National Imaging Associates, Inc.*	
Clinical guidelines **OUTPATIENT HABILITATIVE AND REHABILITATIVE SPEECH THERAPY**	**Original Date: November 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: December 2021**
Guideline Number: NIA_CG_602	**Implementation Date: July 2022**

Policy Statement

Habilitative speech therapy services may or may not be covered by all clients of this organization. If the service is covered, it may or may not require prior authorization. These guidelines apply to all markets and populations, including teletherapy, contracted with this organization through the corresponding state health plans unless a market-specific health plan has been developed. These services must be provided by a skilled and licensed therapy practitioner and in a manner that is in accordance with accepted standards of practice for discipline-specific therapies. It must also be clinically appropriate in amount, duration, and scope to achieve their purpose and considered effective treatment for the current injury, illness, or condition.

Habilitative/Rehabilitative speech therapy should meet the definitions below, be provided in a clinic, an office, at home, or in an outpatient setting and be ordered by either a primary care practitioner or specialist.

Scope

Physical medicine practitioners, including speech language pathologists and speech therapist assistants

Definition

Habilitative Speech Therapy

Treatment provided by a state-regulated speech therapist to help a person attain, maintain, or prevent deterioration of a skill or function never learned or acquired. There must be measurable improvement and progress towards functional goals within an anticipated timeframe toward a patient's maximum potential. Treatment may also be appropriate in a child with a progressive disorder when it has the potential to prevent the loss of a functional skill or enhance the adaptation to such functional loss. The condition must be such that there is a

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reasonable expectation that the services will bring about a significant improvement within a reasonable time frame, regardless of whether the individual has a coexisting disorder. Ongoing treatment is not appropriate when functioning is steady and treatment no longer yields measurable functional progress.

Rehabilitative Speech Therapy

Treatment provided by a state-regulated speech therapist designed to help a person recover from an acute injury or exacerbation of a chronic condition that has resulted in a decline in functional performance. The specific impact of injury or exacerbation on the patient's ability to perform in their everyday environment must be supported by appropriate tests and measures in addition to clinical observations. Services must be provided within a reasonable time frame (frequency/duration) to restore lost function or to teach compensatory techniques if full recovery of function is not possible.

Functional Skills

They are considered necessary communication activities of daily life. The initial plan of care documents baseline impairments as they relate to functional communication with specific goals developed that are measurable, sustainable and time-specific. Subsequent plans of care document progress toward attainment of these goals in perspective to the patients' potential ability. Discontinuation of therapy will be expected when the maximum therapeutic value of a treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value.

National Imaging Associates will review all requests resulting in adverse determinations for Medicaid members for coverage under federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.[1, 2]

INDICATIONS

- Must have written referral from primary care practitioner or other non-physician practitioner (NPP) as permitted by state guidelines.
- Speech therapy initial evaluation and re-evaluations must include age-appropriate standardized tests, documenting a developmental delay or condition that are:
    - Standard/composite score that is ≥ 1.5 standard deviations below the mean
    - Age equivalency scores will be accepted to meet this criterion. To constitute the basis for coverage of habilitative speech therapy, the age equivalency testing must show at least a 25% delay based upon the age of the member in months.
        - When a -1.5 standard deviation or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
        - While providers may include age equivalents, percent delay, or scaled scores in their evaluation summaries, they will not necessarily be accepted as a

measure of developmental delay. Standard deviations gathered from standardized testing are preferred. Raw scores are not sufficient to interpret the measure of standard deviation from the mean on formal assessments.

- While standardized testing is preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention. Test information must be linked to difficulty with or inability to perform everyday tasks.[3]
- In the absence of standardized testing, the report must include detailed clinical observations of current skill sets, parent interview/questionnaire and/or informal assessment supporting functional communication deficits and the medical need for skilled services. The documentation must clearly state the reason formal testing could not be completed.

