National Imaging Associates, Inc.		
Clinical guidelines OUTPATIENT HABILITATIVE SPEECH THERAPY	Original Date: Page 1 of 4	November 2015
Physical Medicine – Clinical Decision Making	Last Review Date:	September 2017
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Policy Statement

Habilitative Speech Therapy may or may not be covered by all clients. If the service is covered it may or may not require a prior authorization. Habilitative 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.

Initial Clinical Reviewers (ICRs) and Physician Clinical Reviewers (PCRs) must be able to apply criteria based on individual needs and based on an assessment of the local delivery system.

Purpose

To provide guidelines for the use of habilitative speech therapy.

Scope

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

Definition

Habilitative Speech Therapy

Treatment provided by a state-regulated speech therapist for conditions resulting in a delay in speech development including impaired articulation, fluency, resonance, receptive or expressive language. 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. Ongoing treatment is not appropriate when a steady state of sensorimotor functioning has yielded no measurable functional progress.

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.

Guidelines

1. Must have written referral from primary care practitioner or other non-physician practitioner (NPP) as permitted by state guidelines.

2. Speech therapy initial evaluation and re-evaluations must include age appropriate standardized tests, documenting a developmental delay or condition that are:
    a. At or below the 10th percentile or ≥ 1.5 standard deviations below the mean in at least one subtest area or composite score
    b. 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. Documentation of the reason a standardized test could not be used must be included in the evaluation.

3. This organization advises that patients be evaluated by and/or be coordinating speech therapy services with other community service agencies and/or school system when available. The extent of these services must be indicated in the documentation. If services are not available then this should be indicated in the documentation.

4. Treatment goals must be realistic, measurable and promote attainment of developmental milestones and functional communication abilities appropriate to the patient's age and circumstances.

5. Documentation should clearly reflect why the skills of a therapist are needed. There must be evidence as to whether the services are considered reasonable, effective treatments requiring the skills of a therapist or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.

6. 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. If the patient is not progressing then documentation of a revised treatment plan is necessary.

7. 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.

8. 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 and self-monitoring.

9. For patients no longer showing functional improvement, a weaning process of one to two months should occur. 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.

10. 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 of a communication disorder, as opposed to normal linguistic variations.

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