SUPERIOR HEALTHPLAN

Specific policy administered by National Imaging Associates, Inc. (NIA)

Clinical guidelines for Superior HealthPlan Medicaid/CHIP Members OUTPATIENT HABILITATIVE AND REHABILITATIVE SPEECH THERAPY	
Physical Medicine – Clinical Decision Making	**Original Date:** November 2015
Guideline Number: NIA_CG_602	**Last Revised Date**: September 2021
	Last Reviewed Date (by NIA Committee): **October 2020**
	Implementation Date: September 2021

*** Refers to health plan specific language**

Policy Statement

Habilitative speech therapy services may or may not be covered **for** all **members** 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.

National Imaging Associates will **not deny** requests for Medicaid members **without consideration of** coverage under federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.

INDICATIONS

- Must have written referral from **practitioner physician** or other non-physician practitioner (NPP) as permitted by state guidelines.
- 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 member's specific progress towards their goals will be required every 60-90 days or per state guidelines.
- Clinical documentation should include:
  - The member's current level of function, any conditions that are impacting the member's ability to benefit from skilled intervention.
  - Objective measures of the member'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 member's response to therapy and why there may be a lack thereof.
  - Well defined, timebound, functional treatment goals that follow a hierarchy of complexity to achieve the target skills for a functional goal. Treatment goals must be realistic, measurable, and promote attainment of developmental milestones and functional abilities appropriate to the member's age and circumstances.
  - Goals of intervention should target the functional deficits identified by the skilled therapist during the assessment.
  - Re-evaluation/annual testing or more frequently if required by state guidelines (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.
- 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 member 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 member, family, and caregiver in home practice exercises, self-monitoring as well as indication of compliance for maximum benefit of therapy.
- For members 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 discharge criteria (ASHA). If the member 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 members 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 member, 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

DEVELOPMENTAL DELAY CRITERIA

To establish a developmental delay, all of the following criteria must be met:

- Tests used must be norm-referenced, standardized, and specific to the therapy provided.
- Retesting with norm-referenced standardized test tools for re-evaluations **must** occur yearly and may occur every 180 days. Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If reuse of the initial testing instrument is not appropriate, i.e. due to change in member status or restricted age range of the testing tool, provider should explain the reason for the change.
- Eligibility for therapy will be based upon a score that falls 1.5 standard deviations (SD) or more below the mean in at least one subtest area of composite score on a norm-referenced, standardized test. Raw scores must be reported along with score reflecting SD from mean.
- When the **member's** test score is less than 1.5 SD below the mean, a criterion-referenced test along with informed evidenced-based clinical opinion must be included to support the

medical necessity of services and will be sent to physician review to determine medical necessity.

- If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable functional short- and long-term goals will be considered along with test results. Documentation of the reason a standardized test could not be used must be included in the evaluation.

Specific developmental delay criteria requirements for speech diagnoses are as follows:

- **Language—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay**
- **Articulation—at least one norm referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay**
- **Apraxia—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay**
- **Fluency—at least one norm-referenced, standardized test with good reliability, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay**
- **Voice—an evaluation from a qualified specialist is required for eligibility and based on medical referral**
- **Oral Motor/Swallowing/Feeding—an in-depth, functional profile of oral motor structures and function and any impact to feeding development**

Additional speech therapy visits or sessions may be considered for moderate speech language, articulation, voice and dysphagia developmental delays when documentation submitted supports medical necessity as delineated in the frequency criteria in this guideline.

Frequency and Duration Criteria for ST Services

- **Frequency must always be commensurate with the member's medical and skilled therapy needs, level of disability and standards of practice; it is not for the convenience of the member or the responsible adult.**
- **Exceptions to therapy limitations may be covered if the medically necessary criteria are met for the following:**
  - **Presentation of new acute condition**
  - **Therapist intervention is critical to the realistic rehabilitative/restorative goal, provided documentation proving medical necessity is received.**
- **When therapy is initiated, the therapist must provide education and training of the member and responsible caregivers, by developing and instructing them in a home treatment program to promote effective carryover of the therapy program and management of safety issues.**