- Treatment goals must be realistic, measurable, and promote attainment of developmental milestones and functional communication abilities appropriate to the patient's age and circumstances. They should include the type, amount, duration, and frequency of therapy services.[4] The amount, frequency, and duration of the services must be consistent with accepted standards of practice. Treatment goals must be individualized and measurable in order to identify the functional levels related to appropriate maintenance or maximum therapeutic benefit. Goals of intervention should target the functional deficits identified by the skilled therapist during the assessment and promote attainment of:
    - Age-appropriate developmental milestones, functional skills appropriate to the patient's age and circumstances. Although identified as component parts of participation, underlying factors, performance skills, client factors or the environment should not be the targeted outcome of long-term goals. For sustained positive benefits from therapeutic interventions, activities can be practiced in the child's environment and reinforced by the parents or other caregivers. Practice in one's natural environment is essential for success.[5]
    - The plan of care must include goals detailing type, amount, duration, and frequency of therapy services required to achieve targeted outcomes. The frequency and duration must also be commensurate with the patient's level of disability, medical and skilled therapy needs, as well as accepted standards of practice while reflecting clinical reasoning and current evidence.[4]

- Frequency and duration of skilled services must also be in accordance with the following:
    - Intense frequencies (3x/week or more) will require additional documentation and testing supporting a medical need to achieve an identified new skill or recover function with specific, achievable goals within the requested intensive period.4 Details on why a higher frequency is more beneficial than a moderate or low frequency must be included. Higher frequencies may be considered when delays are classified as severe as indicated by corresponding testing guidelines used in the evaluation. More intensive frequencies may be necessary in the acute phase,

however, progressive decline in frequency is expected within a reasonable time frame.
    - Moderate frequency (2x/week) should be consistent with moderate delays as established in the general guidelines of formal assessments used in the evaluation. This frequency may be used for ongoing care when documentation supports this frequency as being clinically effective toward achieving the functional goals in the treatment plan within a reasonable time frame.
    - Low frequency (1x/week or less) may be considered when testing guidelines indicate mild delays or when a higher frequency has not been clinically effective and a similar outcome is likely with less treatment per week.
    - All requested frequencies must be supported by skilled treatment interventions regardless of level of severity of delay.
    - Additional factors may be considered on a case-by-case basis.

- There must be evidence as to whether the services are considered reasonable, effective, and of such a complex nature that they require the technical knowledge and clinical decision-making skill of a therapist or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.
    - Treatment that requires the technical knowledge and clinical decision-making expertise to meet the skilled service needs of the individual. This includes analyzing medical/behavioral data and selecting appropriate evaluation tools/protocols to determine communication/swallowing diagnosis and prognosis.
    - Progress notes/updated plans of care that cover the patient's specific progress towards their goals with review by the primary care practitioner or other NPP will be required every 60-90 days or per state guidelines. Documentation should include:
        - The patient's current level of function, any conditions that are impacting his/her ability to benefit from skilled intervention.
        - Objective measures of the patient's overall functional progress relative to each treatment goal as well as a comparison to the previous progress report.
        - Skilled treatment techniques that are being utilized in therapy as well as the patient's response to therapy and why there may be a lack thereof. Treatment goals that follow a hierarchy of complexity to achieve the target skills for a functional goal.
        - Re-evaluation/annual testing (for habilitative therapy) using formal standardized assessment tools and formal assessment of progress must be performed to support progress, ongoing delays and medical necessity for continued services.
        - An explanation of any significant changes in the plan of care and clinical rationale for why the ongoing skills of a SLP are medically necessary.
    - In the case of maintenance programs, clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided.

The notes must also clearly demonstrate that the specialized judgment, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.

