| National Imaging Associates, Inc. | |
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| **Clinical guidelines**<br>**OUTPATIENT HABILITATIVE / REHABILITATIVE SPEECH THERAPY** | **Original Date: November 2015** |
| **Physical Medicine – Clinical Decision Making** | **Last Revised Date: January 2020** |
| **Guideline Number: NIA_CG_602** | **Implementation Date: July 2020** |

**Policy Statement**

Habilitative/ Rehabilitative 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/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 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. The condition must be such that there is a 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.

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.

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

**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. Documentation of the reason a standardized test could not be used must be included in the evaluation.*

- 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.

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 (Bailes 2008). The amount, frequency, and duration of the services must be consistent with accepted standards of practice.

There must be evidence as to whether the services are considered reasonable, effective and of such a complex nature that they require 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.

- 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.

- 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 and self-monitoring.

- 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.

- 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.

- 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

**POLICY HISTORY:**

**Review Date:** July 30, 2019

**Review Summary:**

- 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

**Review Date**: January 2020

**Review Summary:**

- Added the *italiced* 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.*

**REFERENCES**


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