High Frequency

- **High frequency (3 times per week) can only be considered for a limited duration (approximately 4 weeks or less) or as otherwise requested by the prescribing provider with documentation of medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma, acute medical condition, or acute exacerbation of a medical condition, with well-defined specific, achievable goals within the intensive period requested.**
- **Therapy provided three times a week may be considered for 2 or more of these exceptional situations:**
  - **The member has a medical condition that is rapidly changing.**
  - **The member has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).**
  - **The member has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).**
  - **The member's therapy plan and home program require frequent modification by the licensed therapist.**
- **On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation:**
  - **Letter of medical need from the prescribing provider documenting the member's rehabilitation potential for achieving the goals identified.**
  - **Therapy summary documenting all of the following:**
    - **Purpose of the high frequency requested (e.g., close to achieving a milestone)**
    - **Identification of the functional skill which will be achieved with high frequency therapy**
    - **Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.**
- **A higher frequency (4 or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why 3 times a week will not meet the member's medical needs.**

Moderate Frequency

- **Therapy provided two times a week may be considered when documentation shows one or more of the following:**
  - **The member is making very good functional progress toward goals.**
  - **The member is in a critical period to gain new skills or restore function or is at risk of regression.**

- **The licensed therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.**
- **The member has complex needs requiring ongoing education of the responsible adult.**

Low Frequency

- **Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:**
  - **The member is making progress toward the member's goals, but the progress has slowed, or documentation shows the member is at risk of deterioration due to the member's development or medical condition.**
  - **The licensed therapist is required to adjust the member's therapy plan and home program weekly to every other week based on the member's progress.**
  - **Every other week therapy is supported for members whose medical condition is stable, they are making progress, and it is anticipated the member will not regress with every other week therapy.**

  Note: As the member's medical need for therapy decreases, it is expected that the therapy frequency will decrease as well.

Maintenance Level/Prevent Deterioration

- **For members who are 20 years of age and younger only, this frequency level (e.g., every other week, monthly, every 3 months) is used when the therapy plan changes very slowly, the home program is at a level that may be managed by the member or the responsible adult, or the therapy plan requires infrequent updates by the skilled therapist. A maintenance level or preventive level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments and consultations and the member meets one of the following criteria:**
  - **Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration.**
  - **The submitted documentation shows that the member may be making limited progress toward goals or that goal attainment is extremely slow.**
  - **Factors are identified that inhibit the member's ability to achieve established goals (e.g., the member cannot participate in therapy sessions due to behavior issues or issues with anxiety).**
  - **Documentation shows the member and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the member's needs.**
  - **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.

Criteria for Discontinuation of Therapy

- **Discontinuation of therapy may be considered in one or more of the following situations:**
  - **Member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.**
  - **Member has returned to baseline function.**
  - **Member can continue therapy with a home treatment program and deficits no longer require a skilled therapy intervention and, for members who are 20 years of age and younger only, maintain status.**
  - **Member has adapted to impairment with assistive equipment or devices.**
  - **Member is able to perform ADLs with minimal to no assistance from caregiver.**
  - **Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.**
  - **Member is unable to participate in the treatment plan or plan of care due to medical, psychological, or social complications; and responsible adult has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service.**
  - **Testing shows member no longer has a developmental delay.**
  - **Plateau in response to therapy/lack of progress towards therapy goals. Indication for therapeutic pause in treatments or, for those under age 21, transition to chronic status and maintenance therapy.**
  - **Non-compliance due to poor attendance and with member** or responsible adult, non-compliance with therapy and home treatment program.
  - Member has achieved 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.
  - For patients no longer showing functional improvement, a weaning process of one to two months may occur. If the patient shows signs of regression in function, the need for skilled physical or occupational therapy can be re-evaluated at that time. Periodic episodes of care may be needed over a lifetime

BACKGROUND

Definition

Habilitative Speech Therapy

- Treatment provided by a state-**licensed** 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 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 **licensed** 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 **member'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, **attainable, relevant and time-based (SMART format)** 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

POLICY HISTORY SUMMARIES:

July 30, 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

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.*

August 3, 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

September 15, 2021

- **Addition of language from Texas Medicaid Provider Procedures Manual related to frequency and duration, developmental delay**
- **Removal of age equivalency score references**
- **Removal of coordination of services section**
- **Moved background section to end of guideline**

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