Verification of Benefits Tips

Calling a payer to get coverage confirmation can be tricky. Here's a handy list of tips, information you'll need, and a script for when you get a representative on the phone.

TIPS:

- Avoid calling on Monday. Wednesday is the best day to call.
- Put it on your calendar. Call early or late, not at lunchtime.
- Be prepared. Have all of the info you know that they're going to ask for. Verify coverage for multiple clients at once.
- Check multiple service codes for each new client.
- Press "0" or say representative to skip electronic prompts.
- ALWAYS collect the name of the representative, a call reference number, and a callback number/the number you're being transferred to before you let someone end the call.
- Don't hesitate to call back and speak with another rep or a supervisor.

INFO CHECKLIST:

- ☐ Billing NPI
- ☐ Practice Address
- ☐ Payer specific provider number (if applicable)
- ☐ Client's full name
- ☐ Client's date-of-birth
- ☐ Client's subscriber ID
- ☐ Client's complete address or phone number

SCRIPT:

1. On the automated prompt indicate that you need to be connected with Provider Services.
2. "I would like to verify eligibility and benefits for Speech Therapy for a new client"
3. "Before we start, can you please confirm that I am an in-network provider for this client's plan. My billing NPI is-"
4. If the they are not in-network- verify whether they have OON coverage
5. "Please verify that you have the correct address for my practice. It is-"
6. "The subscriber ID, DOB, first and last name, and client address are..."
7. "I need to confirm the following CPT codes..."
8. "I want to confirm whether there is a number of visit limitation or authorization required for any of these services"
9. "What will the client pay for these services? Is there a copay?"
10. "Does this client have an outstanding deductible? If yes, how much have they accumulated towards it and how much is left?"
11. "What is this client's out of pocket maximum?"
12. "When did this policy begin and when will it end?"
13. "What address or electronic payer ID should I file these claims to?"
14. "Can you please provide me with your name and a call reference number?"

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Speech-Language Pathology Insurance Codes

CPT Codes	SERVICES THAT YOU PROVIDE AND ARE ALLOWED TO CHARGE FOR CPT stands for Current Procedural Terminology. These codes are created and reviewed each year by the American Medical Association.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Group, two or more individuals
92511	Nasopharyngoscopy with endoscope (separate procedure)
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
92521	Evaluation of speech fluency (stuttering, cluttering)
92522	Evaluation of speech sound production (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
92610	Evaluation of oral and pharyngeal swallowing function
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96110	Developmental screening, with interpretation and report, per standardized instrument form
96111	Developmental (including assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Each additional 30 minutes (List separately in addition to code for primary procedure.)

*Coding rules may vary based on the insurance companies you work with, and will also change over time, so make sure your codes are up to date. This guide is put together considering the CMS Medicare billing standards (6/2019).

G-Codes* Non-payable progress codes	CURRENT STATUS at initial therapy treatment/ outset and reporting intervals	PROJECTED GOAL STATUS at initial therapy treatment/outset and at discharge from therapy	DISCHARGE STATUS at discharge from therapy/end of reporting on limitation
Swallowing	G8996	G8997	G8998
Motor Speech	G8999	G9186	G9158
Spoken Language Comprehension	G9159	G9160	G9161
Spoken Language Expression	G9162	G9163	G9164
Attention	G9165	G9166	G9167
Memory	G9168	G9169	G9170
Voice	G9171	G9172	G9173

*As of January 1, 2019 Medicare does not require Functional Limitation Reporting. Other payers may still elect to continue the requirement.

G-Code Modifier	IMPAIRMENT LIMITATION RESTRICTION**	FCM LEVEL Functional Communication Measures
CH	0%	7
CI	At least 1% but less than 20%	6
CJ	At least 20% but less than 40%	5
CK	At least 40% but less than 60%	4
CL	At least 60% but less than 80%	3
CM	At least 80% but less than 100%	2
CN	100%	1

CPT Modifiers	USED TO GIVE MORE CONTEXT FOR A SERVICE PROVIDED
GN	Rendered under a speech-language pathology or dysphagia plan of treatment
KX	Continuation of services medically necessary and documentation is available to review
22	Length of treatment was extended significantly under atypical pretenses
52	Abbreviated length of treatment
59	Distinguishes one procedure from the other (when billing two similar procedures on the same day)

**Amount patient is impaired, limited, or restricted. Every G-Code must include a modifier.