- If the patient is not progressing, then documentation of a revised treatment plan is necessary. Discontinuation of therapy will be expected when the maximum therapeutic value of a treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value.
- It is expected that a specific discharge plan, with the expected treatment frequency and duration, must be included in the plan of care. The discharge plan must indicate the plan to wean services once the patient has attained their goals, if no measurable functional improvement has been demonstrated, or if the program can be carried out by caregivers or other non-skilled personnel.
- It is expected that there be evidence of the development of age-appropriate home regimen to facilitate carry-over of target skills and strategies and education of patient, family, and caregiver in home practice exercises, self-monitoring as well as indication of compliance for maximum benefit of therapy.
- For patients no longer showing functional improvement, a weaning process of one to two months should occur. Behaviors that interfere with the ability to progress with therapy qualify under the ASHA discharge criteria guidelines.[6] If the patient shows signs of regression in function, the need for skilled speech therapy can be re-evaluated at that time. Periodic episodes of care may be needed over a lifetime to address specific needs or changes in condition resulting in functional decline.
- For patients whose language background differs from the rendering therapist and in situations in which a clinician who has native or near-native proficiency in the target language is not available, use of an interpreter is appropriate and should be documented accordingly. If an interpreter is not present, rationale for this should be documented. Further, the assessment must contain appropriate tests and measures to clearly denote the presence that a communication disorder is present as opposed to normal linguistic variations related to second language learning.[7, 8]
- Swallowing disorders (dysphagia) and feeding disorders will need documentation of an oral, pharyngeal, and/or esophageal phase disorder, food intolerance or aversion. There must be evidence of ongoing progress and a consistent home regimen to facilitate carry-over of target feeding skills, strategies and education of patient, family, and caregiver. Therapies for picky eaters who can eat and swallow normally meeting growth and developmental milestones, eat at least one food from all major food groups (protein, grains, fruits, etc.) and more than 20 different foods is not medically necessary.
- Documentation should include any applicable coordination of services with other community service agencies and/or school systems. If services are not available, then this should be indicated in the documentation.

- Treatment that includes goals for reading/literacy must also have a primary diagnosis of a speech or language disorder. Documentation must support that the deficits in reading/literacy are affecting functional activities of daily living and are not the primary focus of treatment. They must show how the services for reading/literacy are of such a complex nature that they require the skills of a speech language pathologist.

POLICY HISTORY

Date	Summary
December 2021	• Added "General Information" statement • Added "resulting in adverse determinations" to EPSDT statement • Reworded for clarity indication regarding bilingual patients (patients whose language background differs from rendering therapist) • Added criteria stating that treatment including goals for reading/literacy must have primary diagnosis of speech or language disorder with documentation support showing how services for reading/literacy require skills of a speech language pathologist
August 2020	• Changed guideline name to include 'rehabilitative': Outpatient Habilitative and *Rehabilitative* Speech Therapy • Added to definition of Habilitative and Rehabilitative Therapy • Criteria for delay was revised to include clearer and more detailed specifications for functional delays, preferred scoring, and what is required in the absence of standardized testing. • Additional specifications included for linking testing to the treatment goals, inclusion of functional treatment goals, utilizing appropriate dosing of therapy and specifying skilled interventions. • Moved coordination with school program to end of guideline. • Added EPSDT language in policy statement section • Added indication of home program compliance for max benefit of therapy as part of updated POC • Added ASHA guideline for discharge qualification due to behavior • Added teletherapy to the policy statement • Formatted and adjusted language to match the PT/OT habilitative guideline where applicable
January 2020	• Added the *italicized* clauses as follows: For bilingual patients whose primary language differs from the rendering therapist and in situations in which a clinician who has native or near-native proficiency in the target language is not available, use of an interpreter is appropriate and should

	be documented accordingly. If an interpreter is not present, rationale for this should be documented. Further, the assessment must contain appropriate tests and measures to clearly denote the presence that a communication *disorder is present in both languages*, as opposed to normal linguistic variations *or a language learning problem for the non-dominant language.*
July 2019	• Added the following definition for rehabilitative speech therapy: Rehabilitative Speech Therapy Treatments provided by a state-regulated speech therapist designed to improve, maintain, and prevent the deterioration of skills and functioning for daily living that have been lost or impaired. • Added the following to the definition of functional skills: Discontinuation of therapy will be expected when the maximum therapeutic value of a treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value. • Speech therapy initial evaluation revised to require developmental delay or condition that has a standard/composite score that is ≥ 1.5 standard deviations below the mean • Clarified "picky eater" to state that for those who can eat and swallow normally meeting growth and developmental milestones, eat at least one food from all major food groups (protein, grains, fruits, etc.) and more than 20 different foods outpatient habilitative ST is not medically necessary

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ADDITIONAL RESOURCES

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Reviewed/Approved by NIA Clinical Guideline Committee

GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.